

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Broken Bow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 West Jones Broken Bow, OK 74728	
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>33097</p> <p>Based on observation, record review, and interview, the facility failed to assess a resident for self-administration of medication for one (#54) of one sampled resident who was reviewed to self-administer medication.</p> <p>The administrator identified three residents who self-administered medications.</p> <p>Findings:</p> <p>A policy titled Self-Administration of Medication read in part, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .If it is deemed safe and appropriate for the resident to self-administer medications, this is documented in the medical record and the care plan .Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room.</p> <p>Resident #54 had diagnoses which included chronic obstructive pulmonary disease, reflux disease, and legal blindness.</p> <p>The care plan, dated 09/23/24, did not document self-administration of medication for the resident.</p> <p>The admission 5 day assessment, dated 09/27/24, documented the resident was cognitively independent and was independent with most ADLs.</p> <p>On 12/10/24 at 12:33 p.m., the resident was sitting on the side of the bed in their room. An inhaler (Spiriva HandiHaler inhaler), an over-the-counter bottle of cold medicine, and a tube of Cortisone 10 cream was on the resident's bedside table. The resident obtained an inhaler from their pocket and stated they had another inhaler for emergencies.</p> <p>On 12/10/24 at 3:52 p.m., LPN #1 reviewed the resident's clinical record and stated they could not locate a medication self-administration assessment record for the resident. The LPN stated if the resident self-administered medication an assessment should have been completed. The LPN stated they were aware of the inhaler at the bedside, but not other medications.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Broken Bow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  700 West Jones Broken Bow, OK 74728	
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 0554  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 12/10/24 4:17 p.m., the DON reviewed the resident's clinical record and stated no self-administration of medication assessment had been completed for the resident. The DON stated they were unaware the resident had medications at the bedside. They stated per policy the medication should stored in a safe and secure place, which was not accessible by other residents.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Broken Bow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  700 West Jones Broken Bow, OK 74728	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to ensure MDS assessments had been completed accurately for two (#10 and #12) of 15 sampled residents reviewed for MDS accuracy.</p> <p>A daily census, dated 12/09/24, documented 57 residents resided at the facility.</p> <p>Findings:</p> <p>A facility policy titled Certifying Accuracy of the Resident Assessment, dated November 2019, read in part, The information captured on the assessment reflects the status of the resident during the observation period (look back) period for the assessment.</p> <p>1. An active physician's order, dated 02/09/24, documented Resident #10 was admitted to long term care under the care a contracted hospice provider.</p> <p>A significant change assessment, dated 02/09/24, documented Resident #10 did not receive hospice services.</p> <p>An active physician's order, dated 09/14/24, documented staff were to assess and document the resident's status and collaborate with a contracted hospice provider.</p> <p>A quarterly MDS assessment, dated 11/11/24, documented in Section O that Resident #10 did not receive hospice services.</p> <p>On 12/11/24 at 2:00 p.m., the MDS coordinator stated the significant change and quarterly assessments for Residents #10 were inaccurate because Resident #10 was on hospice services during the time assessments were created.</p> <p>On 12/11/24 at 2:01 p.m., DON stated the significant change assessment was made because Resident #10 had started hospice services. They stated both the assessment were inaccurate.</p> <p>2. A physician's order, dated 10/08/22, documented the Resident #12 was to be administered Risperdal [an antipsychotic medication] 0.5 mg once daily. The order's discontinue date was 12/11/24.</p> <p>An active physician's order, dated 06/22/23, documented the resident was to be administered Risperdal 1 mg once daily.</p> <p>A MAR, dated 11/01/24 through 11/30/24, documented Resident #12 had been administered Risperdal 0.5 mg once daily and Risperdal 1 mg once daily on each date in that month.</p> <p>A quarterly MDS assessment, dated 11/21/24, documented in Section N that Resident #12 had not been administered an antipsychotic medication during the assessments look back period.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Broken Bow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  700 West Jones Broken Bow, OK 74728	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/11/24 at 11:45 a.m., the MDS coordinator stated the quarterly assessment for Resident #12 were inaccurate because they thought the question was asking if the resident had started an antipsychotic medication during the assessment look back period and not merely being administered the medication.</p> <p>On 12/11/24 at 11:53 a.m., the DON stated regarding Resident #12 quarterly assessment, the MDS coordinator had answered the questions about antipsychotic medication use incorrectly as they were new to the job and still learning. They stated they were in the process of teaching the MDS coordinator the material.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Broken Bow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  700 West Jones Broken Bow, OK 74728	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to provide ADL assistance with showers/baths for one (#9) of one sampled resident reviewed for ADL assistance.</p> <p>The administrator identified 55 residents resided in the facility.</p> <p>Findings:</p> <p>A policy titled Bath, Shower/Tub read in part, Documentation 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual (s) who assisted the resident with the shower/tub bath . Reporting 1. Notify the supervisor if the resident refused the shower/tub bath.</p> <p>Resident #9 had diagnoses which included hemiplegia and hemiparesis following a cerebral infarction and aphasia and dysphagia following a cerebral infarction.</p> <p>The care plan, dated 03/01/22, documented the staff were to assist the resident with a bath at least three times a week and per the resident's request. The care plan documented the resident was a two person assist with shower transfers.</p> <p>A quarterly assessment, dated 09/13/24, documented the resident had modified independent for daily decision making. It was documented the resident required moderate assistance with personal hygiene and supervision with showers/baths.</p> <p>The electronic health record for November 2024 documented the resident received one shower/bath for the month.</p> <p>On 12/10/24 at 10:42 a.m., the resident stated they had not had a shower in five days. They stated they were to get a shower/bath three times a week and did not.</p> <p>The electronic health record for December 2024 documented the resident received one shower/bath for the month.</p> <p>On 12/12/24 at 8:18 a.m., CNA #1 stated there was a paper shower schedule signed by the staff providing the shower and the charge nurse on duty daily.</p> <p>On 12/12/24 at 8:20 a.m., LPN #1 stated at the end of the day the paper shower schedule was given to the DON or ADON for review.</p> <p>On 12/12/24 at 11:14 a.m., the DON stated the form signed by the CNA and charge nurse was for their reference. The DON stated the staff were to chart showers/baths in the electronic health record. The DON reviewed the resident's electronic health record and stated documentation had not been completed regarding the resident receiving showers/baths.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Broken Bow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  700 West Jones Broken Bow, OK 74728	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to ensure a resident did not receive an antipsychotic that had been discontinued by a physician for one (#12) of five sampled residents reviewed for unnecessary medications.</p> <p>The DON identified eight residents in the facility were prescribed antipsychotic medications.</p> <p>Findings:</p> <p>A facility policy titled Medication and Treatment Orders, dated July 2016, read in part, Medication shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.</p> <p>Resident #12 had diagnoses which included major depressive disorder with psychotic features.</p> <p>A medication order, dated 10/08/22, documented Resident #12 was to have been administered Risperdal [an antipsychotic medication] 0.5 mg once daily.</p> <p>A document titled Pharmaceutical Consultant Report, dated 07/17/24, documented a pharmacist recommendation to reduce the dose of four psychotropic medications which included Risperdal 0.5 mg once daily and Risperdal 1 mg once daily. The report also documented a physician's response which was an order to stop the use of Risperdal 0.5 mg once daily. The report had a signature of the physician and the date 10/22/24.</p> <p>A MAR for November 2024 and December 2024 documented the order for Risperdal 0.5mg tablet once daily remained on the records. The records further documented Resident #12 had been administered Risperdal 0.5 mg tablets once on each date 11/01/24 through 12/11/24.</p> <p>On 12/11/24 at 11:07 a.m., LPN #1 stated the pharmaceutical report for Resident #12, dated 04/17/24, did include a physician's order to discontinue Risperdal 0.5mg once daily. They stated after looking at the electronic health record for Resident #12 the order was still active, and the resident had been getting the medication daily. They stated the pharmaceutical reports go through the DON and they distributed them to the nurses.</p> <p>On 12/11/24 at 11:12 a.m., the DON stated they had confirmed the Risperdal 0.5mg once daily order should have been discontinued. They stated the process for the reports from the pharmacist was that once they receive it, they communicate with the appropriate nurse and make any changes ordered. They stated they were new at the time of this report and must have missed it.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Broken Bow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  700 West Jones Broken Bow, OK 74728	

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 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>42171</p> <p>Based on observation, record review and interview, the facility failed to ensure the dish machine temperature and sanitizer concentration was monitored and logged daily, kitchen equipment functioned properly, and food was stored in an appropriate manner.</p> <p>The administrator identified 54 residents received meals from the kitchen.</p> <p>Findings:</p> <p>An initial tour of the kitchen was conducted on 12/09/24 at 2:45 p.m. The following observations were made:</p> <ul style="list-style-type: none"> <li>a. the paper towel dispenser at the handwashing sink was not functioning;</li> <li>b. the Dish Machine Temperature Log, for December 2024 did not document the temperature or the concentration of sanitizer for 12/05/24, 12/06/24, 12/07/24, 12/08/24, or 12/09/24;</li> <li>c. there were two opened bottles of prune juice with no received on date or opened date;</li> <li>d. there were 10 individual sized cups of ranch dressing with no date of preparation;</li> <li>e. there was an opened 32-ounce carton of whole eggs with no received on or opened date;</li> <li>f. there was an opened uncovered can of pudding with no received on or opened date;</li> <li>g. there was an opened uncovered bulk container of brown sugar sitting on the floor in the storeroom;</li> <li>h. there was an opened uncovered bulk container of flour;</li> <li>e. there was an opened uncovered box of long grain rice;</li> <li>f. there was an undated case of canned pears sitting on the floor; and</li> <li>g. there was an undated case of turnip greens sitting on the floor.</li> </ul> <p>On 12/09/24 at 3:06 p.m., the DM stated the temperature of the dish machine and the chemical concentration of the sanitizer should be checked three times a day. They also stated the paper towel machine at the handwashing sink needed to be repaired. The DM further stated dry goods should be stored off the floor in closed containers and all food items should have a received date and should be dated when they were opened.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Broken Bow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  700 West Jones Broken Bow, OK 74728	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure medical records were accurate for one (#34) of two sampled residents reviewed for pressure ulcers.</p> <p>The administrator reported the facility census was 55.</p> <p>Findings:</p> <p>A facility policy titled Charting and Documentation, read in part, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .The following information is to be documented in the resident medical record .Treatments or services performed.</p> <p>Resident #34 had diagnoses which included congestive heart failure and urinary incontinence.</p> <p>An admission assessment, dated 11/13/24, documented Resident #34 had one stage II and two stage III pressure ulcers that were present upon admission.</p> <p>A physician's order, dated 11/09/24, documented Resident #34 was to receive wound care to the left ankle daily.</p> <p>A physicians orders, dated 11/21/24, documented Resident #34 was to receive wound care to the left heel daily and the coccyx daily.</p> <p>A review of Resident #34's TAR did not document wound care had been performed on 12/05/24, 12/07/24, 12/08/24 or 12/09/24.</p> <p>On 12/11/24 at 2:30 p.m., the ADON stated they had performed the wound care on Resident #34 on 12/05/24 and they must have forgotten to document it. They also stated wound care should always be documented on the TAR.</p> <p>On 12/11/24 at 3:02 p.m., LPN #3 stated they had performed the wound care on Resident #34 on 12/09/24 and forgotten to document it.</p> <p>On 12/12/24 at 11:14 a.m., LPN #2 stated wound care should always be documented on the TAR.</p> <p>On 12/12/24 at 11:24 a.m., the DON wound care should always be documented.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Broken Bow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  700 West Jones Broken Bow, OK 74728	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to implement a water management plan to prevent the spread of water borne pathogens.</p> <p>The administrator reported the census was 55.</p> <p>Findings:</p> <p>A facility policy titled Legionella Surveillance and Detection, read in part, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella .Legionnaire's disease will be included as part of our infection surveillance activities.</p> <p>On 12/12/24 at 7:53 a.m., the administrator reported they were unable to locate any documentation of monitoring for water-borne pathogens.</p>		