| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375171 | A. Building<br>B. Wing | 08/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Village Health Care Center | 1709 South Main<br>Broken Arrow, OK 74012 |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on record review and interview, the facility failed to ensure residents were not prescribed antipsychotic medication for the medical diagnosis of dementia for 2 (#40 and #45) of 5 sampled residents reviewed for unnecessary medications.The ADON stated seven residents in the facility were prescribed antipsychotic medications. Findings:A facility policy titled Antipsychotic Medication Use, dated July 2022, read in part, Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.1.A medication order for Res #40, dated 06/19/25, showed the resident was to be administered Seroquel (a medication approved to treat psychotic disorders) 25 mg, 2 tablets to equal 50 mg by mouth every day and evening for vascular dementia, mild, with other behavioral disturbance.A medication administration record for Res #40, dated 08/01/25 through 08/31/25, showed the resident had received 47 doses of Seroquel 50 mg on and between the dates of 08/01/25 and 08/26/25.2.A medication order for Res #45, dated 06/23/25, showed the resident was to be administered Seroquel (a medication approved to treat psychotic disorders) 12.5 mg by mouth every day for unspecified dementia, unspecified severity, with psychotic disturbance.A medication administration record for Res #45, dated 08/01/25 through 08/31/25, showed the resident had received 26 doses of Seroquel 12.5 mg on and between the dates of 08/01/25 and 08/26/25.On 08/27/25 at 11:37 a.m., LPN #1 was asked regarding Res #40 and #45's prescribed use of Seroquel, what reason the medication was being used. They stated it was being used for behaviors such as hitting or refusing care. They were asked what diagnosis was documented as being treated by the Seroquel. They stated it was dementia. They were asked if Seroquel had been approved for the treatment of dementia. They stated they did not know.On 08/28/25 at 11:55 a.m., DON was asked to explain the use of antipsychotic medications for the treatment of dementia at the facility. The DON stated they had worked at geriatric psychiatric facility previously. The DON stated they preferred antipsychotic medication not be used and their goal for this facility was to get the residents off those medications. The DON stated antipsychotic medications were not approved for the treatment of dementia and should be used for specific problems such as delusions. |

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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a written notice of transfer for residents who transferred to a hospital for 3 (#28, 40, and #47) of 3 sampled residents reviewed for hospitalizations. The ADON stated 54 residents had been transferred to a hospital between 02/27/25 and 08/27/25.Findings:An undated facility policy titled Transfer or Discharge, Emergency, did not show the requirement to send a written notice of transfer to the resident and resident representative prior to transfer.1.A progress note for Res #40, dated 07/21/25 at 10:45 p.m., showed the resident was transferred to a hospital on that date for tremors and unresponsiveness.On 08/27/25 at 11:44 a.m., the ADON was asked about the paperwork that was sent with Res #40 when they were sent to a hospital on [DATE]. The ADON described the various forms but did not state the resident had received a written notice of transfer. They were asked if Res #40 had received a written notice of transfer prior to being sent to the hospital. The ADON stated they had not as they had never heard of the requirement to do so.2.A progress note for Res #47, dated 07/29/25 at 9:18 a.m., showed the resident was transferred to a hospital on that date for an abnormal heart rate and report of difficulty breathing.On 08/27/25 at 2:58 p.m., the interim DON was asked if Res #47 had been given a written notice of transfer when they were transferred to a hospital on [DATE]. They stated they had not been giving any residents a written notice of transfer when they were sent out to a hospital.3.A progress note for Res #28, dated 08/11/25 at 1:31 p.m., showed the resident was transferred to a hospital on that date for abnormal Co2 levels.On 08/27/25 at 1:50 p.m., LPN #1 was asked if Res #28 had been given a written notice of transfer when they were sent to a hospital on [DATE]. The LPN stated they had never heard of a written notice of transfer and was not aware they were supposed to give the resident the letter.On 08/27/25 at 3:06 p.m., the interim DON stated they had looked through the EMR's of Res #28, 40, and #47 and had not found any letters of transfer for any of them. They stated they had not been aware of the regulation to present those letters to residents so that had not been done. |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>Based on record review and interview, the facility failed to ensure laboratory tests were completed as ordered by the physician for 1 (#45) of 5 sampled residents whose labs were reviewed.The administrator reported 48 residents resided in the facility.Findings:An undated facility policy titled Lab and Diagnostic Test Results - Clinical Protocol, read in part, 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test request and arrange for tests.An admission record, dated 02/25/22, showed Res #45 had diagnoses which included dementia and osteoarthritis.A quarterly assessment, dated 07/25/25, showed Res #45 had a BIMS score (a test for cognition) of 6 which was indicative of severe cognitive impairment.A physician's order, dated 01/07/24, showed Res #45 was to receive the following lab tests every six months in January and July: Complete Blood Count, Comprehensive Metabolic Panel, Thyroid Stimulating Hormone, Lipid Panel, Vitamin B-12, and Vitamin D.A review of Res #45's health record did not show any lab results since 01/10/24.On 08/26/25 at 2:12 p.m., LPN #1 stated the most recent lab results for Res #45 were from 01/10/24. They stated the labs for July 2024, January 2025, and July of 2025 had not been completed.On 08/28/25 at 11:56 a.m., the DON stated if there was an order for lab work from the physician, the lab work should have been completed. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on record review and interview, the facility failed to ensure routine catheter care was documented in the clinical record for 1 (#5) of 1 sampled resident reviewed for catheter care.The ADON reported 5 residents had an indwelling urinary catheter.Findings:An undated Catheter Care, Urinary policy, read in part, The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual(s) giving the catheter care.A quarterly assessment, dated 07/24/25, showed Res #5 had a BIMS (a test for cognition) score of 12, which was indicative of moderate cognitive impairment. The assessment showed the resident had an indwelling urinary catheter, and diagnoses which included acute kidney failure and diabetes mellitus.A review of Res 5's medical record for 06/2025, 07/2025, and 08/2025 did not document catheter care had been performed.On 08/27/25 at 11:05 a.m., Res #5 stated the staff provided frequent catheter care.On 08/27/25 at 3:38 p.m., the ADON stated catheter care should be documented on the TAR, and if it was not documented, they could not say if it had been completed or not.On 08/28/25 at 11:56 a.m., the DON stated if catheter care was not documented, then it was not done. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>Based on record review and interview, the facility failed to ensure residents were offered pneumonia immunizations as required for 2 (#3 and 45) of 5 sampled residents reviewed for immunizations.The administrator reported 48 residents resided in the facility.Findings:1. A physician's order, dated 08/02/25, showed Res #3 was to be offered a pneumonia immunization if indicated.A review of Res #3's medical record did not show they had received or been offered a pneumonia immunization.2. A physician's order, dated 02/25/22, showed Res #45 was to be offered a pneumonia immunization if indicated.A review of Res #45's medical record did not show they had received or been offered a pneumonia immunization.On 08/28/25 at 10:37 a.m., the infection preventionist stated the facility did not have a policy regarding pneumonia immunizations and had not been offering pneumonia immunizations to residents consistently.On 08/28/25 at 11:56 a.m., the DON stated that the facility should have a policy related to pneumonia immunizations and residents should be offered to the residents according to that policy. |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>Based on observation, record review, and interview, the facility failed to ensure routine safety inspections of resident bed frames and bed rails were conducted for 3 (#3, 4, and #28) of 4 sampled residents reviewed for accident hazards.Maintenance #1 identified 48 residents who used facility-maintained bedframes. Findings:On 08/26/25 at 10:13 a.m., Res #4 was observed laying in their bed. The bed was observed to have a 1/8 sized side rail attached to the bed frame.On 08/26/25 at 11:02 a.m., Res #28 was observed laying in their bed. The bed was observed to have a 1/8 sized side rail attached to the bed frame.On 08/27/25 at 12:30 p.m., Res #3 was observed laying in their bed. The bed was observed to have two 1/8 sized side rails attached to the bed frame.On 08/28/25 at 1:38 p.m., Maintenance #1 was asked if the facility had conducted bed frame and bed rail inspections. They stated they had not performed inspections of the bed frames or side rails. They stated when they started, they were told a bed rail would at least cover half of the bed and they did not consider the smaller ones they used as bed rails. When asked if there were any records of bed frame and bed rail inspections, they stated they did not find any such records. They stated 46 beds had side rails attached to them |