

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Sequoyah Manor, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 615 East Redwood Sallisaw, OK 74955	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure dignity with an indwelling urinary catheter for one (#15) of three sampled residents reviewed for indwelling urinary catheters.</p> <p>The DON identified 11 residents who had indwelling urinary catheters.</p> <p>Findings:</p> <p>The Dignity policy, dated February 2021, read in parts, Staff are expected to promote dignity and assist residents .helping the resident to keep urinary catheter bags covered.</p> <p>Resident #1 had diagnoses which included obstructive and reflux uropathy.</p> <p>On 12/16/24 at 3:32 p.m., Resident #15 was observed in their bed with the door to their room open. The urinary catheter bag was observed from the hallway and was not in a dignity bag.</p> <p>On 12/17/24 at 9:16 a.m., Resident #15 was observed in their bed from the hallway. The urinary catheter bag was observed from the hall and was not in a dignity bag.</p> <p>On 12/19/24 at 8:28 a.m., Resident #15 was observed sitting on the side of their bed. The urinary catheter bag was observed from the hall and was not in a dignity bag.</p> <p>On 12/19/24 at 9:43 a.m., Resident #15 stated they wanted their catheter bag covered and the staff were supposed to keep it in a bag so people could not see it.</p> <p>On 12/19/24 at 10:31 a.m., CNA #5 stated they were to place catheter bags into privacy bags to maintain dignity.</p> <p>On 12/19/24 at 10:37 a.m., LPN #1 stated staff were to keep catheter bags covered at all times to promote dignity.</p> <p>On 12/19/24 at 11:10 a.m., the DON stated staff were to utilize privacy bags to cover catheter bags to maintain the resident's dignity.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure assessments were accurate for one (#37) of 16 sampled residents whose assessments were reviewed.</p> <p>The DON identified 64 residents who resided in the facility.</p> <p>Findings:</p> <p>Resident #37 had diagnoses which included hypertension.</p> <p>The quarterly assessment, dated 10/30/24, documented the resident was moderately impaired in cognition for daily decision making and had one fall with major injury since the prior assessment.</p> <p>Review of the state reported incidents and the electronic clinical record did not reveal the resident had experienced a fall with major injury.</p> <p>On 12/17/24 at 8:30 a.m., Resident #37 stated they had not had a fall with major injury.</p> <p>On 12/17/24 at 11:33 a.m., the MDS coordinator stated they had reviewed the clinical record and Resident #37 had not experienced a fall with major injury and the 10/30/24 assessment had been inaccurately coded.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure a copy of the baseline care plan had been provided to the resident and/or resident representative for three (#2, 15, and #29) of 19 sampled residents whose baseline care plans were reviewed.</p> <p>The DON identified 64 residents who resided in the facility.</p> <p>Findings:</p> <p>The Care Plans - Baseline policy, dated March 2022, read in part, The resident and/or resident representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand).</p> <p>1. Resident #2 had diagnoses which included Alzheimer's disease.</p> <p>The Baseline Care Plan, dated 04/29/24, did not document a resident or resident representative signature in the indicated areas.</p> <p>Review of the clinical record did not reveal documentation the resident and/or the resident representative had been provided a summary of the baseline care plan.</p> <p>2. Resident #15 had diagnoses which included obstructive and reflux uropathy.</p> <p>The Baseline Care Plan, dated 04/27/24, did not document a resident or resident representative signature in the indicated areas.</p> <p>Review of the clinical record did not reveal documentation the resident and/or the resident representative had been provided a summary of the baseline care plan.</p> <p>On 12/16/24 at 3:32 p.m., the resident stated they did not think they had received a summary of the baseline care plan upon admission.</p> <p>3. Resident #29 had diagnoses which included Parkinson's disease.</p> <p>The Baseline Care Plan, dated 03/12/24, did not document a resident or resident representative signature in the indicated areas.</p> <p>Review of the clinical record did not reveal documentation the resident and/or the resident representative had been provided a summary of the baseline care plan.</p> <p>On 12/18/24 at 5:58 p.m., the MDS coordinator stated they had reviewed the baseline care plans and electronic health records for the residents and did not find documentation the resident and/or resident representative had been provided a summary of the baseline care plans.</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan had been developed for one (#15) of 19 sampled residents whose care plans were reviewed.</p> <p>The DON identified 64 residents who resided in the facility.</p> <p>Findings:</p> <p>The Resident Mobility and Range of Motion policy, dated July 2017, read in part, The care plan will be developed by the interdisciplinary team based on the comprehensive assessment.</p> <p>The Care Plans, Comprehensive Person-Centered policy, dated March 2022, read in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>Resident #15 had diagnoses which included history of transient ischemic attack.</p> <p>The significant change assessment, dated 10/02/24, documented the resident had range of motion impairment to one side of their upper body and both sides of their lower body.</p> <p>The Care Plan, revised 12/18/24, did not document the residents range of motion impairment to the upper extremity.</p> <p>On 12/19/24 at 9:12 a.m., Resident #15 was observed in bed. Resident #15's right hand was observed to be contracted. The resident stated their hand had been contracted since they had experienced a stroke approximately [AGE] years ago.</p> <p>On 12/19/24 at 1:39 p.m., the MDS coordinator stated they had missed developing a care plan with interventions related to the limited range of motion for Resident #15.</p> <p>On 12/19/24 at 1:52 p.m., the DON stated a care plan to include the resident's limited range of motion/contracture to the right hand should have been developed with interventions implemented.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure range of motion services were provided to one (#15) of three sampled residents who were reviewed for limited range of motion.</p> <p>The MDS coordinator identified 18 residents who had limited range of motion.</p> <p>Findings:</p> <p>The Resident Mobility and Range of Motion policy, dated July 2017, read in part, Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM.</p> <p>Resident #15 had diagnoses which included history of transient ischemic attack.</p> <p>The significant change assessment, dated 10/02/24, documented the resident had range of motion impairment to one side of their upper body and both sides of their lower body.</p> <p>The Care Plan, revised 12/18/24, did not document the residents range of motion impairment to the upper extremity.</p> <p>On 12/19/24 at 9:12 a.m., Resident #15 was observed in bed. Resident #15's right hand was observed to be contracted. The resident stated their hand had been contracted since they had experienced a stroke approximately [AGE] years ago.</p> <p>Review of the electronic clinical record did not reveal interventions for the resident's contracture to the right hand.</p> <p>On 12/19/24 at 1:37 p.m., LPN #1 stated Resident #15 had a contracture to the their right hand since admission to the facility. They stated usually the facility applied hand rolls when residents had contractures.</p> <p>On 12/19/24 at 1:39 p.m., the MDS coordinator stated they had reviewed the care plan and there were no interventions in place for the resident's contracture/limited range of motion.</p> <p>On 12/19/24 at 1:52 p.m., the DON stated Resident #15 had a contracture to the right hand since admission. They stated they did not have interventions in place for the contracture/limited range of motion.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>33097</p> <p>On 12/16/24, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure chemicals were secured away from wandering residents on a locked dedicated memory care unit.</p> <p>On 12/16/24 at 10:15 a.m., an unlocked closet (with gauze stuffed in the door latch not allowing the door to shut) had bug spray (Spectracide Bug Stop Home Barrier), a can of paint, shaving lotion, and other personal care items documenting keep out of reach of children. Three residents were observed wandering in the hall aimlessly. At 10:33 a.m., CNA #1 assigned to the locked memory unit stated the key to the door had been lost over the weekend, so the gauze was placed to allow access. CNA #1 stated there were nine residents on the unit and five that wandered independently. At 10:42 a.m., the DON stated the door should be locked and was unaware there was a problem with the lock. The DON viewed the linen closet and stated there was poison and other items that should be locked up.</p> <p>On 12/16/24, the ADON identified there were six of nine residents who wandered on the memory unit.</p> <p>On 12/16/24 at 12:20 p.m., the Oklahoma State Department of Health was notified of the existence of the IJ situation.</p> <p>On 12/16/24 at 2:04 p.m., the Oklahoma State Department of Health verified the existence of the IJ situation.</p> <p>On 12/16/24 at 2:17 p.m., the administrator was notified of the IJ situation.</p> <p>On 12/17/24 at 10:27 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal, read in part,</p> <p>December 16, 2024</p> <p>[Name withheld]</p> <p>Immediate Jeopardy Response</p> <p>At 10:45 a.m., the DON was made aware by an OSDH Surveyor that an unlocked linen closet on the secure unit with nine residents (6 residents who wander) had bug spray, can of paint, shaving lotion, and other personal care items stored in it. The gauze that was stuffed in the latch preventing the door from locking was immediately removed and the door was locked.</p> <p>At 10:30 a.m. the maintenance department replaced the door lock with a new lock. Combination locks were installed on the shower room cabinets to prevent any potential risk of harm to store and lock all personal care items that may be potentially hazardous to residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>At 10:55 a.m. the facility staff inspected all linen closets and shower rooms in the facility for any chemicals and or personal care items that were not properly stored or locked to prevent any potential for more than minimal harm. No chemicals or personal care items were found to be stored improperly.</p> <p>Beginning at 3:00 p.m. all staff was in-serviced in person and or by phone on how to properly store chemicals and personal care items that may be potentially harmful to residents. Staff also provided with education on identifying and storing such products and was completed by 4:33 p.m.</p> <p>All residents on the secured unit have been assessed for adverse side of effects with none noted. Charge Nurses scheduled to continue to monitor.</p> <p>[name withheld], Administrator</p> <p>On 12/17/24 at 11:48 a.m., the survey team completed a tour of the facility. A soiled linen closet on the short hall A was unlocked and a container of bleach wipes was found.</p> <p>On 12/17/24 at 12:51 p.m., the Oklahoma State Department of Health was notified of the soiled linen closet unlocked and a container of bleach wipes found.</p> <p>On 12/17/24 at 12:59 p.m., the Oklahoma State Department of Health determined the IJ immediacy could not be removed and an amended plan of removal was required.</p> <p>On 12/17/24 at 1:05 p.m., the administrator was notified of the determination the IJ immediacy remained due to the findings of an unlocked soiled linen closet containing bleach wipes was found. The administrator was made aware of the need for an amended plan of removal.</p> <p>On 12/17/24 at 4:18 p.m., an acceptable amended plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal, read in part,</p> <p>December 17, 2024</p> <p>[Name Withheld]</p> <p>Immediate Jeopardy Response</p> <p>At 11:50 a.m. A OSDH Surveyor discovered an unlocked soiled linen closet on Long A that had a container with bleach wipes on a shelf. The container of bleach wipes were removed immediately.</p> <p>At 12:44 p.m. the maintenance department replaced the door lock with a new self-locking door lock on that soiled linen closet.</p> <p>At 1:10 p.m. the facility staff inspected all soiled linen closets to ensure no chemicals were improperly stored behind unlocked doors. The bleach wipes have been removed from the room that they were stored in and placed in a closet by the ADON office that only she has a key to. This was done in an effort to control who can access them and when.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Beginning at 1:30 p.m. all staff was in-serviced in person and or by phone on the storing items that my be potentially harmful to residents in soiled linen closets. Staff also provided with education on identifying and storing such products correctly and was completed by 3:13 p.m.</p> <p>[name withheld], Administrator</p> <p>The IJ was lifted effective 12/18/24 at 3:13 p.m. when all components of the plan of removal had been completed. The deficient practice remained at a pattern with no actual harm with potential for more than minimal harm.</p> <p>Based on observation, record review, and interview, the facility failed to ensure resident environments remained free of accident hazards for six (#43, and #101 through #105) of six wandering residents on the locked dedicated memory care unit.</p> <p>The administrator identified 64 residents who resided in the facility. The ADON identified there were six residents who wandered on the memory unit.</p> <p>Findings:</p> <p>A policy titled Hazardous Areas, Devices and Equipment, revised July 2017, read in parts, A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to the following .Open area or items that should locked when not in use;.</p> <p>A policy titled [Name withheld] Chemical Safety and Storage, revised 12/17/24, read in part All soaps, detergents, cleaning compounds, or similar substances will be stored in an area separate from resident access.</p> <p>On 12/16/24 at 9:48 a.m., three containers of Micro Kill bleach wipes in a linen closet on D hall was observed. The door had the latch portion of a lock, but there was no lock present. The label on the container of wipes documented to keep out of reach of children.</p> <p>On 12/16/24 at 10:14 a.m., LPN #1 stated Micro Kill bleach wipes were not to be stored in the linen closet. They stated they were to be kept secured in a locked cabinet.</p> <p>On 12/16/24 at 10:15 a.m., a unlocked closet on the memory unit had gauze stuffed in the lock area, not allowing the door to shut completely. The room contained linens, undergarments, shaving cream, wound wash, a can of white paint partially used that documented warning harmful if inhaled, eight bottles of Medline aftershave that documented keep out of reach of children, two bottles of Dermacen hand sanitizer that documented keep out of reach of children, four bottles of freshscent antiperspirant deodorant spray that documented keep out of reach of children, a partial gallon jug of Dermacen perineal wash , and a partial used gallon container of Spectracide Bug Stop Home Barrier spray that documented keep out of reach of children. Three residents were observed wandering in the hall aimlessly.</p> <p>On 12/16/24 at 10:21 a.m., a shower room shelf on short Hall A contained Micro Kill bleach wipes, therapeutic dandruff shampoo, Dawn dish soap, rosemary mint hair masque, and fresh scent shave cream. The labels of the listed items all documented to keep out of reach of children.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 12/16/24 at 10:24 a.m., RN #1 stated there was shaving cream, shampoo, and conditioner that documented keep out of reach of children. The RN removed the items and stated there was no way to lock the whirlpool room door.</p> <p>On 12/16/24 at 10:25 a.m., an unlocked, unidentified room on short Hall A contained a container of Micro Kill bleach wipes. The label on the container documented to keep out of reach of children.</p> <p>On 12/16/24 at 10:26 a.m., CNA #7 stated they did not know why the items were in the shower room. They stated the therapeutic dandruff shampoo should be placed in the locked medication room.</p> <p>On 12/16/24 at 10:33 a.m., CNA #1 stated they were the only staff assigned to the memory unit. The CNA stated the charge nurse assigned to the memory unit sat at the nurse station outside the locked memory unit doors. The CNA stated the closet was a linen closet and the key had been lost. The CNA stated if the door shut and locked they could not gain access. The CNA identified five residents who wandered independently on the locked memory unit.</p> <p>On 12/16/24 at 10:36 a.m., the DON stated chemicals should be locked and stored and obtained from housekeeping when needed.</p> <p>On 12/16/24 at 10:42 a.m., the DON was made aware of the linen closet door with gauze not allowing the door to close and lock with chemicals on the locked memory unit. The DON opened the linen closet door showing the gauze in place not allowing the door to latch and lock when closed. The DON viewed the room and stated there was poison and chemicals in the room. The DON stated the room should be locked at all times.</p> <p>On 12/16/24 at 11:38 a.m., CNA #6 stated currently they were the only staff working on the locked memory unit. The CNA stated if they were providing care in a resident room they would not know if a wandering resident went into an unlocked area. The CNA stated with a current census of nine or less residents residing on the locked memory unit only one staff was assigned to the hall.</p> <p>On 12/16/24 at 11:42 a.m., an unlocked whirlpool room with unlocked cabinets contained a container of Micro Kill bleach wipes that documented keep out of reach of children.</p> <p>On 12/17/24 at 11:48 a.m., an unlocked soiled linen closet on short Hall A contained Micro Kill bleach wipes that documented keep out of reach of children.</p> <p>On 12/17/24 at 11:52 a.m., the DON was notified of the unlocked soiled linen closet containing Micro Kill bleach wipes.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control was maintained for indwelling urinary catheters, failed to secure indwelling urinary catheters, and failed to document catheter care in accordance with the care plan for one (#15) of three sampled residents who were reviewed for indwelling urinary catheters.</p> <p>The DON identified 11 residents who had indwelling urinary catheters.</p> <p>Findings:</p> <p>The Catheter Care, Urinary policy, dated August 2022, read in parts, Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site .Be sure catheter tubing and drainage bag are kept off the floor .The following information should be recorded in the resident's medical record .The date and time that catheter care was given.</p> <p>Resident #15 had diagnoses which included obstructive and reflux uropathy.</p> <p>The significant change assessment, dated 10/02/24, documented the resident had an indwelling urinary catheter.</p> <p>The Care Plan, updated 12/16/24, read in part, Catheter care q shift.</p> <p>Review of the clinical record did not reveal catheter care had been documented when completed.</p> <p>On 12/16/24 at 8:49 a.m., Resident #15 was observed sitting on their bed eating breakfast. The urinary catheter tubing was observed to touch the floor.</p> <p>On 12/16/24 at 3:32 p.m., Resident #15 was observed in their bed. The catheter bag was observed hanging from the side of the bed, touching the fall mat.</p> <p>On 12/17/24 at 9:16 a.m., Resident #15 was observed in bed. The catheter bag was observed to be half way out of the privacy bag and touching the floor.</p> <p>On 12/19/24 at 9:15 a.m., CNA #1 and CNA #4 were observed to provide catheter care. The urinary catheter was not observed to be secured before or after catheter care.</p> <p>On 12/19/24 at 9:43 a.m., Resident #15 stated at times the catheter pulled and was not secured.</p> <p>On 12/19/24 at 10:31 a.m., CNA #5 stated catheter bags and tubing were not to touch the floor. They stated they did not utilize anchors for the catheters on their hall because they did not have any. They stated they completed catheter care every shift and documented in the clinical record.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/19/24 at 10:34 a.m., CNA #4 stated they were to keep catheter bags and tubing off of the floor. They stated Resident #15 had not had an anchor or securement device for their catheter for approximately three weeks.</p> <p>On 12/19/24 at 10:37 a.m., LPN #1 stated the resident's catheter bag and tubing were to be kept off of the floor and they did not know why Resident #15 did not have an anchor or securement device for their catheter.</p> <p>On 12/19/24 at 11:10 a.m., the DON stated they had reviewed the clinical record and did not find documentation catheter care had been completed as indicated in the care plan. They stated staff were to ensure catheter bags and tubing were kept off the floor. The DON stated they had securement devices available for urinary catheters, but was not aware if Resident #15 had one or not.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were accurately assessed for bedrails for two (#30 and #48) of two sampled residents who were reviewed for bedrails.</p> <p>The DON identified nine residents who had bedrails.</p> <p>Findings:</p> <p>1. Resident #30 had diagnoses which included pain and left sided hemiplegia.</p> <p>A Physician's Order, dated 05/11/21, documented the resident was to utilize quarter side rails bilaterally for repositioning.</p> <p>The Side Rail Consent, dated 08/15/24, documented the use of quarter side rails bilaterally.</p> <p>The Bed Rail/Assist Bar Evaluation, dated 12/02/24, did not indicate the type of bed rail evaluated. The MDS coordinator had completed the evaluation.</p> <p>On 12/16/24 at 3:48 p.m., Resident #30 was observed in bed with half side rails in the up position bilaterally.</p> <p>On 12/18/24 at 4:06 p.m., Resident #30 was observed in bed with half side rails in the up position bilaterally.</p> <p>On 12/19/24 at 11:19 a.m., the DON stated Resident #30 utilized side rails and was assessed quarterly by the MDS coordinator. They stated they thought the resident used quarter side rails.</p> <p>On 12/19/24 at 11:44 a.m., the DON stated they had observed the side rails for Resident #30 and the rails on the resident's bed were larger than quarter side rails. They stated they did not know why the resident did not have quarter rails which were ordered by the physician and documented on the signed consent.</p> <p>On 12/19/24 at 11:47 a.m., the MDS coordinator stated they did not know why the physician order and side rail consent documented the use of quarter rails, but the resident had half side rails on their bed.</p> <p>33097</p> <p>2. Resident #48 had diagnoses which included falls and altered mental status.</p> <p>A physician order, dated 07/31/24, documented the resident was to have bilateral quarter side rails to assist with bed mobility and repositioning every shift.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A form titled Side Rails Informed Consent and Release, dated 08/20/24 and signed by the physician and family representative, documented they were aware side rails were used for mobility aid and not a physical restraint. The form documented in hand writing bilateral quarter rails were used.</p> <p>The care plan, revised 11/15/24, documented the resident needed assistance with bed mobility and repositioning. The care plan documented the resident would have no injury related to the use of side rails through the next review date.</p> <p>On 12/16/24 at 8:44 a.m., the resident was sitting on the side of the bed. The bed had bilateral half side rails.</p> <p>On 12/19/24 at 11:44 a.m., the DON stated they had observed the side rails for Resident #48 and the rails on the resident's bed were larger than quarter side rails. They stated they did not know why the resident did not have quarter rails which were ordered by the physician and documented on the signed consent.</p> <p>On 12/19/24 at 11:47 a.m., the MDS coordinator stated they did not know why the physician order and side rail consent documented the use of quarter rails, but the resident had half side rails on their bed.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>41809</p> <p>Based on observation, record review, and interview, the facility failed to ensure a medication error of less than five percent order for two (#5 and #34) of 27 residents who were reviewed for medication administration. The medication error rate was 7.41%.</p> <p>The DON identified 64 residents who received medications.</p> <p>Findings:</p> <p>On 12/19/24 at 9:00 a.m., CMA #1 was observed to administer one tab of levothyroxine (hormone) 125 mcg to Resident #34. The order documented to administer the medication daily before the morning meal. The resident was observed to return from the morning meal prior to the medication being administered. Resident #34 stated they had eaten the morning meal.</p> <p>On 12/19/24 at 11:21 a.m., CMA #2 was observed to administer Refresh eye drops to Resident #5. The order documented to administer two drops into both eyes four times daily. One drop was observed to be applied in both eyes.</p> <p>On 12/19/24 at 12:18 p.m., CMA #2 stated they had made an error. They stated the order was for two drops in both eyes.</p> <p>On 12/19/24 at 12:28 p.m., the DON stated they ensured medications were administered per physician orders with in-services, education, and annual competencies. They stated the errors were due to staff non-compliance.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>33097</p> <p>Based on observation and interview, the facility failed to follow the menus for the residents.</p> <p>The DM identified the kitchen prepared meals for 64 residents.</p> <p>Findings:</p> <p>On 12/18/24 at 4:20 p.m., the evening meal was prepared by cook #1. The cook was preparing the pureed diet for the residents. The cook stated they were unsure how many ounces the breaded piece of chicken weighed. The cook weighed the breaded piece of chicken and stated it weighed 1.5 ounces. The cook stated the menu documented one patty per serving.</p> <p>On 12/18/24 at 4:38 p.m., the DM stated the recipe for a breaded chicken sandwich documented to serve one each breaded chicken piece equaling three ounces of meat. The DM stated they were not aware the breaded piece of chicken for the sandwich needed to weigh three ounces. They stated they only knew the menu called for one breaded piece of chicken.</p> <p>On 12/18/24 at 5:21 p.m., the DM stated peas and carrots was to be the vegetable for the evening meal. The DM stated corn was substituted because they did not have peas and carrots. The DM stated the entire meal menu prepared for the evening meal was actually the menu for the next day and had switched the menu.</p> <p>On 12/18/24 at 5:27 p.m., [NAME] #1 was serving sandwich bread for the meal instead of a bun per the menu.</p> <p>On 12/18/24 at 5:52 p.m., the DM stated the cook was making the breaded chicken sandwich with sandwich bread instead of a bun because all the buns were used for the lunch meal.</p> <p>On 12/19/24 at 8:24 a.m., the administrator stated dietary staff should follow the recipe and menus. The administrator stated changes or substitutions should only be made with the approval of the dietitian.</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 prepare and serve food in a sanitary manner.</p> <p>The DM identified the kitchen prepared meals for 64 residents.</p> <p>Findings:</p> <p>A policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, read in parts, Gloves and Direct Food Contact .Gloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed and gloves are replaced .c. between handling raw meats and ready-to-eat foods; and d. between handling soiled and clean dishes.</p> <p>On 12/18/24 at 5:30 p.m., [NAME] #1 was observed serving the evening meal. The cook donned a pair of gloves and handled a resident's menu sheet, obtained a clean plate, handled different serving utensils to place food on the plate, reached into a bag of sandwich bread to obtain slices of bread, and then placed a slice of cheese on the breaded chicken using their gloved hand. The cook continued this process preparing the meal plates without changing their gloves or washing their hands between tasks and touching unclean surfaces.</p> <p>On 12/18/24 at 5:37 p.m., [NAME] #1 stated they should have changed their gloves and washed their hands between tasks and used tongs for handling the bread and cheese.</p> <p>On 12/18/24 at 5:52 p.m., the DM stated the cook should have changed their gloves and washed their hands when touching unclean surfaces and handling food to prevent cross contamination.</p> <p>On 12/19/24 at 8:29 a.m., the administrator stated staff should change their gloves and wash their hands between tasks and unclean surfaces.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>35474</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. proper PPE was worn during catheter care for one (#15) of three sampled residents who were reviewed for catheter care;</p> <p>b. hand sanitation was completed during catheter care for one (#4) of three sampled residents who were reviewed for catheter care; and</p> <p>c. hand sanitation was completed during medication administration for four (#5, 34, 51, and #60) of 27 sampled residents who were reviewed for medication administration.</p> <p>The DON identified 11 residents who had catheters, 13 residents who were on enhanced barrier precautions, and 64 residents who received medications.</p> <p>Findings:</p> <p>A Catheter Care, Urinary policy, revised August 2022, read in part, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.</p> <p>The undated Enhanced Barrier Precautions policy, read in parts, Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities .High-contact resident activities include .Device care or use .urinary catheter.</p> <p>1. Resident #15 had diagnoses which included malignant neoplasm of the prostate.</p> <p>On 12/19/24 at 9:15 a.m., CNA #5 and CNA #4 were observed to provide catheter care for Resident #15. Neither of the two CNAs were observed to don gowns prior to providing catheter care.</p> <p>On 12/19/24 at 10:31 a.m., CNA #5 stated Resident #15 was on precautions due to the catheter and they did nothing different than they did for everyone else.</p> <p>On 12/19/24 at 10:34 a.m., CNA #4 stated Resident #15 was on something for their catheter and the staff were to wear the gowns for catheter care, but they forgot because they were not used to doing it.</p> <p>On 12/19/24 at 10:37 a.m., LPN #1 stated staff should wear gloves and a gown for catheter care.</p> <p>On 12/19/24 at 11:10 a.m., the DON stated staff were educated if anyone had a device they were to provide enhanced barrier precautions for direct care.</p> <p>41809</p> <p>2. Resident #4 had diagnoses which included paraplegia and retention of urine.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/19/24 at 9:57 a.m., CNA #2 and CNA #3 donned gown and gloves from the door. CNA #2 performed catheter care and was not observed to sanitize their hands between glove changes throughout the catheter care.</p> <p>On 12/19/24 at 10:30 a.m., CNA #2 stated they ensured infection control during catheter care by washing away from the opening, changing gloves, keeping dirties away in a bag at the end of the bed, and wearing PPE. When asked what was done between glove changes CNA #2 stated they used hand sanitizer, but that they had not performed hand sanitization between glove changes.</p> <p>On 12/19/24 at 11:13 a.m., RN #1 stated infection control was maintained during catheter care by wearing PPE, performing hand hygiene between glove changes, wiping away from the opening, and using a clean cloth for each area. RN #1 stated they felt the only way to ensure infection control was maintained was to watch during catheter care, but they did not watch every time catheter care was provided.</p> <p>On 12/19/24 at 11:44 a.m., the DON stated hand sanitizer should be used with glove changes to ensure infection control was maintained during catheter care. They stated to ensure infection control was maintained, the facility provided in-services and competency check-offs.</p> <p>3. On 12/19/24 at 8:32 a.m., during medication administration for Resident #5, CMA #1 was not observed to sanitize their hands prior to checking the blood pressure and before administering medications.</p> <p>On 12/19/24 at 8:40 a.m., during medication administration for Resident #34, CMA #1 was not observed to sanitize their hands prior to checking the blood pressure and before administering medications.</p> <p>On 12/19/24 at 8:59 a.m. during medication administration for Resident #51, CMA #1 was not observed to sanitize their hands after checking the blood pressure and before administering medications.</p> <p>On 12/19/24 at 9:14 a.m., during medication administration for Resident #60, CMA #1 was not observed to sanitize their hands prior to checking the blood pressure or administering medications.</p> <p>On 12/19/24 at 3:02 p.m., the DON stated staff were to sanitize their hands between each resident when administering medications.</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure beds and side rails were regularly inspected as part of a maintenance program for two (#30 and #53) of three sampled residents who were reviewed for side rails.</p> <p>The DON identified nine residents who utilized side rails.</p> <p>Findings:</p> <p>The Bed Safety and Bed Rails policy, dated August 2022, read in part, Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks.</p> <p>1. Resident #30 had diagnoses which included pain and left sided hemiplegia.</p> <p>A Physician's Order, dated 05/11/21, documented the resident was to utilize quarter side rails bilaterally for repositioning.</p> <p>On 12/16/24 at 3:48 p.m., Resident #30 was observed in bed with half side rails in the up position bilaterally.</p> <p>2. Resident #53 had diagnoses which included hemiplegia and hemiparesis.</p> <p>A Physician's Order, dated 09/05/23, documented the resident utilized one side rail to assist in bed mobility and transfers.</p> <p>On 12/18/24 at 4:08 p.m., Resident #53 was observed in bed with a quarter side rail in the up position on the right side of the bed.</p> <p>On 12/19/24 at 10:15 a.m., the maintenance supervisor stated the housekeeping supervisor conducted safety checks on resident beds for the use of side rails.</p> <p>On 12/19/24 at 10:51 a.m., the housekeeping supervisor stated the maintenance supervisor monitored the resident beds and side rails for safety.</p> <p>On 12/19/24 at 11:19 a.m., the DON stated the maintenance supervisor conducted safety checks of resident beds for the use of side rails.</p> <p>On 12/19/24 at 11:44 a.m., the maintenance supervisor stated they had just found out they were supposed to regularly monitor and inspect the residents' beds and side rails for safety.</p>