

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Extended Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 841 North 38th Street Muskogee, OK 74401	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>43023</p> <p>Based on record review and interview, the facility failed to provide a SNF ABN to one (#23) of three sampled residents whose beneficiary notices reviewed.</p> <p>The MDS Coordinator identified four residents who were discharged from skilled services with Medicare benefit days remaining.</p> <p>Findings:</p> <p>Res #23 was admitted to skilled services on 01/18/24 and discharged from skilled services on 02/21/24 and remained in the facility.</p> <p>A SNF Beneficiary Protection Notification Review documented an ABN was not provided to the resident.</p> <p>On 03/20/24 at 11:10 a.m., the MDS coordinator reported Res #23 was not provided an ABN form.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <ul style="list-style-type: none"> a. the floors were maintained in a safe manner; b. the window blinds, wall, and wheelchair was in good repair for one (#30) of eight sampled resident rooms observed; and c. the washing machines were in proper working order. <p>The administrator identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility's Maintenance Service policy, revised 12/2009, read in part, .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe operable manner at all times . Functions of maintenance personnel include .Maintaining the building in good repair and free from hazards .</p> <p>The facility's undated Work Orders, Maintenance policy, read in part, .In order to establish a priority of maintenance service, work orders must be filled out in the log book .It shall be the responsibility of employees to fill out the log book and identify the area of concern for repairs .</p> <p>The maintenance request log books were reviewed and revealed the floor, window blinds, wheelchair, and wall had not been documented as needing to be repaired.</p> <p>1. On 03/18/24 at 12:55 p.m., the dining room was observed to have two missing tiles, the surface was uneven, the area was not blocked off to keep the residents from stepping on the uneven surface. The floor in the hall entrance to the resident care areas had cracked, loose, and missing tiles, the floor in the common area/dining area had loose, cracked, and missing tiles. The floor leading to the dining room, common area, smoking area and extending to the resident halls was observed to have uneven floor surfaces.</p> <p>On 03/20/24 at 11:26 a.m., maintenance #1 stated they tried to apply quick cement to level out the surfaces when the tile was broken or they would block off the area to avoid accidents. Maintenance #1 observed the tile in the dining rooms and the hall. Maintenance #1 stated the tile had been like that for approximately two to three months. They stated the uneven surfaces were a trip hazard for the residents.</p> <p>On 03/20/24 at 11:30 a.m., the administrator stated the whole floor needed to be replaced.</p> <p>2. On 03/18/24 at 12:44 p.m., Res #30's room was observed to be missing sheetrock on the lower corner of the wall, the window blinds had broken slats hanging down, and the resident's wheelchair arm rests were torn and had the padding showing through.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/20/24 at 11:34 a.m., maintenance #1 stated the wall looked like the corner at the bottom of the wall had a piece missing. Maintenance #1 stated the window blinds covering the window were missing two slats, and the wheelchair arm rests needed to be replaced. They stated they were not aware of the broken window blinds or the missing sheetrock on the wall. They stated the staff were supposed to put maintenance requests in a log book.</p> <p>43023</p> <p>3. On 03/25/24 at 10:29 a.m., a tour of laundry room was conducted. The washer on the left was observed to have a blanket and a bucket observed on the floor under in front of the washer. The washer on the right was observed to have a bucket under the drainage pipe behind the washer. The bucket had a small amount of water in it. An area of drywall behind the washers was pushed in and broken The electric and water lines behind the washers and dryers have a moderate amount of dust on them. Laundry detergents stored behind the washers was sitting directly on the floor. There were two boxes and one basket observed stored directly on the ground under the clean hanging clothes. Several areas of tile in front of the washers and in between the washers and dryers is missing.</p> <p>On 03/25/24 at 10:35 a.m., laundry staff #1 reported the washer on the left has been leaking for at least a year and was not sure how long the other washer had been leaking. They reported the area behind the washers and dryers do not get cleaned.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure a significant change resident assessment was completed within 14 days of the assessment reference date for one (#26) of four sampled residents whose resident assessment were reviewed.</p> <p>The administrator identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility's Resident Assessment Instrument policy, revised 10/2010, read in part, .The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following scheduled .When there has been a significant change in the resident's condition .</p> <p>Res #26's significant change assessment, dated 10/19/23, was not completed and signed until 11/09/23.</p> <p>03/22/24 at 1:02 p.m., the administrator reported the resident assessment should have been signed within 14 days. The administrator could not explain why the assessment wasn't completed and signed within the required timeframe.</p>

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure quarterly resident assessments were completed within 14 days of the assessment reference date for two (#24 and #29) of four sampled residents whose resident assessments were reviewed.</p> <p>The administrator identified 49 residents who resided in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Res #24's quarterly resident assessment, dated 10/12/23, was not completed and signed until 11/09/23. 2. Res #29's quarterly resident assessment, dated 10/22/23, was not completed and signed until 11/28/23. <p>On 03/21/24 at 1:12 p.m. the administrator reported the resident assessments should have been completed and signed within 14 days and could not explain why that was not done.</p>

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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>45913</p> <p>Based on record review and interview, the facility failed to ensure a resident assessment was accurate for two (#4 and #14) of four sampled residents whose resident assessments were reviewed.</p> <p>The administrator identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>1. Res #4 had diagnoses which included congestive heart failure.</p> <p>A physician's order, dated 11/09/22, read in part, Aspir-Low (anti-platelet) Oral Tablet Delayed Release 81 mg, administer one tablet by mouth daily.</p> <p>A quarterly resident assessment, dated 01/05/24, documented in error Res #4 was on an anti-coagulant. Res #4 was not documented to be on an anti-platelet.</p> <p>A quarterly resident assessment, dated 10/07/23, documented in error Res #4 was on an anti-coagulant. Res #4 was not documented to be on an anti-platelet.</p> <p>On 03/22/24 at 1:10 p.m., the administrator and MDS Coordinator #1 reported they were not aware aspirin was an anti-platelet. The administrator report the MDS coordinator should have documented the aspirin as an anti-platelet and not an anti-coagulant.</p> <p>43023</p> <p>2. Res #14 admitted to the facility with diagnoses of type 2 diabetes mellitus with ketoacidosis without coma, recurrent depressive disorders, and chronic viral hepatitis C.</p> <p>A side rail assessment, dated 01/14/24, documented the resident did not require bedrails.</p> <p>An MDS re-admission assessment, dated 01/19/24, documented the use of other restraints.</p> <p>On 03/25/24 at 9:30 a.m., the administrator reported the resident has never required the use of restraints and the MDS was inaccurate.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>43023</p> <p>Based on record review and interview, the facility failed to refer a resident with a new mental health diagnosis to OHCA for a PASRR level II evaluation for one (#23) of three sampled residents reviewed for PASRR.</p> <p>The Administrator reported 49 residents resided in the facility.</p> <p>Findings:</p> <p>Res #23 admitted to the facility with diagnoses of diffuse traumatic brain injury with loss of consciousness of unspecified duration.</p> <p>Review of the resident's diagnosis documented he was diagnosed with Mood disorder due to known physiological condition, unspecified on 12/23/19 and with Major depressive disorder, recurrent, severe with psychotic symptoms on 12/09/20.</p> <p>On 03/22/24 at 8:31 a.m., the administrator reported OHCA should have been notified of the new mental health diagnosis.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>43023</p> <p>Based on record review and interview, the facility failed to ensure the PASARR for a resident with a mental health diagnosis was filled out correctly and referred to the OHCA for two (#18 and #41) of three sampled residents reviewed for PASARR evaluations.</p> <p>The Administrator identified 49 residents resided in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> Res #18 admitted to the facility with diagnoses of major depressive disorder and anxiety. A PASARR level I, dated 03/04/20, did not document the resident had a mental health diagnosis. Res #41 admitted to the facility with diagnoses of delusional disorders and major depressive disorder. A PASARR Level I, dated 06/14/21, did not document the resident had mental health diagnosis. <p>On 03/22/24 at 8:30 a.m., the administrator reported mental health diagnosis should have been documented and OHCA should have been notified.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>36191</p> <p>Based on record review and interview, the facility failed to ensure a baseline care plan included hospice services and interventions for pain management for one (#100) of two sampled residents who were on hospice.</p> <p>The administrator identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility's Care Plans-Preliminary policy, revised 04/2006, read in part, .A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident .To assure that the resident's immediate care needs are met and maintained .IDT to review all orders/treatments/medications and implement nursing care plans to meet residents' needs .</p> <p>Resident #100 was admitted the facility on 03/19/24 with diagnoses which included chronic pain. The resident was on hospice prior to admission to the facility.</p> <p>The baseline care plan was reviewed and revealed the baseline care plan did not document Res #100 was on hospice. The baseline care plan documented the resident had diagnosis of chronic pain. The care plan did not document interventions for pain or which services would be provided by hospice.</p> <p>On 03/21/24 at 10:05 a.m., Res #100 stated they were receiving hospice services. Res #100 stated they had not received their pain medication since 03/20/24 because it was delivered to the wrong facility.</p> <p>On 03/25/24 at 1:00 p.m., the administrator stated the pain interventions and hospice services should have been documented on the baseline care plan.</p>

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<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>45913</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. baths were given as schedule for two (#15 and #16) of two sampled residents whose baths were reviewed; and</p> <p>b. assistance with eating was provided for one (#18) of one sampled resident who required assistance with eating.</p> <p>The administrator identified five residents who required assistance with eating and 47 residents who required assistance with bathing.</p> <p>Findings:</p> <p>1. Res #15 had diagnoses which included chronic obstructive pulmonary disease, neuropathy, and rheumatoid arthritis.</p> <p>The Bathing Schedule documented Res #15 was to receive a shower on Mondays and Thursdays.</p> <p>There was no documentation Res #15 received a shower from 03/01/24 to 03/22/24.</p> <p>On 03/18/24 at 10:38 a.m., Res #15 complained they had not received a shower this month and reported they have gone three to four weeks without a shower before.</p> <p>On 03/22/24 at 11:30 a.m., MDS Coordinator #1 reported Res #15 frequently refused baths, but was not able to provide documentation regarding the refusals. The MDS Coordinator reported Res #15's noncompliance with bathing should have been care planned and wasn't.</p> <p>03/22/24 at 1:15 p.m., the administrator reported Res #15 does refuse showers but those refusals should have been documented and were not. The administrator reported they did not offer another day or time to make up missed showers. The administrator reported if it is not documented then it is not done.</p> <p>2. Res #16 had diagnoses which included Parkinson's disease, neuralgia, and pain.</p> <p>The Bathing schedule documented Res #16 was to receive a shower on Tuesdays and Fridays.</p> <p>Res #16 received a shower on 03/20/24. There was no documentation Res #16 received a shower from 03/01/24 through 03/22/24.</p> <p>On 03/19/24 at 9:44 a.m., Res #16 reported they do not receive shower on their scheduled days and has gone one to two weeks without a shower before.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>03/22/24 at 1:15 p.m., the administrator reported Res #16 does refuse showers but those refusals should have been documented and were not. The administrator reported they did not offer to another day or time to make up missed showers. The administrator reported if it is not documented then it was not done.</p> <p>36191</p> <p>3. Resident #18 had diagnoses which included hemiplegia and hemiparesis following cerebrovascular disease</p> <p>An assessment, dated 01/09/24, documented Res #18's cognition was moderately impaired, required cues and supervision for decision making, had limited range of motion to the upper and lower extremity on one side, and required supervision or touching assistance for eating.</p> <p>A care plan for ADL, dated 01/15/24, read in part, .I need some help with ADL care .Set up all meal trays and encourage me to eat .</p> <p>On 03/20/24 at 11:14 a.m., Res #18 was observed sitting in dining room with lights off eating their meal with their right hand. There was no staff in dining room to assist or supervise the resident.</p> <p>On 03/20/24 at 11:15 a.m., a staff member walked through the dining room. The staff member asked Res #18 if their food was good. They did not turn on the lights or encourage the resident to use utensils to eat their food.</p> <p>On 03/20/24 at 11:16 a.m., a staff member walked through the dining area. The staff member did not cue Res #18 to use a spoon or fork to eat their meal and did not turn the lights on in the dining room.</p> <p>On 03/20/24 at 11:17 a.m., the administrator observed Res #18 in the dining room with the lights off. The administrator found a staff member and asked them to move the resident to a lighted area.</p> <p>On 03/20/24 at 11:18 a.m., Res #18 continued to eat ground meat, strawberry dessert, green beans, and mashed potatoes with their hands.</p> <p>On 03/20/24 at 11:23 a.m., Res #18 continued to eat their meal with their hands.</p> <p>On 03/20/24 at 11:24 a.m., CNA #2 brought another resident into the dining area and assisted them with their meal. Res #18 was observed to use their spoon to eat their dessert after CNA #2 sat at the dining room table.</p> <p>On 03/22/24 at 9:38 a.m., the administrator stated the staff had not provided Res #18 supervision during lunch on 03/20/24. They stated the staff should not have given the resident their tray and left.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36191</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was coordinated with hospice to ensure resident's medications were available for administration for one (#100) of two residents reviewed for hospice.</p> <p>The administrator identified 13 residents who received hospice services.</p> <p>Findings:</p> <p>The undated, Hospice policy, read in part, .It shall be the policy .to remain responsible for primary care for all residents .staff will communicate and coordinate residents care with Hospice .</p> <p>The facility's Medication Ordering and Receiving from Pharmacy policy, dated 04/2018, read in part, . Reorder medication four days in advance of need .to assure an adequate supply is on hand .</p> <p>A document titled, Hospice-Skilled Nursing Facility Service Agreement, dated 03/18/24, read in part, . Coordination of Care .Hospice and Facility shall communicate with one another regularly and as needed for the Hospice Patient .to ensure that the needs of the Hospice Patient are met 24 hours per day .</p> <p>Res #100 was admitted to the facility on [DATE] with diagnoses which included COPD and chronic pain.</p> <p>Current physician's order, dated 03/19/24, documented to administer Albuterol Sulfate Inhalation Nebulization Solution Albuterol 2.5 mg/ml every six hours at 2:00 a.m., 8:00 a.m., 2:00 p.m., and 8:00 p.m. The orders documented to administer oxycodone-acetaminophen oral tablet 10-325 mg every four hours at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m.</p> <p>A nurse's note, dated 03/20/24 at 2:51 p.m., documented the nurse was notified by the staff that the resident was completely out of their Oxycodone/acetaminophen tablet 10-325 mg that was due every four hours routine. The note documented the nurse notified the hospice nurse.</p> <p>On 03/21/24 at 9:59 a.m., CMA #2 stated Res #100 had been out of their pain medication since yesterday at noon.</p> <p>On 03/21/24 at 10:05 a.m., Res #100 stated they were on hospice and had transferred from another nursing home. They stated their pain medication had been delivered to the wrong facility and they had not been administered a nebulizer treatment since they were admitted to the facility on [DATE].</p> <p>On 03/21/24 at 10:15 a.m., the DON stated the pain medication was delivered to the wrong facility. The DON was asked if the resident had their nebulizer treatment. They stated they did not know.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/21/24 at 10:28 a.m., LPN #1 stated they could not find the Albuterol nebulizer inhalation medication. LPN #1 stated there had been a mix up with Res #100's medications. LPN #1 stated Res #100 had breathing treatments ordered but did not have the medication in the building to administer the breathing treatments.</p> <p>On 03/21/24 at 10:29 a.m., CMA#2 who was present during the interview with LPN #1 stated they had signed the nebulizer treatment out on the MAR in error. They stated the Albuterol nebulizer treatment had not been administered.</p> <p>On 03/21/24 at 10:39 a.m., LPN #1 looked for the Albuterol nebulizer inhalation medication in Res #100's room. They did not find any medication in the resident's room. Res #100 reported to LPN #1 they had not had a breathing treatment since they had been admitted to the facility on [DATE].</p> <p>On 03/21/24 at 11:44 a.m., the hospice nurse stated when a resident was admitted to a facility they would have someone from the hospice company come and ensure the resident was settled in with all of their medications and belongings. The hospice nurse stated they were notified on 03/21/24, Res #100 did not have their nebulizer inhalation treatment medication. They stated they were notified Res #100 was out of their pain medication yesterday (03/20/24) at 2:56 p.m., after the last dose had been administered.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Extended Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 841 North 38th Street Muskogee, OK 74401	
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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>36191</p> <p>Based on observation, interview, and record review the facility failed to ensure residents with limited range of motion were offered assistance with splints for one (#30) of two sampled residents reviewed for limited ROM.</p> <p>The administrator identified one resident who had a contracture and 14 residents who had limited range of motion.</p> <p>Findings:</p> <p>Res #30 had diagnoses which included cerebrovascular disease with left sided hemiplegia.</p> <p>An ADL care, dated 01/23/24, read in part, .I have left sided hemiplegia with some contractures to LUE .I have a left hand spling (sic) I may or may not wear .Assist me with enough staff for safety .</p> <p>An assessment, dated 01/15/24, documented Res #30 had moderately impaired cognition, limited range of motion to upper and lower extremity on one side, and required moderate to partial assistance with upper body dressing.</p> <p>On 03/19/24 at 9:47 a.m., Res #30 stated the staff did not assist them with exercises for their arms or hands. Res #30's left hand was observed closed and they were unable to open their hand and did not have a splint on their left hand.</p> <p>On 03/21/24 at 10:44 a.m., restorative aide stated they thought Res #30 was on their list to do range of motion. The restorative aide stated they could not determine when they were last able to perform restorative range of motion exercises for the residents because they were working as a CNA providing care to the residents.</p> <p>On 03/21/24 at 10:44 a.m., the OT stated they may have turned the range of motion exercises over to the nurse aides. The OT stated Res #30's hand was very tight.</p> <p>On 03/21/24 at 10:52 a.m., the OT was observed applying the splint to Res #30's left hand. The OT stated Res #30 has had a partial contracture for a long time.</p> <p>On 03/21/24 at 10:55 a.m., Res #30 stated the staff had not offered to help them with applying the splint this morning. Res #30 was asked when the last time they had worn the splint. They stated about two months ago. Res #30 stated the OT had found the splint in their drawer. Res #30 was asked if they wanted to wear the splint to keep their hand from becoming more contracted. They stated, Yes.</p> <p>On 03/21/24 at 2:30 p.m., the administrator stated Res #30 could wear the splint on her left hand if she wanted to wear it and the staff should offer to assist the resident with putting it on.</p> <p>On 03/22/24 at 7:55 a.m., Res #30 was observed in the beauty shop without her left hand in the splint.</p> <p>(continued on next page)</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>On 03/22/24 at 7:55 a.m., Res #30 was asked if the staff offered to help them apply the splint this morning. They stated, No, I need to put it on.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45913</p> <p>Based on observation, record review, and interview the facility failed to have physician orders for maintaining an indwelling urinary catheter for one (#36) of one sampled resident whose indwelling urinary catheter was reviewed.</p> <p>The administrator identified six residents who had indwelling urinary catheters.</p> <p>Findings:</p> <p>Res #36 was admitted on [DATE] with an indwelling urinary catheter and diagnoses which included urinary retention, calculus of kidney and ureter.</p> <p>The How to insert, remove and care for a patient with a Foley catheter policy, undated, read in part, .j. If foley catheter is to remain indwelling for 30 days, obtain an order for foley catheter and bag change at 30 day intervals .</p> <p>A physician's order, dated 02/19/24, read in part, .provide catheter care per protocol every shift and as needed.</p> <p>A physician's order, dated 02/19/24, read in part, .obtain output and record every shift and as needed.</p> <p>There was no physician's order to the changing of the catheter and drainage bag at least every 30 days.</p> <p>The nursing notes did not document a catheter and drainage bag change and indwelling urinary catheter had been in place over 30 days.</p> <p>03/19/24 at 2:22 p.m., Res #36 was in their room in bed with an indwelling urinary catheter in place.</p> <p>On 03/22/24 at 12:35 p.m., the administrator reported the resident was admitted from the hospital with a catheter. The administrator reported Res #36's indwelling urinary catheter and bag should have been changed since it had been in place for longer than 30 days. The administrator reported there should have been a physician's order for the catheter tubing and bag to be changed at least monthly and as needed.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>43023</p> <p>Based on observation, record review, and interview, the facility failed to follow physician's orders for oxygen therapy for one (#4) of one resident sampled for oxygen therapy.</p> <p>The administrator reported 49 residents resided in the facility.</p> <p>Findings:</p> <p>Res #4 admitted to the facility with diagnoses of acute respiratory failure and tracheostomy.</p> <p>A physician's order, dated 04/15/23, documented O2 @3.5 liters per minute per nasal cannula or trach mask, pulse ox Q shift, titrate to keep O2 sats >92% **Fill humidifier bottle Q shift/PRN**</p> <p>On 03/19/24 at 10:28 a.m., the resident's oxygen setting was observed at 2.5 liters per minute per nasal cannula.</p> <p>On 03/20/24 at 8:21 a.m., the resident's oxygen setting was observed at 2.5 liters per minute per nasal cannula.</p> <p>On 03/21/24 at 10:16 a.m., the resident's oxygen setting was observed at 2.5 liters per minute per nasal cannula.</p> <p>On 03/22/24 at 8:20 a.m., LPN #1 was asked what the resident's oxygen setting was set on. She reported she did not know what is was set at. LPN #1 reported she would have to look at the orders to see what it said.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure pain medication was administered as ordered for one (#100) of one sampled resident who was reviewed for pain management.</p> <p>The administrator identified 29 residents who received pain management.</p> <p>Findings:</p> <p>The facility's Medication Ordering and Receiving from Pharmacy policy, dated 04/2018, read in part, . Reorder medication four days in advance of need .to assure an adequate supply is on hand .</p> <p>A document titled, Hospice-Skilled Nursing Facility Service Agreement, dated 03/18/24, read in part, . Coordination of Care .Hospice and Facility shall communicate with one another regularly and as needed for the Hospice Patient .to ensure that the needs of the Hospice Patient are met 24 hours per day .</p> <p>Res #51 was admitted to the facility on [DATE] with diagnoses which included chronic pain and opioid dependence.</p> <p>A baseline care plan, dated 03/19/24, documented Res #30 had diagnoses of chronic pain issues. The care plan did not document interventions for chronic pain.</p> <p>A Controlled Drug Receipt form, dated 03/19/24, documented Res #30 was admitted to the facility with six oxycodone/acetaminophen 10-325 mg tablets.</p> <p>Res #30's clinical record did not contain a pain assessment completed by a nurse.</p> <p>Current physician's orders, dated 03/19/24, documented to administer oxycodone-acetaminophen 10-325 mg every four hours at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and at 8:00 p.m.</p> <p>On 03/21/24 at 9:59 a.m., CMA #2 stated Res #100 had been out of their pain medication since yesterday at noon.</p> <p>On 03/21/24 at 10:05 a.m., Res #100 was observed in bed.</p> <p>On 03/21/24 at 10:05 a.m., Res #100 stated their feet was killing them. They stated they had neuropathy and they were dealing with a lot of pain. Res #100 was asked to rate their pain on a scale of one-10 with 10 being the worst pain. They stated their pain level was a 10. Res #100 stated they were taking gabapentin and oxycodone for pain. They stated they had been out of their oxycodone pain medication since yesterday (03/20/24) at 12:00 p.m. They were asked if the pain was keeping them from doing anything. They stated Oh yes. Res #30 stated they usually took the pain medication and then were able to get up some.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident was not administered their oxycodone-acetaminophen 10 mg on 03/20/24 at 4:00 p.m., 8:00 p.m., or on 03/21/24 at 12:00 a.m., 4:00 a.m., or 8:00 a.m. Res #30 was not administered five doses of their pain medication.</p> <p>On 03/21/24 at 10:15 a.m., the DON stated the pain medication was sent to the wrong nursing home. They stated the pain medication was on the way.</p> <p>On 03/21/24 at 11:22 a.m., Res # 100 stated after taking their oxycodone their pain level usually went down to a two, and every four hours their body would know it was time for more pain medication.</p> <p>On 03/21/24 at 11:24 a.m., CMA #2 was observed administering Res #100 their oxycodone for pain.</p> <p>On 03/21/24 at 11:24 a.m., CMA #2 stated the pain medication had just arrived at the facility.</p> <p>On 03/21/24 at 11:44 a.m., The hospice nurse stated they were notified Res #100 was out of their pain medication yesterday (03/20/24) at 2:56 p.m.</p> <p>On 03/21/24 at 12:14 p.m., administrator stated they expected to staff to reorder medication when the resident had two -three days supply left in the building.</p> <p>On 03/21/24 at 12:41 p.m., LPN #1 stated they had done a few of the required assessments for Res #100 when they were admitted . They stated they had not done a pain assessment and did not find one in the clinical record. LPN #1 stated the staff should perform a pain assessment for the residents on admission. LPN #1 stated the facility staff should have notified hospice at the time of admission to reorder the oxycodone.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>45913</p> <p>Based on observation, record review, and interview the facility failed to document and retain the required staffing information.</p> <p>The administrator identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>On 03/18/24 at 12:00 p.m., and throughout the survey there were two white boards observed to be at each nursing station. The facility name, date, census and staff with titles were documented on each board. Staffing hours worked were not documented.</p> <p>03/22/24 at 12:56 p.m., the administrator reported they were unaware of the requirements regarding posted staffing information and keeping staffing information for at least 18 months.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>36191</p> <p>Based on interview and record review the facility failed to ensure each resident's drug regimen was free from unnecessary drugs without adequate indication for use one (#48) residents reviewed for unnecessary medications.</p> <p>The administrator identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>Res #48 had diagnoses which included ESRD.</p> <p>Current physician's orders, dated 01/11/24, read in part, .Eliquis Oral tablet 5mg diagnosis .Hypertension secondary to other renal disorder . (Eliquis is a blood thinner that reduces blood clotting.)</p> <p>A pharmacy review, dated 01/15/24. read in part, .Suggest clarification of Eliquis diagnosis, this is not for hypertension .</p> <p>The physician's response to the pharmacy recommendation, dated 01/21/24, read in part, I DO concur.</p> <p>On 03/25/24 at 11:53 a.m., the administrator was asked about diagnoses for Eliquis. The administrator called the medical director. The administrator stated the medical director reported the Eliquis was not prescribed for hypertension. They stated the diagnosis should have been changed. They stated it was a preventative medication because the resident had a fistula for dialysis.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure insulin and/or blood pressure medication was administered per physician's orders for two (#31 and #46) of three sampled residents whose medication regime was reviewed.</p> <p>The administrator identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility's Medication Administration-General Guidelines policy, revised 01/2018, read in part, . Medications are administered as prescribed .A triple check .is recommended .Check #1: Select the Medication- label, container and contents .compared against the medication administration record .Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR . Check #3: Complete the preparation of the dose and re-verify the label against the MAR .</p> <p>1. Res #31 had diagnoses which included hypertension and diabetes.</p> <p>A physician's order, dated 06/27/23, read in part, Insulin Detemir subcutaneous 100u/ml, administer 20u subcutaneously at 7am and 4pm. HOLD IF FSBS <100 .</p> <p>A physician's order, dated 08/09/23, read in part, Metoprolol Succinate ER (an anti-hypertensive) .50mg, 1 tablet by mouth at am/HOLD FOR SBP LESS THAN 100 OR APICAL PULSE LESS THAN 60.</p> <p>The insulin administration/glucocheck record documented the following:</p> <p>On 01/05/24 at 4:42 p.m., Res #31's blood sugar was 97, 20u of Detemir was administered but should have been held.</p> <p>On 01/14/24 at 4:12 p.m., Res #31's blood sugar was 76, 20u of Detemir was administered but should have been held.</p> <p>On 01/25/24 at 4:11 p.m., Res #31's blood sugar was 86, 20u of Detemir was administered but should have been held.</p> <p>On 02/16/24 at 3:59 p.m., Res #31's blood sugar was 94, 20u of Detemir was administered but should have been held.</p> <p>The MAR for March 2024 documented the following:</p> <p>On 03/17/24 for the am/morning medication administration Metoprolol ER 50mg was held due to vital signs being too low.</p> <p>The vital sign flow sheet for 03/17/24, documented a blood pressure of 111/60 and a pulse of 67.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/20/24 at 2:00 p.m., the MDS Coordinator reported Res #31's insulin should have been held when their blood sugar was below 100.</p> <p>On 03/20/24 at 2:30 p.m., LPN #1 reported on 01/05/24 they should have held Res #31's insulin but didn't. LPN #1 reported they weren't sure why the administered the insulin and stated it was an error.</p> <p>On 03/20/24 at 2:45 p.m., CMA #1 reported Metoprolol should have been administered on 3/17/24. CMA #1 reported they aren't sure why they medication was held.</p> <p>36191</p> <p>2. Res #46 had diagnosis which included hypertension.</p> <p>Current physician's orders, dated 07/24/23, documented to administer Metoprolol Tartrate 25 mg one tablet by mouth three times a day, hold medication if systolic blood pressure was less than 100 or diastolic blood pressure was less than 60.</p> <p>On 03/19/24 at 8:33 a.m., CMA #2 obtained Res #46's blood pressure. The blood pressure reading was 106/52. CMA #2 reported the blood pressure to LPN #2. CMA #2 was told to give the Metoprolol. CMA #2 prepared the medication to be administered to Res #46. The medication label for the Metoprolol documented to hold the medication if the resident's systolic (top number of blood pressure reading) blood pressure was less than 100 or the diastolic (bottom number of the blood pressure reading) blood pressure was less than 60.</p> <p>On 03/19/24 at 8:44 CMA #2 verified they were going to administer the Metoprolol. The CMA was asked to verify the directions on the medication label. CMA #2 read the label and stated they were not supposed to administer the Metoprolol because the resident diastolic blood pressure was less than 60.</p> <p>On 03/19/24 at 10:35 a.m., CMA #2 stated they had not read the blood pressure parameters on label of the Metoprolol because they were nervous and did not see the hold directions in the computer.</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>Provide and implement an infection prevention and control program.</p> <p>36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <ol style="list-style-type: none"> blood pressure machine was disinfected between residents for three (#14, 39, and #46) of three sampled residents who were observed during medication administration; soiled linens were not placed on the floor; nebulizer mouth piece was stored in a manner to prevent cross contamination for one (#100) of two sampled resident who had breathing treatments; a surveillance system was in place to identify infections and communicable diseases; and the buildings water system was assessed, monitored, and measures put in place to prevent the growth of Legionella and other opportunistic waterborne pathogens. <p>The administrator identified 49 residents who resided in the facility and three residents who received nebulizer treatments.</p> <p>Findings:</p> <p>The facility's Specific Medication Administration procedure, revised 01/2018, read in part, Nebulizer .Rinse and disinfect the equipment according to manufacturer's recommendations .Wash pieces with warm soapy water daily. Rinse with hot water. Allow to air dry completely on paper towel .When equipment is completely dry, store in a plastic bag with the resident's name and the date on it .</p> <ol style="list-style-type: none"> On at 03/19/22 at 8:22 CMA #2 obtained Res #39's blood pressure using a wrist blood pressure monitoring device. The CMA placed the wrist blood pressure device on top of the medication cart without disinfecting the blood pressure cuff. <p>On 03/19/24 at 8:33 a.m., CMA #2 obtained Res #46's blood pressure using the same wrist blood pressure monitoring device used on Res #39. The CMA did not disinfect the blood pressure cuff prior to or after obtaining Res #46's blood pressure.</p> <p>On 03/19/24 at 8:46 a.m., CMA #2 obtained Res #14's blood pressure using the same wrist blood pressure monitoring device used on Res #39 and Res #46. The CMA did not disinfect the blood pressure cuff prior to or after obtaining Res #14's blood pressure.</p> <p>On 03/19/24 at 10:35 a.m., CMA #2 stated they cleaned the blood pressure machine a couple of times a day with alcohol or bleach wipes. They stated they did not usually disinfect the blood pressure machine/cuff in between each resident. They stated they did not know they needed to disinfect the blood pressure machine/cuff in between each resident.</p> <ol style="list-style-type: none"> On 03/21/24 at 10:36 a.m., CNA #1 was observed in a resident room with the door open. There was a strong urine odor and soiled linen on the floor. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Extended Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 841 North 38th Street Muskogee, OK 74401	

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>On 03/21/24 at 10:37 a.m., CNA #1 stated they did not bring a big enough bag for the soiled linens. CNA #1 stated they were not supposed to put soiled linens on the floor.</p> <p>3. On 03/21/24 at 10:39 a.m. Res #100's room was observed with LPN #1 a nebulizer mouth piece was sitting on top of the nebulizer machine.</p> <p>On 03/21/24 at 10:40 a.m., LPN #1 stated the nebulizer mouth piece should not have been stored on top of the nebulizer machine. They stated it should have been stored in a bag.</p> <p>4. The tracking and trending infection control book was reviewed and revealed the facility had not tracked their infections or potential communicable diseases since December 2023.</p> <p>On 03/25/24 at 10:12 a.m., administrator stated they have not tracked the infections since December 2023.</p> <p>On 03/25/24 at 12:51 p.m., the IP stated in March three residents had clostridium difficile infection (A bacterium that causes diarrhea and inflammation of the colon requiring contact isolation.) and were on contact isolation. They were asked if they monitored the staff to ensure they were using the correct PPE and washing their hands with soap and water. They stated they talked about it in stand up. There was no documentation the residents infections or communicable diseases were tracked or monitored to ensure infection control measures were put in place.</p> <p>5. On 03/25/24 at 11:02 a.m., the administrator stated the facility did not have a water Legionella prevention program. The administrator stated the maintenance personnel did not know anything about the water Legionella management program. No documentation was provided related to the facility's water system.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>36191</p> <p>Based on record review and interview, the facility failed to have a system in place to assess residents for infections using standardized tools and criteria for the initiation of antibiotics.</p> <p>The administrator identified 49 residents resided in the facility.</p> <p>Findings:</p> <p>The facility's undated, Communication of Resident Condition and Treatment with Antimicrobial Orders, read in part, .when facility staff suspects a resident has an infection, the nurse should perform and appropriately document a comprehensive assessment of the resident using established and accepted assessment protocols. This assessment will determine if the resident's status meets minimum criteria for initiating antibiotics .</p> <p>The tracking and trending infection control book was reviewed and revealed the facility had not tracked antibiotic use since December 2023.</p> <p>An undated document, titled, Attention All Nurses, read in part, We are initiating a new tool to help with antibiotic stewardship .Please note that there are assessment forms for urinary tract infections, skin and soft tissue infections and respiratory infections. It is required that we fill out the assessment form, as well as the antibiotic/anti-infective order forms .when an infection is identified and/or antibiotics are prescribed .</p> <p>On 03/25/24 at 10:27 a.m., the IP stated they could not determine if an assessment tool had been utilized prior to the initiation of the antibiotics.</p> <p>On 03/25/24 at 12:51 p.m., the IP stated based on the information in the computer 13 residents were administered antibiotics in January 2024, 12 residents were administered antibiotics in February 2024, 15 residents were administered antibiotics in March 2024.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure the microwave used to heat up resident food after hours was in good repair.</p> <p>The administrator identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility's Maintenance Service policy, revised 12/2009, read in part, .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe operable manner at all times .</p> <p>On 03/20/24 at 9:27 a.m., Res #42 stated they were not allowed to have a microwave in their room and the microwave the staff utilized to heat up their food after hours was broken. They stated the staff had told them the microwave would not be replaced for a few weeks. Res #42 stated the staff were unable to heat up their food last night (03/19/24).</p> <p>On 03/20/24 at 10:00 a.m., dietary aide #1 stated when the kitchen was closed the staff used the microwave in the employee break room to heat up the residents' food.</p> <p>On 03/20/24 at 11:58 a.m., the employee break room was observed with dietary aide #1. There was not a microwave located in the employee break room.</p> <p>On 03/20/24 at 11:58 a.m., dietary aide #1 stated there was not away to heat up the resident's food after hours at this time. The dietary aide stated the microwave had not been working for two days. They were asked how they were heating up the resident's food after hours until the microwave could be replaced. Dietary aide #1 stated they would have to get a replacement.</p> <p>On 03/20/24 at 12:04 p.m., the corporate maintenance personnel brought a microwave from the maintenance building for the employee break room. The microwave was observed to be discolored and had stained areas of food build up and was unable to be wiped clean.</p> <p>On 03/20/24 at 12:08 p.m., the administrator stated the staff should not use the microwave provided by the maintenance personnel to heat up the residents' food.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>43023</p> <p>Based on observation and interview, the facility failed to place a call activation call button in an occupied room for one (#39) of one sampled resident reviewed for call lights.</p> <p>The administrator identified 49 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy titled Call Light, Use of, undated, read in part, .Bedside call light in functioning order .</p> <p>Res #39 was admitted to the facility with diagnoses of acquired absence of right leg above the knee and unspecified abnormalities of gait and mobility.</p> <p>On 03/19/24 at 10:19 a.m., an observation of the resident's room was conducted. There was no call light in the room. The resident reported he has not had one since he moved into the room.</p> <p>On 03/20/24 at 11:43 a.m., the administrator reported that every resident should have had a call light regardless of room changes.</p>