

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Enid Senior Care		STREET ADDRESS, CITY, STATE, ZIP CODE  410 North 30th Street Enid, OK 73701	

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 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>45462</p> <p>Based on record review and interview, the facility failed to ensure a significant change MDS assessment was completed for one (#12) of one sampled resident started on hemodialysis.</p> <p>The DON identified one resident residing in the facility who received hemodialysis.</p> <p>Findings:</p> <p>Resident #12 had diagnoses which included chronic kidney disease.</p> <p>A physician's order, dated 11/03/24, documented Resident #12 was to start hemodialysis three times weekly.</p> <p>A care plan, dated 11/04/24, documented Resident #12's risk of complications from kidney failure, new status of attending hemodialysis, and the care of their shunt/fistula.</p> <p>No significant change assessment was present in the clinical record documenting Resident #12's decline in kidney function and starting dialysis treatments.</p> <p>On 11/15/24 at 1:07 p.m., the DON was asked if a significant change assessment should have been completed for Resident #12. They stated, Yes.</p> <p>On 11/15/24 at 1:18 p.m., MDS Coordinator #1 was asked when significant change assessments were done. They stated if a resident had experienced a change in condition that was not expected to resolve within the next 120 days. They were asked if Resident #12 had experienced a significant change. They stated, Yes. They acknowledged a significant change MDS should have been completed.</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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45462</p> <p>Based on record review and interview, the facility failed to ensure a baseline care plan was completed for one (#117) of sixteen sampled residents reviewed for care plans.</p> <p>The administrator identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #117 was admitted to the facility on [DATE] and had diagnoses which included encounter for orthopedic aftercare (right artificial hip joint) and type 2 diabetes.</p> <p>A review of the clinical record for Resident #117 revealed a baseline care plan had not been completed.</p> <p>On 11/14/24 at 1:00 p.m., the DON was asked what was the policy on completion of a baseline care plan for newly admitted residents. They stated the baseline care plan should be completed within the first 24 hours of admission by the admitting nurse or the nurse taking responsibility for the resident immediately after. The DON was asked if a baseline care plan had been completed for Resident #117. They stated, No. They stated the ADON was the admitting nurse.</p> <p>On 11/14/24 at 1:05 p.m., the ADON stated they were the admitting nurse for Resident #117 and should have completed a baseline care plan. They acknowledged a baseline care plan had not been completed and facility policy had not been followed.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>47453</p> <p>Based on record review and interview, the facility failed to ensure a care plan was revised and/or updated for three (#5, #11 and #63) of sixteen sampled residents reviewed for care plans.</p> <p>The administrator identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>A Care Plans, Comprehensive Person-Centered policy, revised December 2020, read in part, Care Plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration.</p> <p>1. Resident #5 had diagnoses which included bipolar, heart failure, and osteomyelitis.</p> <p>A Comprehensive Care Plan, dated 11/12/24, documented there were no updates or revisions completed on the care plan for any focus areas following the resident's annual assessment on 10/28/24.</p> <p>Review of care plan documented the last revision on the resident's care plan was 11/08/22 and 02/23/23.</p> <p>2. Resident #11 had diagnoses which included chronic obstructive pulmonary disease, epilepsy, and history of falls.</p> <p>A Comprehensive Care Plan dated 08/22/24, documented there were no updates or revisions completed for interventions for falls.</p> <p>A review of Resident #11's record documented they had a fall on 11/08/24 with minor injury. There was no documentation interventions were updated on the care plan.</p> <p>A Fall Risk assessment, dated 11/12/24, documented the resident was a high fall risk with a score of 65.</p> <p>3. Resident #63 had diagnoses which included chronic obstructive pulmonary disease, vascular dementia, and cerebral infarction.</p> <p>A Smoking Evaluation, dated 06/07/24, documented Resident #63 was safe to smoke with supervision.</p> <p>A Comprehensive Care Plan, dated 09/25/24, documented no focus for smoking on the care plan.</p> <p>On 11/14/24 at 9:44 a.m., the DON was asked what was the policy for updating and revision of care plan interventions. They stated they tried to update the interventions with every incident. The DON was asked to review Resident #11 care plan and asked if the interventions for falls had been updated. They stated, No.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/15/24 at 8:28 a.m., the DON was asked to review the care plan for Resident #63 and asked if the care plan documented a focus for smoking. They stated No</p> <p>On 11/15/24 at 10:29 a.m., MDS Coordinator #1 was asked what was the facility policy for updating and/or revising a care plan after an annual assessment was completed. They stated the care plan was reviewed after each annual, significant change, or quarterly assessment was completed and then they personalized the care plan for each resident need. They were then asked to review the care plan for Resident #5. They were then asked if the care plan was updated after annual assessment was completed on 10/28/24. They stated, No, it was not.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>45462</p> <p>Based on record review and interview, the facility failed to ensure post-dialysis assessments were completed for one (#12) of one sampled resident receiving hemodialysis.</p> <p>The DON identified one resident residing in the facility who received hemodialysis.</p> <p>Findings:</p> <p>Resident #12 had diagnoses that included chronic kidney disease.</p> <p>A physician's order, dated 11/03/24, documented Resident #12 received hemodialysis three times weekly.</p> <p>On 11/15/24 at 11:20 a.m., the DON was asked how information was communicated between the facility and the dialysis center. They stated the resident took a dialysis communication form with them on each visit and returned the form to the facility after visits. When asked if assessments were done before and after dialysis visits, the DON stated, Yes. They stated they documented on the dialysis communication form and the forms were scanned into the EHR.</p> <p>A review of Resident #12's clinical record revealed the 'Resident Specific Post-Dialysis Assessment' section of the dialysis communication forms for Resident #12 were not completed upon their return from dialysis on 10/31/24, 11/05/24, 11/07/24, and 11/09/24.</p> <p>On 11/15/24 at 1:07 p.m., the DON was asked to review the dialysis communication forms for Resident #12 dated 10/31/24, 11/05/24, 11/07/24, and 11/09/24. After reviewing the forms, the DON acknowledged post-dialysis assessments had not been completed on the dates in question and staff had not followed facility policy.</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>46702</p> <p>Based on record review and interview, the facility failed to ensure annual competency reviews were completed for one (CNA#1) of two sampled CNAs who were reviewed for annual competency review.</p> <p>The HR director identified 38 CNAs were employed at the facility.</p> <p>Findings:</p> <p>The Competency of Nursing Staff policy, revised 10/2017, read in part, Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based upon the facility assessment.</p> <p>On 11/14/24 at 8:54 a.m., CNA #1's employee file was reviewed. The last competency review was completed in 07/2023. There was no documentation an annual competency review was completed annually after 07/2023.</p> <p>On 11/14/24 at 9:00 a.m., the HR director stated that they visited with the administrator and they realized the annual competency review was not completed for CNA#1 after the last review in 07/2023.</p> <p>On 11/14/24 at 10:00 a.m., the administrator stated CNA #1's annual competency review was not completed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47453</p> <p>Based on observation, record review, and interview, the facility failed to adhere to EBP while providing care for one (#33) of one sampled resident reviewed for enhanced barrier precautions.</p> <p>The administrator identified 65 residents resided in the facility. The DON identified five residents on enhanced barrier precautions.</p> <p>Findings:</p> <p>An Enhanced Barrier Precautions policy, revised 07/01/24, read in part, staff will perform hand hygiene and don PPE before entering resident's room .staff will remove PPE and perform hand hygiene before exiting resident's room .examples of high contact resident care are changing linens, device care, and wound care.</p> <p>Resident #33 had diagnoses which included stage 4 pressure ulcer to sacrum, chronic pain, diabetes mellitus type two, and obesity.</p> <p>Resident #33's care plan for EBP, revised 11/05/24, documented the resident was at risk for skin breakdown and pressure ulcers related to decreased mobility, fragile skin, incontinence, and current stage 4 pressure ulcer to sacrum.</p> <p>On 11/14/24 at 10:45 a.m., RN #1 and CNA #2 entered Resident #33's room to perform a dressing change to the resident's pressure ulcer to their sacrum. Upon entering the room both RN #1 and CNA #2 washed their hands and donned gloves. RN #1 and CNA #2 did not don gowns prior to providing incontinent care or the dressing change to the resident's pressure ulcer to their sacrum. RN #1 was asked what was the policy for EBP while providing hands on direct care and if a gown was required while providing hands on direct care. RN#1 stated they were not aware of needing to wear a gown when providing residents' treatment.</p> <p>On 11/14/24 at 11:34 a.m., LPN #1 was asked what was the policy and procedure for EBP, and when did staff use PPE. They stated PPE was used anytime a resident had a wound, Foley, peg tube, or if staff were providing direct care for the resident. They stated staff were to wear gowns and gloves.</p> <p>On 11/14/24 at 11:46 a.m., CNA #3 was asked what did the EBP sign mean when posted outside a resident's room door. They stated they were to wear gowns and gloves if providing direct resident care.</p> <p>On 11/14/24 at 11:50 am., the DON was asked what was the policy for ensuring EBP was followed by staff. They stated the staff should wear gowns and gloves for all direct care. The DON was then asked what did the EBP sign mean outside a resident's door. They stated the staff were to wear gowns and gloves.</p>		