

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Mid-Del Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE  400 South Scott Street Del City, OK 73115	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583</b></p> <p>Based on record review and interview, the facility failed to notify a resident's family member listed as the emergency contact, of a change in condition for 1 (#2) of 3 sampled residents reviewed for notification of change related to assess, monitor, and intervene.</p> <p>The ADON identified 38 residents resided in the facility.</p> <p>Findings:</p> <p>A policy titled Resident's Family or Physician Notification of Change Guideline, dated 12/01/09, read in part, The facility will inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or interested family member of the following events: .A significant change in the resident's physical, mental, or psychosocial status. (i.e. [that is/or in other words] a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications.</p> <p>A quarterly resident assessment, dated 02/25/25, showed Resident #2 had a BIMS of 03 meaning severely impaired cognition.</p> <p>Resident #2's face sheet, dated 09/04/24, showed the resident had diagnoses which included dysarthria and anarthria, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and unspecified dementia without behavior disturbance.</p> <p>A Nurses Progress Note, dated 04/27/25 at 8:24 p.m., read in part, Resident was acting lethargic and not talkative as normal. Resident only ate 20% at dinner and drank 30% of juice. Nurse called on call provider. [provider name withheld] stated since there was no abnormal finding to vitals and resident was alert and coherent, [they] answered by continuing to monitor resident. [Provider name withheld] will be rounding tomorrow, and was advise for resident to be seen by PCP [primary care physician]. Nurse continued to monitor through out shift and night shift. Resident was placed in bed, with call light in reach. v/s [vital signs] bp [blood pressure] 123/71, p [pulse]69, 95% ra [room air]. No pain stated.</p> <p>There was no documentation the emergency contact was notified of Resident #2's change in condition.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Mid-Del Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE  400 South Scott Street Del City, OK 73115	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/15/25 at 1:54 p.m., LPN #1 read the nurse progress note dated 04/27/25 at 8:20 p.m. LPN #1 stated they did not see documentation the family was notified. LPN #1 stated the family should have been notified of any change of condition.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Mid-Del Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE  400 South Scott Street Del City, OK 73115	
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45583</p> <p>Based on record review and interview, the facility failed to ensure a care plan was fully developed for 1 (#2) of 7 sampled residents whose care plans were reviewed.</p> <p>The ADON identified 38 residents resided in the facility.</p> <p>Findings:</p> <p>An undated paper copy labeled patient identification card showed Resident #2 had an insertable cardiac monitor (loop monitor). The document showed the monitor was implanted 08/21/23.</p> <p>Resident #2's face sheet, dated 09/04/24, showed the resident had diagnoses which included dysarthria and anarthria, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and unspecified dementia without behavior disturbance.</p> <p>A history and physical, dated 09/05/24, showed Resident #2 had a loop monitor recorder insertion.</p> <p>A progress note, dated 10/28/24, showed Resident #2 had no a-fibrillation on the implantable loop monitor.</p> <p>A quarterly resident assessment, dated 02/25/25, showed Resident #2 was admitted to the facility on [DATE] and had a BIMS of 03 meaning severely impaired cognition.</p> <p>Resident #2's care plan, dated 03/18/25, did not show the resident had a loop monitor.</p> <p>A physician order, dated 05/02/25, showed to ensure monitor for loop was plugged in and functioning every shift at bedside.</p> <p>The facility was aware the resident had an implanted loop monitor and did not care plan it until after the resident returned from a hospital stay on 05/02/25.</p> <p>On 05/14/25 at 2:36 p.m., certified nurse aide #1 stated they were not aware of a medical device for Resident #2.</p> <p>On 05/15/25 at 1:51 p.m., LPN #1 stated Resident #2 did not have an order for the loop monitor prior to a recent hospital stay on 04/28/25. They stated the nurses knew about the monitor through report. They stated the loop monitor looked like a cell phone and the order was recently placed to make sure everyone knew about it. LPN #1 stated Resident #2 always had it.</p> <p>On 05/16/25 at 11:13 a.m., MDS coordinator #1 stated a care plan gave a summary of the residents' diagnoses, medications, and everything pertinent in their care. They stated the loop monitor was placed on Resident #2's care plan on 05/05/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Mid-Del Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE  400 South Scott Street Del City, OK 73115	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/16/25 at 11:15 a.m., MDS coordinator #1 stated Resident #2 had the loop monitor prior to their recent hospital stay of 04/28/25. They stated they cared for the resident prior to becoming the MDS coordinator and could not speak on why the loop monitor was not present on the care plan then. They stated Resident #2's guardian took care of the monitor and just asked the staff to make sure it was on the resident. MDS Coordinator #1 stated outside of seeing the monitor, and knowing the resident and the family, staff would not have known.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Mid-Del Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE  400 South Scott Street Del City, OK 73115	
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 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>45583</p> <p>Based on observation, record review, and interview, the facility failed to follow hospital transfer orders for 1 (#5) of 1 sampled resident reviewed for respiratory care .</p> <p>The ADON reported 38 residents resided in the facility.</p> <p>Findings:</p> <p>On 05/02/25 at 5:24 a.m., Resident #5 was observed laying in bed with eyes closed. Resident #5 was not observed to wear oxygen, CPAP or BIPAP.</p> <p>An undated medical diagnoses list for Resident #5 showed diagnosis of unspecified asthma.</p> <p>Resident #5's transfer orders from the hospital, dated 04/11/25, showed General Instructions for oxygen at 4 liters/minute by nasal cannula continuously. The orders showed a diagnoses of obesity hypoventilation syndrome and chronic respiratory failure, and CPAP/BIPAP instructions.</p> <p>Resident #5's care plan, initiated on 03/11/25, showed oxygen 1-4 liters as needed.</p> <p>The April and May 2025 treatment record for Resident #5 did not show continuous oxygen at 4 liters.</p> <p>The facility did not follow/implement the hospital orders for oxygen and CPAP/BIPAP.</p> <p>On 05/16/25 at 1:51 p.m., LPN #1 stated the process for new orders upon readmission was to check the orders and compare them to the profile and make changes as needed. LPN #1 stated if there were questions they would call the provider.</p> <p>On 05/16/25 at 1:54 p.m., LPN #1 stated after review of Resident #5's orders and the hospital transfer order general instructions from the 05/02/25 hospital discharge, they did not see a facility order for the CPAP/BIPAP. LPN #1 stated they could not locate the hospital diagnoses of obesity hypoventilation syndrome and chronic respiratory failure, and CPAP/BIPAP instructions in the facility's electronic medication record. They stated the general instructions/orders for oxygen were not implemented.</p>		