STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocola Health and Rehab	200 Home Street Pocola, OK 74902

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)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42171 On 03/24/25, an Immediate Jeopardy (IJ) was determined to exist related to the facilities failure to ensure CMAs were trained and competent to ensure residents were administered medications as ordered. On 03/15/25 at 10:10 a.m., a nurse note showed CMA #1 reported to RN #1 they may have administered the wrong medications to Resident #2. The note showed the DON was notified and camera footage was reviewed, confirming Resident #2 was administered the wrong medications. The note showed the physician was notified and orders were received to send the resident to the emergency room . On 03/24/25 at 8:13 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On 03/24/25 at 8:27 p.m., the DON was notified of the IJ situation and provided the IJ template. On 03/26/25 at 12:58 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. It showed the actions to remove the immediacy of the alleged deficient practice were as follows: The plan of removal read in part, POR for Immediate Jeopardy Template #2. The following is a POR (Plan of Removal) for Pocola Health and Rehab on an Immediate Jeopardy given to this facility at 8:36 pm on 03-24-25 on [resident name withheld] for a medication error on 03-15-25 by a CMA. 1) Policy updated on Medication Administration for all staff members (which include CMAs and Nurses) who give medications. Which will include new hire competency skills check, training which will be determined by experience of a minimum of 2 weeks and more if determined necessary. Yearly competency skills check and evaluation will be done. Job descriptions were also update [sic] on staff who give medications which include CMAs and Nurses. All CMAs are also required to do an 8 hour update class yearly on medication administration. 2) The EHR and the EMAR will be flagged for all staff members who give medications for residents who look alike or similar in appearance and also residents who share the same last name. 3) In services will be held for CMAs and Nurses on medications errors, new policies for medication errors, competency skills checks and evaluation. In services already completed were done on 03-17-25 for CMAs and 03-21-25 for Nurses. (continued on next page)

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: 375188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Pocola Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Home Street Pocola, OK 74902	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4) Competency skills check offs starting today 03-25-25 for all 3 CMAs on duty by a designee of the DON on medication pass for 5 residents reach [sic] and this will continue until all CMAs and Nurses are checked off for their shift and cannot returned [sic] to work until completed. 5) QAPI [Quality Assurance and Performance Improvement] Committee Meeting held this morning at 9:00 am on 03-25-25 for recent IJ for medication error on 03-15-25. A Plan of Removal discussed and will be submitted for approval. 6) To ensure that this does not happen again to the 2 residents that look alike 2 CMAs or Nurse will monitor the medication administration for those 2 residents involved in the most recent medication error on 03-15-25. All of the above mentioned POR have already been completed and if not are in the process of being completed, and will continued [sic] to be Policy [sic] of this facility to ensure that this facility DOES NOT EVER have another medication error. We understand that all residents are at risk for this alleged deficiency which all steps will be done to ensure that this does not happen to another resident in this facility. POR will be competed [sic] by 03-26-25 at midnight. On 03/27/25 after interviews with facility staff, a review of in-service training, and staff competencies, the IJ was lifted effective 03/27/25 at 12:10 p.m. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to ensure CMAs were trained and competent to ensure residents were administered their medications as ordered for 1 (#2) of 4 sampled residents reviewed for medication administration. The DON reported 55 residents resided in the facility. Findings: A facility policy, titled Medication Administration, dated 10/10/16, read in part, It is the policy of Pocola Health and Rehab (PHR) to give the correct medication to the correct resident following the eight rights. The right resident, the right medication, the right dose, the right route, the right time, the right documentation, the right reason, and the right response. Resident #2 had diagnoses which included aphasia, vascular dementia, and cerebrovascular disease. A care plan focus, revised on 09/21/24, showed Resident #2 was at risk for hypotension (low blood pressure). A quarterly assessment, dated 02/06/25, showed Resident #2 had a BIMS score (a test for cognitive function) of 3, which was indicative of severe impairment for daily decision making. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse note, dated 03/15/25 at 10:10 a.m., showed CMA #1 reported to RN #1 they may have administered the wrong medications to Resident #2. The note showed the DON was notified and camera footage was reviewed, confirming Resident #2 was administered another residents medication. The note showed the physician was notified and orders were received to send Resident #2 to the emergency room . An incident note, dated 03/15/25, showed Resident #2's blood pressure was 146/21 when paramedics arrived to transport the resident to the hospital. A nurse note, dated 03/15/25 at 5:33 p.m., showed Resident #2 was admitted to the intensive care unit for adverse reaction to medication, hypotension (low blood pressure), and hyponatremia (low sodium level). An Oklahoma State Department of Health form 283, dated 03/15/25, showed Resident #2 had been admiistered another residents medication including: furosemide 20mg (a diuretic), lisinopril 40mg (a blood pressure medication), citalopram 40mg (an antidepressant), diazepam 2mg (an antianxiety medication), oxycodone/acetaminophen 10/325mg (a pain medication), and carbidopa/levodopa 25/100mg (an antiparkinsonian medication). An After Visit Summary, dated 03/24/25 at 9:05 a.m., showed Resident #2 was admitted to the hospital because they were administered medications which were not prescribed to them that caused very low blood pressure. The summary also showed Resident #2 was administered medications to keep their blood pressure up while the other medications wore off. A review of CMA #1's employee file showed they were hired on 03/22/23 and had no skills evaluation/check off since 05/19/23. A review of CMA #2's employee file showed they were hired on 12/06/22 and had no skills evaluation/check off since 12/09/23. A review of CMA #3's employee file showed they were hired on 04/19/21 and had no skills evaluation/check off since 04/17/23. A review of CMA #4's employee file showed they were hired 12/29/22 and did not show any skills evaluations had been completed. A review of CMA #6's employee file showed they were hired on 03/11/22 and had not had a skills evaluation/check off since 04/19/23. On 03/24/25 at 4:05 p.m., the DON reported CMA's completed skills check offs upon hire, but they were unsure if they were done routinely after hire. The DON stated on 01/21/24 the exact same medication error had occurred when CMA #2 administered Resident #2 the wrong medications. The DON stated Resident #2 was hospitalized on that occasion as well and CMA #2 was educated regarding the 8 rights of medication administration, but no other interventions were put in place. The DON also stated they did not routinely observe medication administration. On 03/24/25 at 5:26 p.m., the DON stated the facility considers the eight hours of annual CMA training to be their annual competencies. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pocola Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Home Street Pocola, OK 74902	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/25/25 at 9:45 a.m., CMA #2 stated they had taken the position of CNA/CMA supervisor in February. They stated they had not completed any annual CMA competencies since then, and they were unsure if the facility was doing them prior to that. On 03/25/25 at 10:47 a.m., CMA #3 stated they did not recall completing a skills check off. On 03/25/25 at 10:55 a.m., CMA #4 stated they were unsure if the facility did annual skills check offs or not. On 03/25/25 at 11:50 a.m., the pharmacy consultant for the facility stated they visited the facility once a month and usually observed medication administration while in the facility. They also stated that they only visited during normal business hours, so they had never observed night shift staff or weekend staff pass medication. On 03/27/25 at 10:26 a.m., the DON stated annual CMA competencies have not been completed consistently for the last two years. They also stated all medication errors are avoidable.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. 42171 On 03/24/25, an Immediate Jeopardy (IJ) was determined to exist related to the facilities failure to ensure CMAs were trained and competent to ensure residents were administered medications as ordered. On 03/15/25 at 10:10 a.m., a nurse note showed CMA #1 reported to RN #1 they may have administered the wrong medications to Resident #2. The note showed the DON was notified and camera footage was reviewed, confirming Resident #2 was administered the wrong medications. The note showed the physician was notified and orders were received to send the resident to the emergency room . On 03/24/25 at 8:13 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On 03/24/25 at 8:27 p.m., the DON was notified of the IJ situation and provided the IJ template. On 03/26/25 at 12:58 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The POR showed the actions to remove the immediacy of the alleged deficient practice were as follows: The plan of removal read in part, POR for Immediate Jeopardy Template #2. The following is a POR (Plan of Removal) for Pocola Health and Rehab on an Immediate Jeopardy given to this facility at 8:36 pm on 03-24-25 on [resident name withheld] for a medication error on 03-15-25 by a CMA. 1) Policy updated on Medication Administration for all staff members (which include CMAs and Nurses) who give medications. Which will include new hire competency skills check, training which will be determined by experience of a minimum of 2 weeks and more if determined necessary. Yearly competency skills check and evaluation will be done. Job descriptions were also update [sic] on staff who give medications which include CMAs and Nurses. All CMAs are also required to do an 8 hour update class yearly on medication administration. 2) The EHR and the EMAR will be flagged for all staff members who give medications for residents who look alike or similar in appearance and also residents who share the same last name. 3) In services will be held for CMAs and Nurses on medications errors, new policies for medication errors, competency skills checks and evaluation. In services already completed were done on 03-17-25 for CMAs and 03-21-25 for Nurses. 4) Competency skills check offs starting today 03-25-25 for all 3 CMAs on duty by a designee of the DON on medication pass for 5 residents reach [sic] and this will continue until all CMAs and Nurses are checked off for their shift and cannot returned [sic] to work until completed. 5) QAPI [Quality Assurance and Performance Improvement] Committee Meeting held this morning at 9:00 am on 03-25-25 for recent IJ for medication error on 03-15-25. A Plan of Removal discussed and will be submitted for approval. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6) To ensure that this does not happen again to the 2 residents that look alike 2 CMAs or Nurse will monitor the medication administration for those 2 residents involved in the most recent medication error on 03-15-25. All of the above mentioned POR have already been completed and if not are in the process of being completed, and will continued [sic] to be Policy [sic] of this facility to ensure that this facility DOES NOT EVER have another medication error. We understand that all residents are at risk for this alleged deficiency which all steps will be done to ensure that this does not happen to another resident in this facility. POR will be competed [sic] by 03-26-25 at midnight. On 03/27/25, after interviews with facility staff, a review of in-service training, and staff competencies, the IJ was lifted effective 03/27/25 at 12:10 p.m. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to ensure CMAs were trained and competent to ensure residents were administered their medications as ordered for 1 (#2) of 4 sampled residents reviewed for medication administration. The DON reported 55 residents resided in the facility. Findings: A facility policy, titled Medication Administration, dated 10/10/16, read in part, It is the policy of Pocola Health and Rehab (PHR) to give the correct medication to the correct resident following the eight rights. The right resident, the right medication, the right dose, the right route, the right time, the right documentation, the right reason, and the right response. Resident #2 had diagnoses which included aphasia, vascular dementia, and cerebrovascular disease. A care plan focus, revised on 09/21/24, showed Resident #2 was at risk for hypotension (low blood pressure). A quarterly assessment, dated 02/06/25, showed Resident #2 had a BIMS score (a test for cognitive function) of 3, which was indicative of severe impairment for daily decision making. A nurse note, dated 03/15/25 at 10:10 a.m., showed CMA #1 reported to RN #1 they may have administered the wrong medications to Resident #2. The note showed the DON was notified and camera footage was reviewed, confirming Resident #2 was administered another residents medication. The note showed the physician was notified and orders were received to send Resident #2 to the emergency room . An incident note, dated 03/15/25, showed Resident #2's blood pressure was 146/21 when paramedics arrived to transport the resident to the hospital. (continued on next page)

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