STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375188	A. Building B. Wing	07/30/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a copy of the facility bed hold policy to residents discharged to the hospital for 2 (#9 and #61) of 2 sampled residents whose clinical records were reviewed for hospital discharge. The DON identified three residents who were discharged to the hospital in the last 90 days. Findings: 1. A significant change assessment, dated 04/16/25, showed Res #61 had diagnoses which included renal failure and hypertension. The assessment showed Res #61 had a BIMS score (a test of cognitive function) of 2, which was indicative of severe cognitive impairment. A health status note, dated 06/01/25 at 10:50 a.m., showed Res #61 was being sent to the emergency room for evaluation and the power of attorney was notified and an ambulance was called. On 07/24/25 at 2:28 p.m., LPN #1 stated they did not give a copy of the bed hold policy to residents when they were sent to the hospital. On 07/24/25 at 2:30 p.m., the DON stated they gave residents a copy of the bed hold policy upon admission, but not at the time of transfer to the hospital. 2. A nurse's progress note, dated 05/15/25, showed Res #9 was sent to the emergency room and later admitted to the hospital for acute cystitis on 05/15/25. There was no documentation in the clinical record the resident received a copy of the facility bed hold policy when they transferred to the hospital. A nurse's progress note, dated 05/17/25, showed Res #9 was readmitted to the facility from the hospital on [DATE]. The quarterly assessment, dated 06/22/25, showed Res #9 was moderately impaired in cognition (BIMS of 10). On 07/24/25 at 2:30 p.m., LPN #1 stated they did not provide residents with copies of the facility bed hold policy when residents were sent to the hospital. On 07/28/25 at 4:10 p.m., the DON stated the facility went over the bed hold policy on admission and normally did not hand out the bed hold policy again after the initial admission. The DON stated the resident was probably told about the bed hold policy 10 years ago and their bed was held ever since.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure PRN psychotropic medication orders were limited to 14 days and then re-evaluated for 1 (#57) of 5 sampled residents reviewed for unnecessary medications.The DON identified 50 residents received psychotropic medications. Findings:An undated Pharmacy Service Policy, read in part, PRN orders for psychotropic drugs are limited to 14 days, unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. Should the attending physician or prescribing practitioner believe that it is appropriate for the PRN order to be extended beyond 14 days, he or she will document his/her rationale in the residents' medical record and indicate the duration for the PRN order.A physician's order, dated 02/22/25, showed Res #57 was to receive 0.5 milligrams of Ativan (an antidepressant medication) by mouth every 12 hours as needed for anxiety. The order did not have an end date.A Pharmaceutical Consultant Report, dated 03/28/25, read in part, This resident has been identified as receiving an 'AS NEEDED' psychoactive medication which could be considered a chemical restraint. The order may be extended beyond 14 days if prescribing physician believes it is appropriate. Physician should document the rationale for the extended time period in the medical record and indicate a specific duration .Physician Response to Review (Please check appropriate line & write needed comments): Report Reviewed-No Changes as I prefer the order remain as a 'PRN', unless directed to change in the future. My rationale for continuance is as follows (Must be handwritten rationale): No duration or handwritten rationale was provided by the physician. A quarterly assessment, dated 06/05/25, showed Res #57 had diagnoses which included anxiety disorder and depression. The assessment showed Res #57 had a BIMS (a test for cognition) of 15 which was indicative of intact cognition and Res #57 received an antianxiety medication.On 07/24/25 at 2:28 p.m., LPN #1 stated PRN antianxiety medications should only be ordered for two weeks at a time.On 07/24/25 at 2:28 p.m., the DON stated PRN psychotropic medications should only be ordered for two weeks unless a rationale and a duration were provided by the physician.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation and interview, the facility failed to ensure an enteral tube feeding bag was properly labeled for 1 (#7) of 1 sampled resident reviewed for tube feeding management. The DON identified one resident who received enteral tube feeding via continuous pump. Findings:On 07/22/25 at 12:51 p.m., Res #7 was observed with tube feeding running at 50ml/hr. No label was observed on the tube feeding bag. On 07/29/25 at 8:04 a.m., Res #7 was observed with tube feeding running at 50ml/hr. No label was observed on the tube feeding bag.On 07/29/25 at 2:03 p.m., certified medication aide #1 stated they could not tell by looking at the tube feeding bag which resident it was intended for or what time it was hung. They stated it should have a label on the bag. On 07/29/25 at 2:06 p.m., LPN #1 stated they could not identify which resident the tube feeding was for because the bag was not labeled. LPN #1 stated they did not know why it was not labeled. On 07/29/25 at 2:30 p.m., the DON stated they could not tell what time or date the bag of tube feeding was hung. They stated they could not tell which resident it was intended for because there was not a label on the bag. The DON stated it should have a label on it and they did not know why it was not labeled.