STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375190	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastgate Village Care & Rehab Center	3500 Haskell Blvd Muskogee, OK 74403

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45583 Based on record review and interview, the facility failed to notify a resident's representative/legal representative for treatment of a UTI for 1 (#1) of 1 sampled resident reviewed for notification of change. The administrator identified 73 residents resided in the facility with two in the hospital. Findings: Resident #1 had diagnoses which included cerebral palsy, ostomy status, and hyponatremia. On 02/03/25 at 3:11 p.m., Resident #1's legal representative stated they were not notified of the resident recently having a UTI until they called to check on the resident. A physician's order, dated 02/04/25, docuented Macrobid (an antibiotic) oral capsule 100 mg via peg-tube two times a day for UTI for 7 days. On 02/06/25 at 9:54 a.m., the ADON stated the process for a resident with a change in condition was to report to the proper parties (Medical director, family, DON, hospice if appropriate) and complete the form, and monitor for 72 hours or longer depending on doctor orders. They stated the form for change in condition was located in the electronic medical record under the forms tab. The ADON stated they were not able to produce documentation of notification for 02/04/24.

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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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 35474 Based on record review and interview, the facility failed to ensure advance beneficiary notices were provided for 2 (#10 and #18) of 3 sampled residents who were reviewed for beneficiary notices. The Beneficiary Notice - Residents discharged Within the Last Six Months form documented four residents who were discharged to home with skilled days remaining in the last six months. Findings: 1. The form Beneficiary Notice-Residents discharged Within the Last Six Months showed Resident #10 was discharged from skilled services, had skilled days remaining, and stayed in the facility as a long term care resident after the discharge from skilled services. The SNF Beneficiary Protection Notification Review form showed Resident #10 was discharged from skilled services on 12/26/24 and the resident and/or resident representative had not been provided an ABN. 2. The form Beneficiary Notice-Residents discharged Within the Last Six Months showed Resident #18 was discharged from skilled services, had skilled days remaining, and stayed in the facility as a long term care resident after the discharge from skilled services. The SNF Beneficiary Protection Notification Review form showed Resident #18 was discharged from skilled services on 09/18/24 and the resident and/or resident representative had not been provided an ABN. On 02/06/25 at 10:27 a.m., the business office manager stated they were responsible to provide residents and/or resident representatives NOMNC and ABNs. They stated they typically provided an ABN for residents with Medicare and a NOMNC for residents who had an Health Maintenance Organization health plan. On 02/06/25 at 12:28 p.m., the administrator stated the business office manager was responsible to provide beneficiary notices upon discharge from skilled services.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 35474 Based on record review and interview, the facility failed to provide a notice of bed hold to 2 (#1 and #80) of 2 sampled residents who were transferred to the hospital. The administrator identified 75 residents who resided in the facility. Findings: The Resident Bed Hold policy, read in part, The Facility will provide written information to the Resident and/or the Resident Representative regarding Bed Hold Policy prior to transferring a Resident to the hospital or Therapeutic Leave as required by State/Federal Guidelines. 1. Resident #80 had diagnoses which included dementia. The electronic clinical record showed the resident was discharged to the hospital on 09/20/24 and 10/31/24. The electronic clinical record did not show the resident and/or the resident representative had been provided a bed hold notice upon transfer to the hospital. On 02/04/25 at 3:23 p.m., the infection preventionist/charge nurse stated the BOM or human resources employee provided the notice of bed hold to residents and/or resident representatives upon transfer to the hospital. On 02/04/25 at 3:25 p.m., the BOM stated they provided the notice for bed holds to residents and/or resident representatives when they admitted to the facility. On 02/04/25 at 3:29 p.m., LPN #2 stated the BOM was responsible to provide a notice of bed hold upon transfer to the hospital. On 02/04/25 at 3:32 p.m., the DON stated they did not know where it was documented a resident and/or resident representative had been provided a notice of bed hold when they were transferred to the hospital, but the BOM was the person responsible to provide them. On 02/04/25 at 4:11 p.m., the DON stated they had not been providing notices of bed holds to residents and/or representatives. They stated they had found out the nursing department was responsible to provide the notices upon transfer to the hospital. 45583 2. Resident #1 had diagnoses which included cerebral palsy and ostomy status. A Discharge Summary, dated 12/31/24 at 3:50 p.m., showed the resident was sent to the hospital via ambulance. It showed the resident left the facility at 2:30 p.m. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note, dated 01/04/25 at 4:24 p.m., showed Resident #1 readmitted to the facility from the hospital. There was no documentation of a bed hold policy being provided. On 02/05/25 at 4:03 p.m., the ADON was asked where the documentation for the bed hold was for when Resident #1 went to the hospital on 12/31/24. They stated they needed to ask as that was new to them and needed to ask someone. On 02/05/25 at 4:04 p.m., the DON stated they keep them in a folder at the nurses station. The DON provided a blank form and the arrived to the conversation. The DON stated they have them signed and put in the hard chart. The DON also stated, when residents were sent out they sent one copy with the emergency medical service and one copy to the hospital. When asked for Resident #1's bed hold provided, the DON stated, We do not have it and will from now on. The administrator was present and verified.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 45583 Based on observation, record review, and interview, the facility failed to ensure resident assessments were accurate for 3 (#1, 52, and #60) of 18 sampled residents whose assessments were reviewed. The administrator identified 75 residents who resided in the facility. Findings: An MDS 3.0 policy, dated 04/2023, read in part, 2 The MDS Coordinator and/or IDT [interdisciplinary team] will use the following when completing the assessment as directed by the RAI User's Manual: Direct Observation, Communication with Residents, Family and Staff, Documentation in the Medical Record 3. MDS assessments will be completed per the 3.0 RAI User's Manual guidelines. 1. Resident #1 had diagnoses which included cerebral palsy, ostomy status, and UTI. A progress note, dated 12/23/24, at 10:09 p.m., showed the resident was alert, seemed to understand what was being said to them, and were laughing/smiling at jokes. A progress note, dated 12/25/24 at 2:47 p.m., showed the resident was pleasant, smiling, and nonverbal. A progress note, dated 12/26/24 at 7:39 p.m., showed the resident was able to communicate with their eyes. A progress note, dated 01/04/25 at 4:24 a.m., showed the resident was alert to stimuli. A progress note dated 01/05/25 at 3:05 a.m., documented resident was alert to stimuli but non verbal. A resident admission assessment, dated 01/05/25, had comatose marked as yes for B0100. On 02/03/25 at 11:44 a.m., Resident #1 was observed in bed, eyes open, and no verbal response. They were observed moving their right arm and heal only and did follow with their eyes. On 02/05/25 at 12:56 p.m., CNA #1 stated Resident #1 used their eyes to communicate by moving them left or right and up and down to say yes or no. They stated the resident laughed and they had heard them try to speak before. CNA #1 stated if the resident was awake they would respond. On 02/05/25 at 1:05 p.m., the regional MDS consultant stated in order to code comatose at B0100 on the MDS, the resident would have to not be reactive to painful stimuli or any stimuli. They stated B0100 was marked yes and they would have to look into it. The regional MDS consultant stated they were confident the coding of B0100 was a mistake. 35474 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #52 had diagnoses which included paroxysmal atrial fibrillation. The quarterly assessment, dated 01/15/25, showed Resident #52 had received an anticoagulant and antiplatelet medication during the seven day look back period. Review of the electronic clinical record did not show Resident #52 had received an anticoagulant or antiplatelet medication during the look back period. On 02/05/25 at 1:18 p.m., the regional MDS consultant reviewed the assessment and the electronic clinical record and stated Resident #52 was not on an anticoagulant or antiplatelet medication during the look back period for the assessment and the assessment was not accurately coded. 3. Resident #60 had diagnoses which included dementia. A physician's order, dated 08/19/24, showed the resident had an active order for Quetiapine (an antipsychotic medication) 200 mg at bedtime. The annual assessment, dated 12/18/24, showed the resident had not received an antipsychotic medication since the admission/entry/reentry, or the prior assessment, whichever was more recent. On 02/06/25 at 12:11 p.m., MDS coordinator #1 reviewed the electronic clinical record and stated the annual assessment did not accurately reflect Resident #60 had received an antipsychotic medication since the last admission/entry/reentry or prior assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34270 Based on record review and interview, the facility failed to ensure a care plan intervention for the creation and implementation of a behavioral flow sheet had been implemented for 1 (#60) 5 sampled residents who were reviewed for unnecessary medications. The DON identified 75 residents who resided in the facility. Findings: Resident #60 had diagnoses which included dementia, anxiety, and mood disorder. The Care Plan, dated 12/20/24, read in part, I am experiencing dementia, anxiety, and insomnia.BEHAVIOR MONITORING: Behavior monitoring is required for residents who take antipsychotic medications. Implement Behavior Monitoring Flowsheet. Review of the electronic clinical record did not show a behavior monitoring flowsheet had been implemented. On 02/06/25 at 10:04 a.m., LPN #2 stated they were unwarned of a behavioral flow sheet for Resident #60. On 02/06/25 at 11:48 a.m., the DON stated the behavioral monitoring for behaviors was documented on the nurses treatment record in the electronic clinical record. The DON reviewed the electronic clinical record for Resident #60 and stated they must have forgotten to put the behavioral monitoring on the treatment record. 35474

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45583 Based on observation, record review, and interview, the facility failed to ensure a care plan was updated/revised for 1 (#1) of 18 sampled residents whose care plans were reviewed. The administrator identified 73 residents resided in the facility with 2 in the hospital. Findings: A Comprehensive Person Centered Care Plan policy, dated 01/2019, read in part, Each resident will have a person centered care plan to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. Resident #1 had diagnoses which included cerebral palsy, ostomy status, and UTI. A care plan, revised 01/09/25, read in part, Potential for elopement risk/wander risk. An Elopement Evaluation, dated 12/23/24 at 11:18 p.m., showed an elopement score of 0.0. It showed no instance of elopement history and no wandering aimlessly. A nutrition note, dated 01/07/25 at 5:05 p.m., showed Resident #1 had noted history of cerebral palsy, quadriplegia with upper and lower extremity contractures. A progress note, dated 12/23/24 at 11:09 p.m., showed the resident arrived via ambulance to the facility and had cerebral palsy and quadriplegia with muscle contractures on all limbs. On 02/03/25 at 11:44 a.m., Resident #1 was observed in bed, eyes open, and no verbal response. They were observed moving their right arm and head only and did follow with their eyes. Their bilateral lower extremities were bent up towards their torso. On 02/05/25 at 2:00 p.m., the IP stated Resident #1 was not and had never been an elopement risk since being in the facility. On 02/05/25 at 2:02 p.m., the regional MDS consultant, ADON, and DON were present. The DON stated Resident #1 was bedbound and was not an elopement risk and used a mechanical lift with total care. They stated they received the resident with contractures, a catheter, a colostomy, and they were total care. The DON stated the care plan was not an accurate reflection of the resident.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35474 Based on record review and interview, the facility failed to ensure residents were weighed weekly for four weeks upon admit for 1 (#78) of 3 sampled residents who were reviewed for nutrition. The DON identified 75 residents who resided in the facility. Findings: The Weight and Hydration Management Practice Guidelines policy, dated February 2016, read in part, Weigh all residents upon admission and readmission, weekly for four weeks and then monthly or as indicated by physician orders and/or the medical status of the resident. Resident #78 had diagnoses which included dementia. The Care Plan, revised 11/01/24, read in part, Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss. Review of the clinical record showed the resident had been weighed on 11/04/24, 12/01/24, and 01/01/25. The electronic clinical record did not show weights had been obtained weekly for four weeks after admission on 10/28/24. On 02/06/25 at 4:15 p.m., the DON reviewed the electronic clinical record for Resident #78 and stated there was not a physician's order for the frequency of obtaining weights, so they had weighed monthly since admission to the facility. The DON stated they needed to review the facility's policy for weight monitoring. On 02/06/25 at 4:33 p.m., the DON stated they had just reviewed the policy regarding weight monitoring and should have obtained weights weekly for four weeks after admission for Resident #78.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45583 Based on observation, record review, and interview, the facility failed to ensure medications were secured for 2 (E hall medication cart, and B/C hall treatment cart) of 6 medication/treatment carts observed. The DON identified six medication/treatment carts were utilized in the facility. A Medication Storage in the Facility policy, dated 2021, read in part, Medication rooms, carts, and medication supplies are locked. On 02/04/25 at 3:40 p.m., an observation was made of an unlocked and unattended cart on E hall across from room E1. Inside the cart were resident medications. There was no staff near the cart nor on E hall at the time of observation. On 02/04/25 at 3:44 p.m., CMA #1 came from around the corner by the dining room to the cart and locked it. They stated the policy for medication storage was to lock the cart. They stated they went to get a laptop and forgot to lock it. On 02/06/25 at 3:36 p.m., the B/C hall treatment cart was observed to be unlocked by the nurses station. Two nurses had their back to it and CMA #2 was facing it from the nurses station. On 02/06/25 at 3:38 p.m., CMA #2 was observed to lock the cart. LPN #1 stated the protocol for medication/treatment carts was to be locked when not in use. They stated they guessed they did not lock it after loaning out a glucometer. On 02/06/25 at 3:42 p.m., the DON stated the protocol for medication/treatment cart storage and safety was they were supposed to keep the carts locked if they were not with them.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35474 Based on observation, record review, and interview, the facility failed to ensure foods were dated when opened for 2 of 2 observations in the kitchen. The DON identified 72 residents who received nourishment from the kitchen. Findings: The Food Storage policy, dated 10/01/18, read in part, To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated.Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. On 02/03/25 at 10:46 a.m., an uncovered and undated bowl of ice cream, was observed in the stand up freezer. Six cups of undated milk were observed in the refrigerator. On 02/06/25 at 11:04 a.m., six small, clear containers with a pink/yellow substance in them were observed in the refrigerator. The containers were not observed to be dated. Two foam cups were observed in the refrigerator to be undated and unlabeled. On 02/06/25 at 11:10 a.m., dietary aide #1 stated the clear containers were snacks for residents who required a puree diet. Dietary Aide #1 stated they had prepared the snacks in the clear container earlier in the morning. They stated one foam cup had milk in it and they thought the other one contained coffee after smelling it. They stated they had seen the foam cup that had coffee in it on 02/05/25. On 02/06/25 at 11:13 a.m., the dietary manager stated staff were to label and date foods before they were placed in the refrigerator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45583 Based on observation, record review, and interview, the facility failed to ensure proper infection control practices were utilized during transportation of linen to the soiled closet for 1 observation during review of infection control practices. The administrator identified the census of 73 in house with 2 in the hospital. Findings: A Handling linen/laundry policy, dated 07/2024, read in part, Linen/Laundry includes resident's personal clothing, linens, (i.e., sheets, blankets, pillows), towels, washcloths .Linen and laundry should be handled, transported, and sorted to prevent the spread of infection .1. Handling soiled linen/laundry .a. Gloves should be worn, and standard precautions followed. b. Bag soiled linen/laundry at point of collection before transporting. c. Bagged linen shall be placed in a leak proof container for transport to laundry facilities. On 02/06/25 at 12:20 p.m., housekeeper #1 was observed to carry white linen with red substance on it to the soiled utility room without being in a bag and without wearing gloves. They were asked what the policy and procedure was for transporting soiled linen. They stated they probably should have taken the barrel to transport it. They stated it was not soiled. Housekeeper #1 was asked where they got the linen from. They stated it was on B hall on a pillow on the couch. They were asked what was on it. They stated nothing. They were asked how they knew nothing was on it and it was not soiled. They stated they did not know. They went down the hall then returned to the soiled utility room and looked at the linen. They stated it was ketchup on it. They were asked if it had been put in a bag for transport. They had no response. They were then asked how should the linen have been transported. They stated in a bag. On 02/06/25 at 2:02 p.m., the DON was aware of findings and stated the staff member was new and were to be educated. On 02/06/25 at 2:28 p.m., the infection preventionist was asked if they were aware of the infection control concern with the linen. They stated they were aware and would address it as soon as they could.