

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375194	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Shawn Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2024 Turner Road Ponca City, OK 74604	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure assessments were accurately coded for two (#3 and #5) of 13 sampled residents whose assessments were reviewed.</p> <p>The DON identified four residents who were ordered antiplatelet medications and five residents who were ordered anticoagulant medications.</p> <p>Findings:</p> <p>1. Resident #3 had diagnoses which included heart failure and long term use of anticoagulant medication.</p> <p>Review of the October 2024 medication administration record did not reveal the resident had received an anticoagulant medication.</p> <p>A physician's order, dated 10/11/24, documented the resident was ordered clopidogrel (an antiplatelet medication) 75mg daily.</p> <p>The admission assessment, dated 10/17/24, documented the resident received an anticoagulant medication. The assessment did not indicate an antiplatelet medication had been received.</p> <p>2. Resident #5 had diagnoses which included atherosclerotic heart disease.</p> <p>A physician's order, dated 06/23/23, documented the resident was ordered clopidogrel 75mg daily.</p> <p>Review of the September 2024 medication administration record did not reveal the resident had received an anticoagulant medication.</p> <p>The quarterly assessment, dated 09/29/24, documented the resident received an anticoagulant medication. The assessment did not indicate an antiplatelet medication had been received.</p> <p>On 11/19/24 at 10:55 a.m., the MDS coordinator reviewed the assessments for Resident #3 and Resident #5 and stated they had coded the residents were on anticoagulant medications because they thought clopidogrel was an anticoagulant.</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
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/19/24 at 11:00 a.m., the DON stated clopidogrel should be coded as an antiplatelet on the assessments for Resident #3 and Resident #5.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>48344</p> <p>Based on record review and interview, the facility failed to ensure the food service supervisor completed certification as a certified dietary manager within three years of beginning employment per State requirement.</p> <p>The administrator identified 26 residents resided in the facility and 23 residents received services from the kitchen.</p> <p>Findings:</p> <p>The Food Services Manager policy, revised 10/08, read in part, The Food Services Manager is a qualified supervisor licensed by this state.</p> <p>The DM was hired on 11/13/2015.</p> <p>There was no documentation the DM had completed certification as a certified dietary manager.</p> <p>On 11/18/24 at 1:07 p.m., the DM stated they had been in the dietary manager role for 9 years. They stated they completed the dietary manager training, but had not taken the exam for the certification.</p> <p>On 11/19/24 at 10:35 a.m., the administrator stated the DM had been in their role since 2015. They stated the DM did not have their certification.</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>48344</p> <p>Based on observation, record review, and interview, the facility failed to adhere to enhanced barrier precautions for:</p> <p>a. one (#9) of one sampled resident reviewed for a urinary catheter; and</p> <p>b. one (#14) of one sampled resident observed for medication administration via peg tube.</p> <p>The administrator identified 26 residents resided in the facility and 11 residents were on enhanced barrier precautions.</p> <p>Findings:</p> <p>An undated ENHANCED BARRIER PRECAUTIONS facility policy, read in part, Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: Device care or use .urinary catheter, feeding tube.</p> <p>1. Resident #9 had diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms.</p> <p>A physician's order, dated 05/31/24, documented enhanced barrier precautions for an indwelling medical device three times a day for infection control.</p> <p>Resident #9's care plan for EBP, revised 07/22/24 documented the resident was on EBP related to their suprapubic catheter. It documented staff only had to wear gowns and gloves when touching the resident or body fluids in the resident's room.</p> <p>On 11/19/24 at 8:51 a.m., CNA #1 and CNA #2 entered Resident #9's room. They provided privacy. Both CNAs donned gloves and changed the resident's shirt. CNA #1 and CNA #2 transferred the resident to their bed using a lift.</p> <p>On 11/19/24 at 8:56 a.m., CNA #1 provided peri care with the assistance of CNA #2. LPN #1 put cream on the resident's buttocks. CNA #1 and LPN #1 changed gloves. A new brief was put on the resident. Resident #9 was repositioned in bed. All three staff removed gloves and exited room. Trash was removed. LPN #1 stated they would be back to complete catheter care. CNA #1, CNA #2, and LPN #1 did not wear a gown during the provision of care. Resident #9 had a suprapubic catheter. There was a wood dresser inside the resident's room by the door with a sticker on top labeled enhanced barrier precautions. The drawer had face masks, sanitizer, and gowns. A box of large gloves hung above the dresser on the wall in the room. A box of medium gloves hung on the wall outside resident's door.</p> <p>On 11/19/24 at 9:02 a.m., LPN #1 went into Resident #9's room to complete catheter care. Privacy was provided.</p> <p>(continued on next page)</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>On 11/19/24 at 9:04 a.m., LPN #1 flushed Resident #9's catheter with 60 ml of uric acid. They changed their gloves and removed the old split gauze from the pubic catheter site. LPN #1 cleansed the site and catheter tubing with cleanser and changed their gloves. They applied a new split gauze and tape. They removed their gloves, adjusted the resident, and took the trash out. LPN #1 did not wear a gown during catheter care.</p> <p>On 11/19/24 at 10:12 a.m., CNA #1 stated the facility process for EBP was to wash hands, wear a gown, gloves, and a face mask.</p> <p>On 11/19/24 at 10:13 a.m., CNA #1 stated EBP signs were posted on resident doors and carts were placed outside of resident rooms. They stated Resident #9 was on EBP.</p> <p>On 11/19/24 at 10:14 a.m., CNA #1 stated they did not wear a gown during the provision of care for Resident #9. They stated they should have worn a gown.</p> <p>On 11/19/24 at 10:15 a.m., LPN #1 stated the resident was on EBP for the suprapubic catheter. They stated they were to use gloves and hand sanitizer during care of the resident.</p> <p>On 11/19/24 at 10:16 a.m., LPN #1 stated they did not wear a gown during the provision of care for the resident. They stated a gown was worn for Covid-19, influenza, and airborne precautions.</p> <p>On 11/19/24 at 10:18 a.m., LPN #1 read the EBP sign on Resident #9's dresser. They stated they should have worn a gown.</p> <p>2. Resident #14 had diagnoses which included gastrostomy status.</p> <p>A Physician Order, dated 05/31/24, documented the resident was on EBP for an indwelling medical device.</p> <p>The Care Plan, dated 06/19/24, documented the resident was on EBP for the presence of a feeding tube.</p> <p>On 11/19/24 at 8:53 a.m., a nightstand inside the door of Resident #14's room was observed to contain PPE and had signage which indicated the resident was on EBP.</p> <p>On 11/19/24 at 9:28 a.m., LPN #1 was observed to administer medications via peg tube to Resident #14. LPN #1 was observed to don gloves, but was not observed to utilize a gown.</p> <p>On 11/19/24 at 9:46 a.m., LPN #1 was observed to perform peg tube care for Resident #14. LPN #1 was observed to don gloves but was not observed to utilize a gown.</p> <p>On 11/19/24 at 10:19 a.m., LPN #1 stated they were supposed to wear a gown and gloves when residents were on EBP. They stated they had only utilized gloves, but should have donned a gown as well when they had provided medications and peg tube care for Resident #14.</p> <p>On 11/19/24 at 10:22 a.m., the DON/IP stated any resident who had an indwelling medical device were on EBP. The DON stated staff were to utilize gowns, gloves, and eye protection if there was a risk of splash, for residents who were on EBP.</p> <p>(continued on next page)</p>		

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