STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375222	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24th Place	600 24th Avenue Southwest Norman, OK 73069

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 49701 Based on record review and interview, the facility failed to ensure resident assessments were accurately coded for two (#17 and #51) of 17 sampled residents reviewed for resident assessments. The Administrator identified 67 residents resided in the facility. Findings: 1. Resident #17 had diagnoses which included open left ankle wound and cerebral palsy. An Annual RAI assessment, dated 04/05/24, documented that Resident #17 had no pressure ulcers on question M0100A, there was a stage 3 present on question M0300C1. On 05/07/24 at 9:35 a.m., the MDS Coordinator stated question M0100A was answered incorrectly. 2. Resident #51 had diagnoses which included Rheumatoid Arthritis A Quarterly RAI assessment, dated 04/26/24, documented that Resident #51 had a stage 3 pressure ulcer that was present on admission and a stage 4 pressure ulcer. A Pressure Ulcer Skin Conditions form, dated 03/11/24, documented that Resident #51 had a sacral pressure wound that measured 1.21cm by 1.0cm by 0.1cm. That form did not document any staging. A Nurses Admission Assessment, dated 03/13/24, documented that Resident #51 had a sacral pressure wound that measured 1.2cm by 1.0cm by 0.1cm and documented it as unstageable. On 05/07/24 at 2:10 p.m., the MDS Coordinator stated they are unsure why stage 4 was documented on the MDS because it should not have been. They stated they documented the wound as a stage 3 after speaking to the wound care nurse. The MDS Coordinator stated present on admission means after returning from the hospital the wound had progressed to a stage 3. On 05/07/24 at 2:16 p.m., LPN #1 stated they called the wound care center and asked for staging on the day of the assessment which occurred on 04/26/24 and was not accurate staging to be documented for a 03/13/24 readmission from the hospital. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 3:51 p.m., the CNO stated the policy is for facilities to follow the RAI manual and assessments should be accurately completed.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46653 Based on observation, record review, and interview the facility failed to ensure: a. adequate supervision was provided to prevent a fall for one (#7); and b. proper transferring techniques were used for one (#51) of three sampled residents reviewed for accident hazards. The Administrator identified 67 residents resided in the facility. 43 residents were dependent on staff for transfers. Findings: 1. Resident #7 had diagnosis which included Parkinson's Disease. A Falls and Fall Risk, Managing policy, revised March 2018, read in part, .5. If falling recurs after despite initial interventions, staff will implement additional or different intervention, or indicate why the current approach remains relevant . A Minimum Data Set, dated dated , 03/25/24, documented Resident # 7 Functional Assessment indicates they are a dependent resident for activities of daily living of which includes eating and transfers. On 05/05/24 at 1:27 p.m., Resident #7 was standing independently up from wheelchair and the wheel chair rolled back as resident attempted to sit back down. On 05/09/24 at 10:32 a.m., the DON stated Resident #7 should have been monitored. 2. Resident #51 had diagnoses which included Rheumatoid Arthritis. A Controlled Lift Policy, undated, read in part, .gait belt usage is mandatory for all resident handling with the exception of bed mobility and medical contraindications and is not needed with lifts . A Care Plan, revised 03/22/24, documented that Resident #51 required one or two staff member participation with transfers. On 05/05/24 at 10:34 a.m., CNA #1 attempted to put a gait belt around Resident #51, but the resident stated they were not comfortable with this. CNA #1 put their arms underneath Resident #51's arms, picked them up, turned and placed them into the bed. Resident #51's feet did not even touch the floor at all during the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/24 at 10:11 a.m., CNA #2 put their arms under Resident #51's arms and grabbed the back of their pants. CNA #2 lifted the resident pivoted and placed them in the bed. Resident #51's feet did not touch the floor during the transfer. On 05/07/24 at 10:17 a.m., CNA #2 stated the condition of the resident dictated how they would go about the transfer. They stated they would get a bear hug and pivot holding the back of the pants. They stated they were taught that a gait belt would be considered a restraint and they have never used them. CNA #2 stated a lift would be used if the chart or the nurse told them to. CNA #2 stated it was normal for Resident #51 to not bear weight during the transfer. On 05/07/24 at 10:21 a.m., the DON stated if a resident was unable to bear weight, a mechanical lift or a two person assist would be necessary dependent upon the residents preference to cause less pain and injury. They stated a gait belt should be used anytime a transfer is occurring without the use of a lift. 49701

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49701 Based on observation, record review, and interview, the facility failed to ensure a physician's order was in place for the use of a catheter for one (#51) of one sampled resident reviewed for catheter use. The DON identified that 13 residents had catheters in the facility. Findings: Resident #51 On 05/05/24 at 10:17 a.m., Resident #51 was observed to have a catheter. On 05/07/24 at 11:06 a.m., the Order Summary Report was reviewed for Resident #51, it had no physican order for a catheter. On 05/07/24 at 11:29 a.m., the DON stated that nurses are responsible for putting in physician orders. They stated we double check orders and note them, and put them into medical records. The DON stated they did not see an order for a catheter. On 05/08/24 at 3:51 p.m., the CNO stated the policy for using catheters was to have an appropriate diagnosis, have a physician's order and put it in the system before providing the cath care. The order should include the size and when to change the catheter.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 46653 Based on record review, observation, and interview, the facility failed to ensure meals were served in a timely manner and frequency for four meal services and, for one of one Resident #3. The Don identified 67 residents resided in the facility. Findings: A undated Meal times documented, read in part .Breakfast 07:00-09:00 .Lunch 11:30-1:30p.m Dinner 5:00p.m.-7:00p.m . A Meal Times and Frequency policy, dated 02/27/21, read in part .1. in nursing facilities, there will be no more than 14 hours between a substantial evening meal (dinner) and breakfast the following day However, the individuals in the group must agree to this meal span and a nourishing snack must be served . a. Resident meals were not served in the 14 hour window. b. Resident #3 meal was not served according to posted meal times. On 05/05/24 at 9:30a.m., the cook stated we are working short staffed in the kitchen and meals are late. On 05/05/24 at 9:32a.m., a breakfast tray was served in the dining hall. On 05/05/24 at 1:41p.m., a lunch tray was served in the dining hall. On 05/05/24 at 1:27p.m., a lunch tray was served to Resident #3. On 05/08/24 at 8:31a.m., no breakfast tray was served. On 05/08/24 at 5:01p.m., a dinner tray was served in the dining hall. On 05/05/24 at 1:58p.m., the Social Services Director stated meals should be served at the times posted.

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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. 46653 Based on observation and interview, the facility failed to store and label food items according with professional standards for food safety. The DON identified 67 residents resided in the facility. Findings: A undated Food Storage policy, read in part .All foods should be covered, labeled, and dated and routinely monitored to assure that foods(including leftovers) will be consumed by their safe use of dates, or frozen (where applicable), or discarded . On 05/07/24 at 11:06a.m., food items where found in the freezer undated and unlabeled. On 05/07/24 at 11:07a.m., LPN #1 identifed the unlabeled and undated the food items as rolls, biscuits and chicken patties. On 05/07/24 at 11:08a.m., the LPN #1 stated the rolls, biscuits and chicken patties should be dated and labeled. FACILITY Kitchen

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on record review and interview, the facility failed to provide residents a binding arbitration agreement that informed the resident or their representative of their right not to sign the agreement as a condition of admission or continued care. The DON identified 67 residents resided in the facility and all residents had signed a binding arbitration agreement. Findings: 1. Resident #11 was admitted on [DATE]. A review of Resident #11's medical record documented a copy of a binding arbitration agreement signed by the Resident on 07/13/18. The agreement did not document the resident could be admitted to the facility without entering into the arbitration agreement. 2. Resident #51 was admitted on [DATE]. A review of Resident #51's medical record documented a copy of a binding arbitration agreement signed by the Resident on 03/31/22. The agreement did not document the resident could be admitted to the facility without entering into the arbitration agreement. 3. Resident #23 was admitted on [DATE]. A review of Resident #23's medical record documented a copy of a binding arbitration agreement signed by the Resident on 10/21/23. The agreement did not document the resident could be admitted to the facility without entering into the arbitration agreement. On 05/07/24 at 10:22 a.m., the Administrator stated the facility's arbitration agreement did not explicitly state that signing the arbitration agreement is voluntary and will not have any bearing on admission.