

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Ranchwood Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 824 South Yukon Parkway Yukon, OK 73099	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to ensure a catheter bag was covered with a vanity bag to maintain residents dignity for one (#96) of three sampled resident reviewed for catheter bags covered to maintain a residents dignity during two of two observations.</p> <p>The DON identified 9 residents had catheters in the facility.</p> <p>Findings:</p> <p>The facility's Insertion of a Straight or Indwelling Urinary Catheter policy, revised on 01/12/23, read in part, Cover drainage bag with privacy bag as necessary.</p> <p>Resident #96 was admitted on [DATE] with diagnoses which included acute respiratory failure with hypoxia and cellulitis.</p> <p>A physicians order, dated 7/19/24, read in part, Foley Catheter Care every 2 shift privacy bag checked and verified Q Shift.</p> <p>On 09/03/24 at 9:20 a.m., Resident #96's catheter bag was observed hanging on the lower bedside from the hall while standing in the door way. The bag was not covered with a vanity bag.</p> <p>On 09/06/24 at 11:15 a.m., Resident #96's catheter bag was observed hanging at the foot of the bed from the hall while standing at the doorway. The bag was not covered with a vanity bag.</p> <p>On 09/06/24 at 11:27 a.m., CNA #1 was asked what they could see from entry of Resident #96's room while standing in the hallway. CNA #1 stated the catheter bag was visible from the entryway and was not covered with a vanity bag. CNA#1 was asked what the policy was for catheter bags. CNA #1 stated the catheter bag should of been covered with a vanity bag and the policy was not followed.</p> <p>On 09/06/24 at 11:30 a.m., LPN #1 was taken to the Resident #96's room . They were asked what they could see from the door way without entering the room. They stated they could see the catheter bag hanging from the bed not covered with a vanity bag. They were asked what the policy was for maintaining residents dignity with a catheter. They stated it was the policy to cover the bag with a vanity bag.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/06/24 at 11:38 a.m., corporate nurse #1 was shown Resident #96's room from the entry way while standing in the hall and asked what they could see. They stated they could see the catheter bag was uncovered hanging on the bed and visible from the hall. They were asked what the policy was for resident dignity and catheter bags covered. They stated they would have to look at the policy and was unsure if it had to be covered while in the residents room.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on record review and interview, the facility failed to ensure residents were offered the choice to formulate an advanced directive for one (#4) of 32 sampled residents whose advanced directive acknowledgments were reviewed.</p> <p>The DON identified 102 residents resided in the facility.</p> <p>Findings:</p> <p>The facility's Advance Directive Management policy, revised 03/27/23, read in part, The Director of Admission will ensure that the Advanced Directive Acknowledgment Form is completed during the admission process and scan the Acknowledgment Form into the resident's EMR.</p> <p>Resident #4 was admitted on [DATE] with diagnoses which included multiple sclerosis and paraplegia.</p> <p>Resident #4's EMR did not document the the resident was assisted with formulating an advanced directive.</p> <p>On 09/04/24 at 2:08 p.m., Corporate Nurse #1 was asked where Resident #4's advanced directive was located in the EMR. Corporate Nurse #1 stated they audited the charts the night before and Resident #4 did not have an advanced directive acknowledgment in their EMR.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to maintain a home like environment during two of two observations by ensuring:</p> <ul style="list-style-type: none"> a. carpets were in good repair and clean, b. walls were in good repair and not damaged, c. outlets and exposed wires were covered, d. tiles were in good repair and not torn or missing e. walls and ceilings were clean and free of debris and stains, and f. strong odors of urine were prevented. <p>The DON identified 102 residents resided in the facility.</p> <p>Findings:</p> <p>The facility's Resident Room Cleaning policy, dated 11/2021, read in part, Purpose: To provide a clean, attractive, and safe environment for residents, visitors, and staff.</p> <p>The facility's Maintenance Work Order Log sheet document, dated 08/08/24, documented a work order for room [ROOM NUMBER]'s carpet being torn was submitted. It did not document the repairs were completed.</p> <p>On 09/06/24 at 1:54 p.m., the following observations were made in room [ROOM NUMBER]: the carpet was torn across the middle of the room with 3-4 inch strings and raised in places and the bathroom tile had missing tiles, torn tiles, and raised and buckled tiles.</p> <p>On 09/06/24 at 1:55 p.m., Resident #20 was asked how they felt about the carpet and tile in room [ROOM NUMBER]. They stated, I'm embarrassed and its dangerous and it not how I live.</p> <p>On 09/06/24 at 1:57 p.m., Resident #45 was asked how they felt about the carpet and tile in room [ROOM NUMBER]. Resident #45 stated they tripped over the carpet tear causing them to fall, the bathroom cant be clean, and its not how they like to live.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/09/24 at 10:12 a.m., the house keeping supervisor was taken to room [ROOM NUMBER] and shown the room and bathroom and asked what they saw. The House Keeping Supervisor stated the carpet had a tear across the length of the room and had fibers and threads coming from the carpet and the bathroom the tile was lifted up and one part was torn near the toilet. They were asked how long the tile and carpet been in disrepair. They stated it was in disrepair for at least one year and maintenance was aware of the issue and they attempted to glue it down in some places but the carpet tear got bigger.</p> <p>On 09/09/24 at 10:22 a.m., the house keeping supervisor was asked if there were any other environmental concerns. A tour of the facility was conducted with the house keeping supervisor and the following observations were made:</p> <p>a. in room [ROOM NUMBER], the carpet was raised and buckled and wall paper was peeling from the wall around window and the air conditioning unit,</p> <p>b. in room [ROOM NUMBER], the carpet was soiled with food debris and trash was observed on the floor,</p> <p>c. in room [ROOM NUMBER], the carpet at bathroom door was damaged and frayed, the carpet in main room was damaged and buckled, there was a hole in the wall with exposed wires and a light fixture by doorway, there was water damage on the wall by air conditioner, the sheet rock by bed side b was damaged, and the paint was missing from the wall,</p> <p>d. in room [ROOM NUMBER], the room had brown drops of an unknown substance on ceiling, walls, and blinds,</p> <p>e. on 900 hall, a strong smell of urine was observed throughout the hall,</p> <p>f. in room [ROOM NUMBER], the wall had a large hole and damaged sheetrock outside bathroom and the carpet was buckled and raised, and soiled. There was a strong urine smell in room,</p> <p>g. in room [ROOM NUMBER], the wall was missing sheetrock and damaged near the window, the carpet was buckled , torn and raised with 3-4 inch strings at bathroom door and in the middle of room, and</p> <p>h. in room [ROOM NUMBER], the carpet was soiled and stained in middle of room and there was a hole in the wall near bed b.</p> <p>On 09/09/24 at 10:44 a.m., the house keeping supervisor was asked about the above referenced observations. The house keeping supervisor acknowledged they saw above referenced observation of the rooms and stated room [ROOM NUMBER] had exposed wires for the last 3 months, was unsure what or how long the spots on the ceiling and the side wall by the window and the blinds were there in room [ROOM NUMBER]. They stated, the holes in the wall in residents room on the 900 hall has been like that for a year. They stated, the staff reports to the maintenance, we clean the carpet but the carpet is damaged and retains the bad odors on the 900 hall which have been damaged for at least 12 months.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/10/24 at 09:56 a.m., the Regional Director of Plant Operations was asked to discuss his observations of room [ROOM NUMBER] and was shown the Maintenance Work Order Log Sheet document, dated 08/08/24. They stated they could see where the carpet was frayed and glued down but it was never brought to their attention. They stated the carpet was unsafe as was unsure if they had a policy for maintaining a home like environment.</p> <p>On 09/10/24 at 10:35 a.m., the Regional Director of Operations walked facility with surveyor and was shown the above referenced observation and asked what was there policy for maintaining a home like environment. They stated, the policy would be anytime an area is soiled or needs maintenance , that is something that any staff who see it will add to maintenance log for completion of work. They were asked if the above referenced observations maintains a homelike environment. they stated, No Sir , I don't think its a home like environment.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>46653</p> <p>Based on record review and interview, the facility failed to document the alleged abuse for one (#44) of three sampled residents.</p> <p>The DON reported 101 residents resided in the facility.</p> <p>Findings:</p> <p>The facility's ABUSE, NEGLECT AND EXPLOITATION AND MISAPPROPRIATION OF RESIDENT PROPERTY dated 06/23/17, read in parts .The person receiving the report or designee must document all incidents of alleged abuse/neglect on incident reports, which are forwarded directly to the Abuse Counselor .</p> <p>Resident #44 had diagnosis of Hypertensive Chronic Kidney Disease and Anxiety Disorder.</p> <p>On 09/20/24 at 10:20 p.m., there was no records of initial report found.</p> <p>On 09/10/24 at 10:58 a.m., LPN # reported that CMA# had received allegation of abuse from Resident #44 and reported to me on 09/06/24 at 7:30a.m. during shift change.</p> <p>On 09/10/24 at 10:59 a.m., LPN# reported there was no documentation.</p> <p>On 09/10/24 at 11:07 a.m., the DON reported the company policy and procedure states that the person receiving the allegation should fill out an incident report and no documentation was completed by the CMA # .</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on record review and interview, the facility failed to ensure quarterly assessments were completed within 92 days of the previous ARD for two(#1 and #75) of 32 sampled residents whose MDS assessments were reviewed.</p> <p>The DON identified 102 residents resided in the facility.</p> <p>Findings:</p> <p>The facility's Resident Assessment policy, revised 01/12/20, read in part, Quarterly assessments will be conducted not less than once every 3 months (92 days).</p> <p>1. Resident #1 was admitted on [DATE] with diagnosis which included morbid obesity and hypotension.</p> <p>A summary of Resident #1's MDS Resident's MDS List document, dated 09/10/24, documented, a quarterly assessment with an ARD date of 04/25/24 was completed. The next assessment documented a significant change assessment with an ARD date 09/04/24 was completed. There was no documentation an MDS assessment was completed within 92 days on 07/25/24 of the 04/25/24 quarterly assessment.</p> <p>2. Resident #25 was admitted on [DATE] with diagnoses which included epilepsy, major depressive disorder, and muscle wasting.</p> <p>A summary of Resident #25's MDS Resident's MDS List document, dated 09/10/24, documented, a quarterly assessment with an ARD date of 04/06/24 was completed. The next assessment documented a significant change assessment with an ARD date 09/04/24 was completed. There was no documentation an MDS assessment was completed within 92 days on 07/05/24 of the 04/06/24 quarterly assessment.</p> <p>On 09/04/24 at 12:14 p.m., Corporate Nurse #1 was asked to review Resident #1 and Resident # 25's MDS assessments. Corporate Nurse #1 stated Resident #1 did not have a MDS assessment completed 07/25/24 and Resident #25 did not have a quarterly assessment completed 07/05/24 after reviewing all residents MDS assessments the night prior. They stated it was not a good thing to admit.</p>		

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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>Ensure each resident receives an accurate assessment.</p> <p>46653</p> <p>Based on record review and interview, the facility failed to ensure that Resident #102 MDS records accurately reflected the residents status of discharge.</p> <p>The DON stated 101 residents resided in the facility.</p> <p>Findings:</p> <p>On 09/09/24 at 10:40 a.m., the MDS assessment records inaccurately documented that Resident #102 discharged from the facility to the hospital.</p> <p>On 09/09/24 at 10:41 a.m., Resident #102 Nursing Notes dated, 06/03/24, documented Resident #102 phone call arrangements were made for resident to be discharged home on Sunday at 10 a.m</p> <p>On 09/09/24 at 10:42 a.m., Resident #102 Physician Orders dated 06/23/24, documented Resident #102 was discharged home.</p> <p>On 09/09/24 at 10:43 a.m., the MDS Coordinator #1 reported the MDS records were inaccurately coded resident discharged home and not to the hospital.</p> <p>On 09/09/24 at 11:01 a.m., the Administrator reported we do not have an policy for inaccurate MDS documentation.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to ensure the residents carpet was not torn and frayed causing a resident to fall for one (#45) of one resident sampled for accidents and hazards.</p> <p>The DON identified 102 residents resided in the facility</p> <p>Findings:</p> <p>The facility's Fall Management policy, dated 01/12/18, read in part, If a fall occurs, the qualified staff assesses for injury from the fall, immediately investigates the reason and determines the intervention to prevent future falls-complete the Incident/Accident Report in the EHR.</p> <p>The facility's Resident Room Cleaning policy, dated 11/2021, read in part, Purpose: To provide a clean, attractive, and safe environment for residents, visitors, and staff.</p> <p>A Maintenance Work Order Log Sheet document, dated 08/08/24 documented a work order was submitted to repair the floor torn. It did not document a repair was completed.</p> <p>Resident #45 was admitted on [DATE] with diagnoses which included Parkinson's disease, dementia, and bipolar disorder.</p> <p>A quarterly assessment, dated 06/07/24, documented Resident #45's cognition was intact, used a walker to ambulate, and ambulated independently.</p> <p>A Incident/Accident Report dated 08/19/24, documented Resident #45 had a fall. It documented uneven flooring, not using their walker as contributing factors, and Resident #45 complained of pain and a skin tear on their left arm as a result of the fall.</p> <p>Resident #45's care plan, dated 08/19/24, intervention after the fall on 08/19/24 read in part, Educated resident to keep walker with {them} and use it while walking at all times. It did not document an intervention addressing the carpet that was torn and frayed as being repaired to prevent future accidents and hazards.</p> <p>On 09/06/24 at 1:04 p.m., a family representative stated the carpet was torn on both sides of the room and Resident #45 had a fall caused by tripping over the torn and frayed carpet. They stated resident #45 had a big bruise on their arm caused by the fall.</p> <p>On 09/06/24 at 1:54 p.m., the following observations were made in room [ROOM NUMBER], the carpet was torn across the middle of the room with 3-4 inch strings and raised in places and the bathroom tile had missing tiles, torn tiles, and raised and buckled tiles.</p> <p>On 09/06/24 at 1:55 p.m., Resident #20 was asked how they felt about the carpet and tile in room [ROOM NUMBER]. They stated, I'm embarrassed and its dangerous and its not how I live.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/06/24 at 1:57 p.m., Resident #45 was asked how they felt about the carpet and tile in room [ROOM NUMBER]. Resident #45 stated they tripped over the carpet tear causing them to fall.</p> <p>On 09/09/24 at 10:12 a.m., the house keeping supervisor was taken to room [ROOM NUMBER] and shown the room and bathroom and asked what they saw. The house keeping supervisor stated the carpet had a tear across the length of the room and had fibers and threads coming from the carpet. They were asked how long had the carpet had been in disrepair. They stated it was in disrepair for at least one year and maintenance was aware of the issue and she attempted to glue it down in some places but the carpet tear got bigger.</p> <p>On 09/10/24 at 9:56 a.m., the Director of Plant Operations was asked to look at room [ROOM NUMBER] and discuss their observations and about the maintenance work order dated 08/08/24 for room [ROOM NUMBER]. They stated they were not aware of the damaged carpet and the work order did not document the repairs were made, and it could grab on someone's foot or walker causing them to fall. They were asked how they felt about the safety of the carpet in room [ROOM NUMBER]. They stated with it being frayed, I don't think its safe.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46653</p> <p>Based on observation and interview, the facility failed to ensure safe food handling practices of covering food in a sanitary condition when on the tray line.</p> <p>The DON stated 101 residents received nutritional meals from the kitchen</p> <p>Findings:</p> <p>On 09/03/24 at 8:23 a.m., it was found that bowls of cereal were unwrapped, stacked and stored on tray line. The bottom of the bowls came in contact with cereal product.</p> <p>On 09/03/24 at 8:24 a.m., the Kitchen Aide #1 reported that the bowls of cereal are supposed to wrapped and not stacked on each other.</p> <p>On 09/10/24 at 9:43 a.m., the Dietary Manager reported the bowls of cereal was an infection control issue and not to serve the cereal to residents.</p> <p>On 09/10/24 at 9:44 a.m., the Dietary Manager reported we have no policy for this issue.</p>