STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375243	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jan Frances Care Center	815 North Country Club Road Ada, OK 74820

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583 Based on record review and interview, the facility failed to ensure a resident's emergency contact was notified of medication changes and the physician and emergency contact were notified of a change in condition for 1(#1) of 3 sampled residents reviewed for notification of change. The AIT identifed 48 residents resided in the facility. Findings: Resident #1 had diagnoses which included painful micturition (act of urinating), personal history of urinary calculi, urinary tract infection, and anxiety disorder. A resident care plan, revised 03/17/25, showed Resident #1 had a catheter and was at increased risk for urinary tract infections. The care plan showed the resident had chronic pain. A physician's order, dated 03/18/25, showed Ativan (antianxiety medication) 0.5 mg two times a day for seven days. A physician's order, dated 03/20/25, showed pyridium (relieves symptoms caused by urinary tract infections and other urinary problems) 200 mg three times a day for seven days. A physician's order, dated 03/24/25, showed Ativan 0.5 mg two times a day. There was no documentation Resident #1's emergency contact was notified of the change in medication orders. A progress note, dated 03/28/25 at 3:58 a.m., read in part, An aide reported that resident was not acting right, resident just staring at the ceiling, VS [vital signs] 89/52, 92, 18, 98.7, 93% on RA [room air], no distress notes, resident not answer questions, resident had vomited earlier this shift.Had given a pain pill earlier for c/o [complain of] back pain. There was no documentation Resident #1's physician and emergency contact were notified of the change in condition. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/04/25 at 2:13 p.m., LPN #1 was asked who was notified for a change in a resident. LPN #1 stated either the resident's physician assistant or doctor. LPN #1 stated administration, the DON, and the family were also notified. LPN #1 stated the staff would assess the resident and notify the doctor of what they found, follow any orders, then notify the DON and the family. On 04/03/25 at 2:25 p.m., LPN #1 was shown the electronic medical record progress notes to review for Resident #1. After review, LPN #1 was asked if the resident's emergency contact was notified for changes to the resident's medication on 03/20/25 for pyridium. LPN #1 stated, Do not see where they did. LPN #1 was asked if the resident's emergency contact was notified for the Ativan order dated 03/24/25 changing to twice a day. They stated, Don't see. LPN #1 was asked where the emergency contact and the physician was notified about Resident #1 Not acting right on 03/28/25. They stated, Don't see. LPN #1 stated they usually completed a note and also an observation note that had all the contact information on it.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 45583 Based on record review and interview, the facility failed to obtain a urinalysis to detect signs of urinary infection and blood for 1 (#1) of 3 residents sampled for unnecessary medication. The AIT identified 48 residents resided in the facility. Findings: Resident #1 had diagnoses which included urinary tract infection, personal history of urinary calci, painful Micturition (painful urination), malignant neoplasm of the prostate and kidney failure. An Encounter Note, dated 01/08/25, showed a TRUS (trans rectal ultrasound) of the prostate had been performed that day. The note showed to obtain a urinalysis to detect signs of urinary infection and blood. The note showed Resident #1 required surgical treatment. There was no documentation to show a urinalysis was obtained in Resident #1's clinical record. A resident care plan, revised 03/17/25, showed Resident #1 had a catheter and was at increased risk for urinary tract infections. On 04/07/25 at 3:27 p.m., the DON was asked to locate the urinalysis requested on the encounter note dated 01/08/25. They stated it may have been thinned and went to look for it. On 04/07/25 at 3:57 p.m., the assistant director of nursing stated they were not able to locate the urinalysis.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45583 Based on observation, record review, and interview, the facility failed to ensure infection control practices were maintained during catheter care for 1 (#2) of 3 sampled residents reviewed for activities of daily living care for dependent residents. The AIT identified 48 residents resided at the facility. Findings: On 04/04/25 at 11:13 a.m., LPN #1 performed hand hygiene, donned gloves, gathered supplies of saline, drain sponge and another sponge, and placed then on the resident's bedside table. LPN #1 removed the old drain sponge from the suprapubic catheter and no drainage observed. LPN #1 cleaned the area, applied an ointment, covered the resident with their blanket, threw away the trash, adjusted the resident's covers, bedside table, television remote, and the resident's phone. LPN #1 did not change their gloves or perform proper hand hygiene during the performance of catheter care. Resident #1 had diagnoses which included painful micturition (act of urinating), personal history of urinary calculi, urinary tract infection, and anxiety disorder. A resident care plan, revised 03/17/25, showed Resident #1 had a catheter and was at increased risk for urinary tract infections. On 04/04/25 at 11:25 a.m., LPN #1 stated they should have changed their gloves after cleaning the tube.