

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Noble Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 North 8th Street Noble, OK 73068	

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>49701</p> <p>Based on observation and interview, the facility failed to promote resident dignity by staff standing over residents while assisting them to eat.</p> <p>The administrator identified 81 residents resided in the building and 17 required assistance with eating.</p> <p>Findings:</p> <p>On 08/06/24 at 8:37 a.m., CMA #1 was observed standing while assisting two residents to eat at the dining table. CNA #1 was at the next table standing while assisting a resident to eat. There were eight empty dining chairs within a few feet of both staff that were standing. There was also another staff that was seated while feeding residents.</p> <p>On 08/06/24 at 9:26 a.m., CMA #1 stated they did not know about standing or sitting because they usually worked the night shift.</p> <p>On 08/06/24 at 9:29 a.m., CMA #1 stated they are supposed to sit down with the resident, but they were just trying to help the resident get the food on the spoon, so it wouldn't get scooped off the plate. They stated they did not mean any disrespect towards the resident.</p> <p>On 08/06/24 at 10:03 a.m., the DON stated the policy is to sit down eye level to feed residents and that staff were aware of the policy.</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 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** 49701</p> <p>Based on record review and interview, the facility failed to ensure residents were offered the choice to formulate an advanced directive for two (#7 and #40) of 24 sampled residents whose advance directive acknowledgements were reviewed.</p> <p>The administrator identified 81 residents resided in the facility.</p> <p>Findings:</p> <p>An Advanced Directives policy, reviewed April 22, 2024, read in part, Upon admission, identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advance directive.</p> <ol style="list-style-type: none"> 1. Resident #7 was readmitted on [DATE] with diagnoses which included traumatic brain injury. 2. Resident #40 was admitted on [DATE] with diagnoses which included hemiplegia of left side and acute kidney failure. <p>On 08/05/24 at 11:57 a.m., the DON stated that they are to ask each resident at admission, and they did not see that an advance directive was uploaded for either resident.</p> <p>On 08/07/24 at 1:20 p.m., the DON stated they were unable to locate the advance directives for Resident #7 or #40, and that it may have been in Resident #7's old chart. They stated they have both been completed as of 08/06/24 and are uploaded into their charts.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701</p> <p>Based on record review and interview, the facility failed to ensure resident assessments were accurately coded on two of the MDS assessments completed for one (#7) of 19 sampled residents reviewed for accurate assessments.</p> <p>The Administrator identified 81 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #7 had diagnoses which included traumatic brain injury, nephrolithiasis, and left upper extremity paralysis.</p> <p>A Resident Summary, dated 01/19/24, 01/20/24/01/21/24, and 01/22/24, all document resident #7 had an indwelling catheter.</p> <p>A Physician's order, dated 01/24/24, documented to change foley catheter as needed for clogged/dislodged/or clinically indicated.</p> <p>The quarterly MDS, dated [DATE], documented Resident #7 had no bowel or bladder appliances.</p> <p>The quarterly MDS, dated [DATE], documented Resident #7 had no bowel or bladder appliances.</p> <p>On 08/07/24 at 11:46 a.m. the MDS Coordinator stated the 01/23/24 and 04/24/24 quarterly MDS were both coded inaccurately because Resident #7 did have an indwelling catheter at the time of both assessments.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387</p> <p>Based on observation, record review, and interview, the facility failed to assess, monitor, and intervene for:</p> <p>A. a resident who tested positive for COVID-19 for one (Res #6) of one sampled resident reviewed for COVID-19, and</p> <p>B. a resident with a PICC line for one (Res #31) of one sampled resident reviewed for IV therapy.</p> <p>The administrator identified 82 residents resided in the facility.</p> <p>Findings:</p> <p>A facility Vascular Access Devices and Infusion Therapy Procedures, dated 2011, documented a PICC line as a peripheral intravenous line that ends just above the atria of the heart. The external length of the PICC line should be measured with every dressing change. The procedure documented the extension kit should be changed every seven days.</p> <p>1. Res #6 had diagnoses which included weakness and difficulty swallowing after a stroke.</p> <p>A quarterly MDS, dated [DATE], documented Res #6 was cognitively intact.</p> <p>A progress note, dated 08/02/24 at 1:30 a.m., documented Res #6 had complained of difficulty breathing and was assessed to have a fever and diminished lung sounds. The note documented the resident was sent to the hospital for evaluation at 10:00 p.m. the prior evening.</p> <p>A progress note, dated 08/02/24 at 1:36 a.m., documented Res #6 returned to the facility around 12:30 a.m. with a diagnosis of COVID-19.</p> <p>There are no progress notes documented on 08/03/24 through 08/05/24.</p> <p>A record review documented no order to monitor the resident's respiratory status.</p> <p>On 08/05/24 at 09:39 a.m., Res #6 was observed receiving their breakfast tray. A sign on the door documented the resident was on isolation due to COVID-19.</p> <p>A physician order, dated 08/08/24 at 12:50 p.m., documented to monitor the resident's respiratory status every 8 hours and report worsening symptoms to the physician. The order documented to monitor temperature, blood pressure, pulse, respirations, and oxygen saturation.</p> <p>On 08/08/24 at 1:34 p.m., the DON stated Res #6 was not being monitored for respiratory status secondary to COVID-19 prior to 08/08/24.</p> <p>2. A discharge MDS, dated [DATE], documented Res #31 was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Res #31 readmitted to the facility on [DATE] with diagnoses which included sepsis.</p> <p>A physician order, dated 07/11/24, documented to administer daptomycin (an antibiotic) intravenously one time per day for UTI.</p> <p>A progress note, dated 07/17/24, documented the resident was receiving antibiotics through a PICC line in the right arm. The note documented there was a clear dressing in place.</p> <p>A progress note, dated 07/18/24, documented the resident was receiving antibiotics through a PICC line in the right arm. The note documented there was a clear dressing in place.</p> <p>A care plan, reviewed 07/18/24, did not document the resident had a PICC line or interventions for the monitoring and management of a PICC line.</p> <p>A progress note, dated 07/20/24, documented the resident was receiving antibiotics through a PICC line.</p> <p>A progress note, dated 07/22/24, documented the resident's PICC dressing was saturated due to their shower and was changed.</p> <p>Skilled nurses notes from readmission to 07/23/24 were reviewed and did not document dressing changes, monitoring, or removal of the PICC line. Record review documented no order for the monitoring or management of the PICC line. There was no order to discontinue the PICC line or change the dressing.</p> <p>There was no further documentation regarding the PICC line in the progress notes.</p> <p>On 08/06/24 at 12:15 p.m., Res #31 was observed seated in their wheelchair in the dining room. When asked if the resident had an IV in their arm they shrugged and shook their head. They were wearing a long sleeve shirt and the upper arm could not be visualized.</p> <p>On 08/07/24 at 9:46 a.m., the DON stated the PICC was discontinued, but there was no documentation when the PICC line was discontinued or by whom.</p> <p>On 08/07/24 at 1:18 p.m., LPN #2 stated PICC care involved ensuring the dressing was clean, dry, and intact with no drainage. They stated the line must be checked for patency and the hubs covered with a green cap (antibacterial cap) when not in use. They stated the PICC should be flushed as ordered and the site should be assessed at least once per shift.</p> <p>On 08/07/24 at 1:21 p.m., the DON stated there should have been an order to monitor the resident's PICC site. They stated there should have been an order to change the dressing every 7 days.</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** 46387</p> <p>Based on record review, and interview, the facility failed to complete neurological checks per protocol after an unwitnessed fall for one (#71) of seven sampled residents reviewed for accidents.</p> <p>The administrator identified 82 residents resided in the facility.</p> <p>Findings:</p> <p>An INCIDENT/ACCIDENT REPORTING policy, reviewed 01/12/22, documented a neurological assessment flow sheet will be immediately initiated and maintained for each incident/accident involving an injury of any kind to the head or any unwitnessed fall. It documented monitoring is triggered to be completed for 72 hours.</p> <p>Res #71 admitted to the facility on [DATE] with diagnoses which included history of right femur fracture and spinal disc disorder.</p> <p>An incident report, dated 07/04/24, documented the resident had an unwitnessed fall resulting in a small bruise to the residents top right side of the head. The incident report documented neuro checks were started.</p> <p>A neuro check log for Res #71 dated 07/04/24 through 07/06/24, documented neuro checks were not completed 16 of 18 opportunities.</p> <p>On 08/08/24 at 11:13 a.m., the DON stated neuro checks were not completed per protocol for the 07/04/24 fall.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387</p> <p>Based on observation, record review, and interview, the facility failed to obtain a physician order for the placement of a foley catheter for one (#31) of three sampled residents reviewed for catheters.</p> <p>The administrator identified 82 residents resided in the facility.</p> <p>Findings:</p> <p>Res #31 readmitted to the facility on [DATE] with diagnoses which included sepsis.</p> <p>A progress note, dated 07/12/2024 at 6:24 p.m., documented a foley catheter was inserted per provider order. A review of physician orders from 07/11/24 to 08/06/24 did not document an order for placement of a foley catheter.</p> <p>On 08/06/24 at 12:15 p.m., Res #31 was observed seated in their wheelchair in the dining room. A foley catheter drainage bag was observed hanging from the wheelchair.</p> <p>On 08/07/24 at 9:46 a.m., the DON stated the nurse did not enter an order to place the foley before it was placed.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>46387</p> <p>Based on observation, record review, and interview, the facility failed to supervise a resident while administering a breathing treatment for one (#49) of one sampled residents reviewed for respiratory treatments.</p> <p>The administrator identified 82 residents resided in the facility.</p> <p>Findings:</p> <p>Res #49 had diagnoses which included COPD.</p> <p>A physician order, dated 05/21/24, documented to administer budesonide 0.5 mg/2 mL suspension for nebulization twice per day for pneumonia.</p> <p>On 08/05/24 at 11:00 a.m., Res #49 was observed seated on the end of their bed holding a breathing treatment mask to their face. A nurse was not observed in the room or in the hall. The resident was observed turning off the treatment and setting the mask aside.</p> <p>On 08/05/24 at 11:06 a.m., Res #49 stated the nurse set up his breathing treatment and left. They stated the nurses never stay to monitor them during the treatment.</p> <p>On 08/05/24 at 11:08 a.m., LPN #2 stated the resident should be monitored during the breathing treatment unless they have been assessed to self administer medications.</p> <p>Res #49 did not have an assessment to self administer medications.</p> <p>On 08/08/24 at 11:13 a.m., the DON stated the nurse should stay with the resident during administration of a breathing treatment to monitor the resident.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>46387</p> <p>Based on record review and interview, the facility failed to ensure psychotropic medications were monitored for target behaviors and side effects for one (#28) of five sampled residents reviewed for unnecessary medications.</p> <p>The DON identified 50 residents received psychotropic medications.</p> <p>Findings:</p> <p>Res #28 had diagnoses which included anxiety disorder.</p> <p>A physician order, dated 06/19/24, documented to administer mirtazapine 7.5 mg at bedtime for anxiety disorder.</p> <p>A physician order, dated 04/24/22, documented to administer buspirone 5 mg twice per day for anxiety disorder.</p> <p>A physician order, dated 02/28/24, documented to administer fluoxetine 40 mg in the morning for anxiety disorder.</p> <p>Behavior and side effect monitoring for 06/01/24 through 06/30/24 documented missing documentation for 25 of 60 opportunities.</p> <p>Behavior and side effect monitoring for 07/01/24 to 07/31/24 documented missing documentation for 25 of 62 opportunities.</p> <p>Behavior and side effect monitoring for 08/01/24 to 08/07/24 documented missed documentation for 11 of 14 opportunities.</p> <p>On 08/08/24 at 11:18 a.m., the DON stated the facility did not do consistent monitoring of psychotropic medications for Res #28.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701</p> <p>Based on observation and interview, the facility failed to ensure food was palatable and served at appetizing temperatures during meals.</p> <p>The Administrator identified 80 residents received services from the kitchen.</p> <p>Findings:</p> <p>08/05/24 at 8:08 a.m., Resident #72 stated the food is not good. trays sit out too long in the hallway, and it is cold when we get it.</p> <p>On 08/05/24 at 8:45 a.m., Resident #37 stated it could be better, the taste is not good and we need variety.</p> <p>On 08/05/24 at 9:23 a.m., Resident #7 stated what is served is never what is on the menu.</p> <p>On 08/05/24 at 11:14 a.m., Resident # 41 stated I would rather have decent food, its atrocious.</p> <p>On 08/06/24 at 9:09 a.m., there were 2 uninsulated wire carts on hall 200 with trays waiting to be passed. At 9:13 a.m., a tray is taken into room [ROOM NUMBER].</p> <p>On 08/06/24 at 9:23 a.m., Resident # 31's tray is observed sitting on the bedside table unopened and not within reach due to a fall mat against the bed. Resident # 31 is lying in bed and did not answer when asked if they were hungry. There were no staff in the room. Resident # 31's roommate stated Resident # 31 is unable to talk and is usually fed in the dining room.</p> <p>On 08/06/24 at 9:46 a.m., Resident # 31 is observed sitting up in wheelchair with tray on bedside table placed in front of them uneaten. There were no staff during this observation.</p> <p>On 08/06/24 at 9:50 a.m., Resident # 31 was observed with oatmeal for breakfast, a large cup of water, Resident # 31 was able to drink with assistance, but had no interest in meal, a CNA was in the room to assist and prompt resident to eat.</p> <p>On 08/06/24 food was temped before being placed on steam table and while on steam table for proper temperatures. The dining room trays were plated first with the first tray going out at 12:03 p.m.</p> <p>On 08/06/24 at 1:20 p.m., the last tray was taken as a test tray. The food was lukewarm. The sweet potato was 118 degrees, the zucchini was 126.7 degrees and very bland with no flavor, and the pork was 116 degrees with a large amount of fat and gristle. The orange juice, apple juice, and cranberry juice were diluted.</p> <p>On 08/06/24 at 1:35 p.m., dietary aide #1 stated usually one of the cooks taste the food, but was unaware if that was done today. Dietary aide #1 is who plated the food for the test tray, when they observed the pork on the test tray they stated that's just pure gristle, I hope one of our residents didn't get a piece like that.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/06/24 at 1:58 p.m., the LD stated the meat should have been trimmed before serving because gristle and fat shouldn't be served. They stated the juice machine doesn't mix properly and that the juice was diluted. They stated it was supposed to be calibrated and they did call the company today. They stated in the future the juice would be taste tested before being served. They stated the policy is for food to be served at a palatable temperature.</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>49701</p> <p>Based on observation, record review, and interview, the facility failed to ensure food items were labeled, dated, and stored according to the facility policy.</p> <p>The administrator identified 80 residents received services from the kitchen.</p> <p>Findings:</p> <p>The facility's Food Storage policy, revised February 6, 2024, read in part, air-tight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and date opened.</p> <p>On 08/05/24 at 7:20 a.m., a container that read sugar was observed with the lid completely open. A large bag of flour was in the original bag, but was ripped open with more than half already absent from the container.</p> <p>On 08/05/24 at 7:24 a.m., the DM stated they believed that one of the unmarked containers in the refrigerator was jello, and the other contained cream corn. They stated there was no label or date.</p> <p>On 08/05/24 at 7:26 a.m., the DM stated they had premade ice cream snacks in cups in the freezer, but agreed they had no label or date.</p> <p>On 08/05/24 at 7:29 a.m., the DM stated they had no idea why the sugar was open and they stated I don't have an answer, we need a container in reference to the ripped open partially used flour in the original container.</p> <p>On 08/06/24 at 10:06 a.m., the LD stated everything needs to be dated, labeled, and securely closed.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701</p> <p>Based on observations, record review, and interviews the facility failed to follow their enhanced barrier precautions while providing wound care for one (# 3) of 20 residents that required enhanced barrier precautions and failed to follow infection control practices during medication pass.</p> <p>The Administrator identified 81 residents resided in the facility.</p> <p>Findings:</p> <p>An Enhanced Barrier Precautions policy, dated April 1, 2024, read in part, this facility uses enhanced barrier precautions as a strategy to decrease transmission of CDC-targeted and epidemiologically important MDROs when contact precautions do not apply. Indications: Wounds and high contact resident care activities that include wound care.</p> <p>1. Resident # 3 was readmitted on [DATE] and had diagnoses which included stage 4 pressure ulcer to right buttocks, congenital scoliosis, and contractures of right upper arm and bilateral lower legs.</p> <p>A physician order, dated 04/10/24, documented to conduct hand hygiene before entering and after leaving room, all healthcare personnel must wear gown and gloves for the following high-contact resident care activities: dressing, bathing, transfers, changing linens, providing hygiene, changing briefs/toileting, indwelling device care or use, and wound care on chronic wounds.</p> <p>On 08/07/24 at 2:30 p.m., no signage was posted for EBP precautions, no PPE was observed near resident's door.</p> <p>On 08/07/24 at 2:31 p.m., LPN #1 prepared supplies and walked into resident # 3's room to do wound care. LPN #1 donned gloves and positioned resident for wound care. LPN #1 removed old dressings and discarded used gloves. LPN #1 then donned clean gloves to clean wounds to right shoulder and right ischium. LPN #1 donned new gloves before applying santyl with a q-tip to both wounds, finished wound care, applied dressings, and repositioned resident #3.</p> <p>LPN #1 was not wearing a gown and did not wash or sanitize their hands at any point during the observation of wound care being provided.</p> <p>On 08/07/24 at 2:43 p.m., LPN #1 stated they wished they would have put on a gown and used sanitizer when changing gloves.</p> <p>On 08/07/24 at 2:50 p.m. the DON stated LPN #1 is the wound care nurse, and they must have been nervous being watched by a state surveyor.</p> <p>46387</p> <p>2. On 08/07/24 at 8:25 a.m., medication pass was observed performed by CMA #2. Upon arrival to the medication cart an open purple can of energy drink and an open package of wafer cookies on top of the medication cart on the towel placed under the resident water container was observed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Noble Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 North 8th Street Noble, OK 73068	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/07/24 at 8:34 a.m., CMA #2 entered a resident's room and obtained a blood pressure from the resident. They did not perform hand hygiene before returning to the medication cart and preparing the resident's medications.</p> <p>On 08/07/24 at 8:38 a.m., the CMA was observed touching three pills with their bare hands to place them into the medication cup.</p> <p>On 08/07/24 at 8:44 a.m., the CMA left a residents room after administering medications and did not perform hand hygiene before returning to the medication cart and preparing the next resident's medications.</p> <p>On 08/07/24 at 8:45 a.m., the CMA was observed touching one pill with their bare fingers to place it into the medication cup.</p> <p>On 08/07/24 at 8:51 a.m., the CMA was observed touching one pill with their bare fingers.</p> <p>On 08/07/24 at 8:55 a.m., CMA #2 stated hand hygiene should be performed before and after each resident. They stated medications should not be touched with bare hands. They further stated personal food and drink are not to be on the medication cart. They were observed removing the can and package of cookies and placing them into the bottom drawer of the medication cart.</p> <p>On 08/07/24 at 9:05 a.m., the ADON stated medication should not be touched with bare hands. They stated hand hygiene should be performed before and after each patient interaction and before touching the medications. They stated an open can and food should not be on the medication cart.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>34460</p> <p>Based on record review and interview, the facility failed to maintain an antibiotic stewardship program and infection surveillance to monitor antibiotic use for residents from April 2024 through June 2024.</p> <p>The MDS coordinator identified 6 residents who were prescribed antibiotics.</p> <p>Findings:</p> <p>The facility's Antibiotic Stewardship Program policy, dated January 2022, read in part, .</p> <p>stewardship actions .prescription record keeping, dose, duration, route, and indication of every prescription MUST be documented in the medical record of every resident, regardless of prior prescriptions or documentation elsewhere .records will be reviewed monthly to assess compliance with this requirement as well as prescription appropriateness .site and type of infection .utilize the McGreer's Criteria .data will be compiled monthly .interpret monthly data .compile monthly information for the Quality Committee .</p> <p>During antibiotic stewardship and infection surveillance review, there was missing documentation of the McGreers criteria, symptoms, organism from culture from April to June 2024.</p> <p>On 08/08/24 at 12:14 p.m., the DON stated there was no documented antibiotic stewardship/infection surveillance from April to June 2024.</p>		