

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER Shawnee Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 West Gilmore Shawnee, OK 74804	

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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents narcotic pain medications were able to be refilled and arrange for a pain specialist for 1 (#1) of 3 sampled residents reviewed for pain management. Resident #1 ran out of morphine and went six days without the medication which caused increased pain levels.</p> <p>Findings:</p> <p>On 05/14/25 at 10:00 a.m., Resident #1's bubble pack of morphine tablets were observed with CMA #1. The fill date on the morphine showed it was filled on 05/09/25.</p> <p>Resident #1's admission orders, dated 04/28/25, showed they had the following orders:</p> <p>Schedule II morphine extended release; 30 milligrams, one tablet by mouth twice a day for chronic pain.</p> <p>Schedule two oxycodone 10 milligrams one tablet by mouth every four hours as needed for chronic pain.</p> <p>Resident #1 admission morphine count sheet, dated 04/28/25, showed they were admitted with eleven tablets.</p> <p>Resident #1's base line care plan, dated 04/30/25, showed Resident #1 received opioid's of morphine and oxycodone for chronic pain.</p> <p>The medication administration record, dated 04/28/25 through 05/13/25, showed Resident #1 received 11 doses of morphine after admission with the last dose being received on 05/04/25 at 10:14 a.m.</p> <p>The medication administration record also showed the resident did not receive the next 12 doses of morphine from 05/04/25 until 05/10/25 during the 4:00 p.m. to 8:00 p.m. medication pass. Resident #1 went without 12 doses (six days) of their routine morphine.</p> <p>Resident #1's nurses progress note, dated 05/05/25 at 9:20 a.m., showed they went to the emergency room due to being out of morphine and the script was pending.</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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1's nurses progress note, dated 05/06/25 at 6:00 p.m., read in part, Call from [Name deleted doctor] r/t [Resident #1] coming to ER for Rx. He advised that he had discussed with [Resident #1] his need to come to the ER. He advised [Resident #1] he would not prescribe PRN meds in ER.</p> <p>There was no documentation Resident #1 pain level was assessed prior to going to the emergency room.</p> <p>Resident #1 nurses progress note, dated 05/07/25 at 6:07 a.m., read in part, At 0210, 0422, and 0630, [2:10 a.m., 4:22 a.m., and 6:30 a.m.] the charge nurse and CNA entered room together to inform resident that it was time to turn and reposition d/t skin breakdown. Each time the resident very politely told staff that he will not turn until he gets his demands. Staff asked what he was referring to and he stated #1 I want a bariatric bed and #2 I want to see the pain doctor. The note was entered by RN #1.</p> <p>Resident #1's face sheet, dated 05/13/25, showed they were admitted to the facility on [DATE] and had diagnoses of anxiety, depression, paraplegia, and chronic pain. The face sheet showed Physician #1 was the attending physician for the resident.</p> <p>On 05/13/25 at 11:55 a.m., Resident #1 stated they had been at the facility three weeks and did not have a doctor. Resident #1 stated they ran out of their morphine and could not get it refilled and they went six days without their pain medication. Resident #1 stated they could live with a pain level of five ,but their pain went up to a seven without their morphine twice a day. Resident #1 stated they took other pain medication but it was not as effective without the morphine and the highest the pain got was a seven out of ten.</p> <p>On 05/14/25 at 10:17 a.m., CMA #1 stated the MDS coordinator was responsible for ordering all narcotic medications when it was needed. CMA #1 stated Resident #1 usually complained of pain in the neck and shoulder. CMA #1 stated Resident #1 came with some morphine and it ran out. CMA #1 stated there was a discrepancy on who Resident #1 physician was, and who was filling the morphine when it ran out. CMA #1 stated Resident #1 went to the emergency room to get the morphine, but they would not fill the script. CMA #1 stated they were not aware of Resident #1 being referred to a pain specialist and they went six days without the morphine. CMA #1 stated Resident #1 would complain of pain at a level of seven without the morphine. CMA #1 stated they did not document the level of pain, just where the pain was located when they provided as needed medication and/or routine pain medication.</p> <p>On 05/14/25 at 10:39 a.m., the corporate nurse consultant stated the facility had not been monitoring pain levels properly because it was not added to the medication administration record. The corporate nurse consultant stated the messages on the medication administration record were when medications were not provided as ordered. They reviewed the medication administration record and stated Resident #1 did not have morphine to take for six days.</p> <p>On 05/14/25 at 10:57 a.m., LPN #1 stated Resident #1 did not have a physician after April 30th and went to the emergency room to try and get their morphine. LPN #1 stated they thought there would be a new physician by now, but there continued to be no physician for Resident #1. LPN #1 stated physician #1 was contacted by the hospital emergency room and agreed to fill the morphine at the request of the emergency room. LPN #1 stated physician #1 worked at the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/14/25 at 11:36 a.m., the social service director stated they were responsible for making arrangements for outside services like pain management specialist. The social service director stated they were not aware of Resident #1's request for a pain management specialist.</p> <p>On 05/14/25 at 12:00 p.m., RN #1 stated they worked nights from 11:00 p.m. through 7:00 a.m. RN #1 stated Resident #1 had requested to see a pain specialist and they talked to RN #2 about it, but nothing more was done. RN #1 stated Resident #1 stated they were in more pain without the morphine and rated the pain between seven and eight. RN #1 stated Resident #1 went without their morphine for more then two days. RN #1 stated they could not get a prescription for the medication because the facility was transitioning to a new physician. RN #1 stated physician #1's last day was in April and the facility was attempting to get a new physician. RN #1 stated Resident #1 went to the emergency room to get their morphine two or three times. RN #1 stated Resident #1's normal pain level was a five and it was consistently at a seven to eight without the pain medication.</p> <p>On 05/14/25 at 12:33 p.m., RN #2 stated Resident #1 wanted to see a pain management doctor and spoke with the former administrator about it and no referrals were made. RN #2 stated they went to the administrator because the facility had no director of nursing and the resident did not have an attending physician. RN #2 stated Resident #1 went to the emergency room to attempt to get the morphine because there was no doctor to sign the script. RN #2 stated the emergency room would not write a script for Resident #1. RN #2 stated the hold up with getting the morphine prescription was Resident #1 did not have an attending physician. RN #2 stated they did not tell the social service director about the need for a pain specialist. RN #2 stated Resident #1's pain was back down with the morphine back in stock.</p> <p>On 05/14/25 at 2:13 p.m., the corporate nurse consultant, stated physician #1 was to fill prescriptions until a new physician was found. The corporate nurse consultant stated Resident #1 was without the pain medications for six days. The corporate nurse consultant stated there was no physician after 04/30/25, and that delayed the morphine prescription being written and filled.</p> <p>On 05/14/25, at 3:22 p.m., Physician #1 stated they sent an email in February to provide plenty of notice for a replacement for a medical director and physician for the residents. They stated it was very clear April 30th was going to be the last day. Physician #1 stated they were no longer filling prescriptions or providing care to residents after April 30th. Physician #1 stated the emergency room contacted them because they worked at the hospital and as a courtesy signed a prescription for morphine to be filled. Physician #1 stated Resident #1 came to the emergency room because the facility did not have a physician to fill the prescription.</p>		

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<p>F 0710</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>Based on record review and interview, the facility failed to have a supervising physician for 6 (#1, 2, 4, 5, 6, and #7) of 6 sampled residents reviewed for physician services. Physician #1 no longer provided services to the residents after 04/30/25.</p> <p>The corporate nurse consultant identified 39 residents who resided in the facility and had physician services from physician #1 and was without the supervision of a physician.</p> <p>Findings:</p> <p>The facility policy, Physician Services, last revised February 2021, read in part, The medical care of each resident is supervised by a licensed physician. Supervising the medical care of residents includes (but is not limited to) prescribing medications and therapy.</p> <p>An email, dated 02/26/25, read in part, Please accept this as my letter of resignation as the medical director of Shawnee Care Center. I will provide services through April 30, 2025. If you choose to replace me prior to that date, I would understand. The email was sent from physician #1.</p> <p>On 05/13/25 at 10:34 a.m., Resident #2's family stated Physician #1 was no longer the physician and they did not know who replaced them.</p> <p>On 05/13/25 at 10:55 a.m. Resident #5 stated they did not have a physician after Physician #1 left.</p> <p>On 05/13/25 at 11:08 a.m., Resident #7 stated Physician #1 use to come see them and they did not know who was going to come now.</p> <p>On 05/13/25 at 11:25 a.m., Resident #4 stated Physician #1 was their doctor and they had to get a new one. Resident #4 stated they did not know who the new doctor was going to be.</p> <p>On 05/13/25 at 11:50 a.m., Resident #6 stated Physician #1 came monthly but quit the end of April.</p> <p>On 05/13/25 at 11:55 a.m., Resident #1 stated they had been at the facility three weeks and did not have a doctor. Resident #1 stated they ran out of their morphine and could not get it filled and they went six days without their pain medication. Resident #1 stated they can live with a pain a level of five but their pain went up to seven without their morphine twice a day. Resident #1 stated they took other pain medication but it was not as effective without the morphine and the highest the pain got was seven out of ten.</p> <p>On 05/14/25 at 2:13 p.m., the corporate nurse consultant, stated there was no physician, after 04/30/25, for 39 residents, and they did not know why it took so long for a replacement. The corporate nurse consultant stated on 05/01/25 there was no physician for Resident #1 and that delayed the morphine prescription from being written and filled.</p> <p>(continued on next page)</p>		

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F 0710 Level of Harm - Actual harm Residents Affected - Few	On 05/14/25 at 3:22 p.m., Physician #1 stated they sent an email in February to provide plenty of notice for a replacement for a medical director and physician for the residents. They stated it was very clear April 30th was going to be the last day. Physician #1 stated they were no longer filling prescriptions or providing care to residents after April 30, 2025.

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on observation, record review, and interview, the facility failed to have a registered nurse as the director of nursing.</p> <p>The corporate nurse consultant identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>On 05/12/25 at 1:48 p.m., the posted nurse staffing was observed without a name listed as the director of nursing.</p> <p>The undated facility employee list did not have a name of a registered nurse listed as the director of nursing.</p> <p>The undated list of facility key staff, provided by the corporate nurse consultant, did not contain a name listed as the director of nursing.</p> <p>A review of time cards for RN #3, the former director of nursing showed the last day of employment was April 1, 2025.</p> <p>On 05/13/25 at 2:34 p.m., the corporate nurse consultant stated the requirements were for the facility to have a full time registered nurse as the director of nursing. The corporate nurse consultant stated they did not have anyone designated as the director of nursing since the last one quit. The corporate nurse consultant stated they would need to look at the time cards to see when the last day RN #3 worked. They left and returned and stated April 1, 2025 was the last day of employment for RN #3.</p>

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<p>F 0841</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.</p> <p>Based on record review, and interview, the facility failed to have a medical director after 04/30/25.</p> <p>The corporate nurse consultant identified 49 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility policy Medical Director, last revised July 2016, read in part, Physician services shall be under the supervision of the medical director. Medical director functions also include, but are not limited to helping assure that the residents receive adequate services appropriate to meet their needs.</p> <p>An email, dated 02/26/25, read in part, Please accept this as my letter of resignation as the medical director of Shawnee Care Center. I will provide services through April 30, 2025. If you choose to replace me prior to that date, I would understand. The email was sent from physician #1, who was also the medical director.</p> <p>A review of the facility medical directors contracts showed the only contract for services was with physician #1. No new contracts were located that showed a new physician replaced physician #1.</p> <p>On 05/14/25 at 2:13 p.m., the corporate nurse consultant, stated there was no medical director after 04/30/25, and they did not know why it took so long for a replacement. The corporate nurse consultant stated on 05/01/25, there was no active medical director or signed contract for an active medical director.</p> <p>On 05/14/25 at 3:22 p.m., physician #1, the former medical director, stated they were the medical director until April 30th. Physician #1 stated they sent an email in February to provide plenty of notice for a replacement. They stated it was very clear April 30, 2025 was going to be the last day.</p>		