STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375246	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Care Center	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on observation, record review, and interview, the facility failed to ensure a gradual dose reduction for a psychotropic medication was initiated when ordered by the physician for 1 (#1) of 3 sampled residents whose medications were reviewed.The MDS coordinator identified 39 residents who received psychotropic medications.Findings:On 08/11/25 at 4:20 p.m., Res #1's medications were reviewed with CMA #1. A pill medication blister card, dated 07/07/25, showed a 30-day supply of olanzapine 15 mg tablets. The card showed the first dose of olanzapine 15 mg (an antipsychotic medication) had been popped on 07/19/25 and six tablets currently remined in the blister card.An undated face sheet showed Res #1 had diagnoses which included bipolar disorder and recurrent depressive disorders.A physician order, dated 12/16/24, showed to administer olanzapine 20 mg daily.A pharmacist monthly medication review, dated 07/01/25, showed a request for a gradual dose reduction of olanzapine 20 mg daily. The review showed the physician had agreed to decrease the dosage to 15 mg daily.A quarterly assessment, dated 07/07/25, showed Res #1 had a BIMS score of 11 and was moderately cognitively impaired. The assessment showed Res #1 had no symptoms of depression, no behaviors, and had received antipsychotic and antidepressant medication.A physician order, dated 07/07/25, showed to discontinue olanzapine 20 mg daily.A physician order, dated 07/07/25, showed to administer olanzapine 15 mg daily.A medication error report, dated 07/19/25, showed the dosage of olanzapine was changed from 20 mg daily to 15 mg daily on 07/07/25. The report showed CMA #1 was unaware the dosage had changed and continued to administer 20 mg daily until the error was noticed on 07/19/25. The report showed no apparent effects as an outcome for Res #1.On 08/11/25 at 4:20 p.m., CMA #1 stated the first dose of olanzapine 15 mg had been administered out of the pill medication blister card on 07/19/25. On 08/11/25 at 4:23 p.m., CMA #1 was asked what dosage of olanzapine Res #1 had received from 07/08/25 through 07/18/25. CMA #1 stated they had not realized the physician order had changed from 20 mg daily to 15 mg daily on 07/07/25 and continued to give the 20 mg pill until the error was noticed on 07/19/25. CMA #1 stated they should have verified the dosage shown on the physician order in the medical record with the dosage on the pill card prior to administration. On 08/12/25 at 12:15 p.m., the DON stated they completed an investigation after they were informed of a possible medication error for Res #1 on 07/19/25. They stated the physician order for olanzapine had changed from 20 mg to 15 mg daily on 07/07/25. The DON stated Res #1 continued to receive olanzapine 20 mg daily until the medication error was verified on 07/19/25. They stated CMA #1 should have verified the correct dosage on the pill card with the physician order prior to administration. The DON stated Res #1 received the wrong dosage of olanzapine for 11 days.

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