STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375256	A. Building B. Wing	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowlake Estates	959 Southwest 107th Street Oklahoma City, OK 73139

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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47751 Based on record review and interview, the facility failed to obtain signatures by the responsible party on admissions agreements for one (#44) of one resident reviewed for admissions. The director of nursing identified 114 residents who resided in the facility. A facility policy titled, Admissions, revised 03/13/2023, read in part, .Pre- Admission: .4. the director of admissions or designee will meet with the resident or the resident's agent or guardian .and will answer all questions pertaining to admission to the community .5. An acknowledgment Form, indicating that these items have been discussed with the resident/guardian, will be signed and dated by the resident/guardian and witnessed by the community representative. A copy of this signed form will be given to the resident . Findings: Res #44 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation, UTI, hyponatremia, CVA, and bulimia. The facility's admission packet, at the time of the resident's admission, contained the following: ~ Patient information, ~ Medicare Secondary Payer Screening Form, ~ Resident Influenza, Pneumococcal, COVID-19 Vaccine and Tuberculosis Consent. ~ Informed Consent for Telemedicine Services, ~ Advance Directive Acknowledgment and Request Form, ~ Resident and Family Handbook Receipt, ~ Consent to Treatment and Release of Medical Information, ~ Exhibit A to Resident Admission Agreement, (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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Resident Admission Agreement, ~ Advanced Directive Acknowledgement, ~ Authorization to Release Medical Information, On 02/13/24 at 10:25 a.m., during a phone interview with Res #44's representative, they stated they were never asked to and did not sign any admission paperwork when their family member was admitted to the facility nor were they asked to sign admission paperwork after the admission. No admission paperwork was located in the clinical record. On 02/16/24 at 3:46 p.m., the admission coordinator was asked what their procedure was for admissions. They stated they conducted the admission paperwork in the facility upon admission or emailed the admission packet to the resident's responsible party. They were asked if they had a signed consent to treat for Res #44. They stated they did not.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47751 Based on record review and interview, the facility failed to ensure a discharge summary was completed for five (#41, 44, 99, and #115) of five sampled residents reviewed for discharge summaries. The DON identified 114 residents resided in the facility. Findings: A facility policy titled Recapitulation Summary, revised on 01/12/202, read in part, .Standard of Practice: The staff will complete a recapitulation summary per standard guidelines in order to ensure the facility communicates necessary information to the resident, continuing care provider .Procedure: Follow Discharge Process or residents discharging from the facility .The summary should be completed within 20 days of the date of discharge. 1. Res #41 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, CVA affecting non-dominant side, chronic pain, insomnia, GERD, depression, muscle spasms, and hyperlipidemia. An admission/discharge summary report, dated 01/01/24 through 02/13/24, documented the resident was discharged to another facility on 01/12/2024. There was no documentation a discharge summary had been completed. 2. Res # 44 was admitted to the facility 12/24/23 with diagnoses which included UTI, CVA, personal history of malignant neoplasm of breast, muscle spasms, atrial fibrillation, insomnia, hyperlipidemia, and HTN. An admission/discharge summary report, dated 01/01/24 through 02/13/24, documented the resident was discharged to the hospital on 01/03/24. There was no documentation a discharge summary had been completed. 3. Res #99 was admitted to the facility on [DATE] with diagnoses which included chronic pain syndrome, diabetes, COPD, and HTN. An admission/discharge summary report, dated 01/01/24 through 02/13/24, documented the resident was discharged to home with home health services on 01/01/24. There was no documentation a discharge summary had been completed. 4. Res #115 was admitted to the facility on [DATE] with diagnoses which included CVA, HTN, diabetes, CKD, hypothyroidism, and neuromuscular disorder of the bladder. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission/discharge summary report, dated 01/01/24 through 02/13/24, documented the resident was discharged to home with home health services on 01/02/24. There was no documentation a discharge summary had been completed. On 02/16/24 at 3:10 p.m., the DON was asked if a discharge summary had been completed for residents #41, 44, 99, and #115. They stated if the discharge summary is blank in the EHR then a discharge summary was not completed. They stated the MDS coordinator was responsible for completing the discharge summaries.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47751 Based on record review, observation, and interview, the facility failed to provide enough staff on a 24-hour basis to meet the needs of the residents for one (#48) of six residents reviewed for ADL care. The DON identified 114 residents resided in the facility. Findings: A Staffing policy, revised 03/27/23, read in part, Policy: A facility must develop and implement staffing policies, which require staffing ratios based upon the needs of the residents .Procedure: 1. The Director of Resident Care Services will determine staffing ratios based on the level of care required by the residents . Res #48's quarterly assessment, dated 11/17/23 documented the resident's cognition was intact, required substantial assistance with most ADL's, and was always incontinent of bowel and bladder. Daily Staffing sheets, dated from 01/26/24 to 02/13/24, documented 27 of 57 shifts did not meet the staffing ratio requirements for the facility census. On 2/14/24 at 2:14 p.m., Res #48 was asked if they had any concerns regarding her care. They stated no one had been in to change their brief today. They were asked when it was changed last. They stated at 9:00 p.m. last night. The resident stated when she turned her call light on the CNAs come in and turn it off and say they will be right back and they hardly ever come back. They stated they have to call the DON at home to get a CNA to change their brief. CNA #9 was asked how often they check on their incontinent residents. They stated at least every two hours. They were asked when the last time they checked on Res #48. They stated they had not been in the resident's room today. CNA #9 was asked to demonstrate incontinent care on Res #48. The resident's brief was soaked with urine dripping onto their bed pad. On 2/14/24 at 2:27 p.m., CNA #5 was asked how often they check on their incontinent residents. They stated every hour and a half to two hours. They were asked when the last time they checked on resident #48. They stated they had not been in the resident's room today. On 2/14/24 at 2:34 p.m., CNA #6 was asked how often they check on their incontinent residents. They stated at least every hour. They were asked when the last time they checked on resident #48. They stated they had not been in the resident's room today. 02/15/24 at 6:43 a.m., RN #2 was asked if they felt they had adequate staff on the 11 p.m. to 7 a.m. shift. They stated not always. On 02/15/24 at 6:50 a.m., LPN #4 was asked if they felt they had adequate staff on the 11 p.m. to 7 a.m. shift. They stated they did not. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/15/24 at 12:25 p.m., CNA #7 was asked if they felt they had adequate staff on the 7 a.m. to 3 p.m. shift. They stated they did not have adequate staff on the shift. On 02/16/24 at 3:07 p.m., the DON was made aware of the insufficient staffing. They stated it is the staffing coordinator's responsibility to ensure the facility has adequate staff to meet the needs of the residents. The DON stated Res #48 often calls her at home to receive care.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 47751 Based on observation and interview, the facility failed to post nurse staffing information, which included all the required components, in an area where it could be reviewed by all residents and visitors. The DON identified 114 residents resided in the facility. Findings: On 02/13/23 through 02/16/23 hall 200 nurse staffing information was not posted. On 02/13/23 through 02/16/23 hall 300 nurse staffing information was not posted. On 02/13/23 through 02/16/23 hall 400 nurse staffing information was not posted. On 02/13/23 through 02/16/23 hall 500 nurse staffing information was not posted. On 02/16/24 at 3:03 p.m., the DON reported the nurse staffing information should have been posted in a prominent area daily.

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 47751 Based on observation, interview, and record review the facility failed to follow physician orders to provide diabetic residents with an HS snack and ensure snacks were served to all residents at times in accordance with resident's needs, preferences, and requests for four (#18, 26, 32, and #38) of four sampled residents reviewed for food and nutrition services. The DON identified 34 residents diagnosed with diabetes resided in the facility. Findings: A facility policy titled, Snacks and Supplements, dated 08/01/2018, read in part, .The Nutrition Services employee will prepare snacks and supplements in accordance with physician's order .1. Physician-ordered supplements (or snacks) and all-purpose snacks are prepared and available to residents three times daily .4. HS snacks will include a variety of foods to ensure each resident has an opportunity for a snack . 1. Resident #18 had diagnoses which included diabetes mellitus and protein-calorie malnutrition. A physician order, dated 03/02/22, documented to provide a daily bedtime snack. On 02/13/24 at 2:10pm., Res #18 was asked if they were offered a bedtime snack. They stated they rarely received a bedtime snack. 2. Resident #26 had diagnoses which included diabetes mellitus with diabetic polyneuropathy. A physician order, dated 03/29/22, documented to provide a daily bedtime snack. On 02/13/24 at 1:39 p.m., Res #26 was asked if they were offered bedtime snacks. They stated they rarely received a bedtime snack and if they got one, they have to go into the hall and ask for a snack. They stated most of the time there are not any snacks left. They stated they have observed the staff eating the residents' snacks. 3. Resident #32 had diagnoses which included diabetes mellitus. A physician order, dated 03/17/23, documented to provide a daily bedtime snack. On 02/14/24 at 9:45 a.m., Res #32 was asked if they were offered bedtime snacks. They stated no snacks have not been offered for quite a while. 4. Resident #38 had diagnoses which included diabetes mellitus. A physician order, dated 03/31/22, documented to provide a daily bedtime snack. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/15/24 at 8:25 a.m. Res #38 was asked if they were offered bedtime snacks. They stated they never receive a bedtime snack. 5. A resident council meeting form, dated 08/10/23, read in part, .Dietary .Snacks need to be passed by aides . A resident council meeting form, dated 09/07/23, read in part, .Dietary .Need more snacks. Snacks not being given to diabetic residents . A resident council meeting form, dated 12/05/23, documented, .Dietary .Need more snacks . On 2/13/24 at 12:13 p.m., the DM was asked about the resident snack schedule. They stated they prepare snacks for the residents at 10 a.m., 2 p.m., and a bedtime snack around 7 p.m. They stated fruit, sandwiches, and cake were usually available. They were asked what snacks are offered to the diabetics. They stated fruit, sandwiches, and the icing is left off the cake for the diabetics. On 02/15/24 at 1:14 p.m., the DON was made aware of the above stated. They stated they were not aware the residents were not being offered bedtime snacks.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 47751 Based on observation, record review, and interview, the facility failed to ensure residents' call lights were in reach for five (#3, 5, 21, 50 and #64) of five sampled residents who were reviewed for call light placement. The DON identified 114 residents resided in the facility. Findings: A Call Lights: Answering policy, dated 01/19/23, read in part, .Procedure .7. When leaving the room, be sure the call light is placed within the resident's reach. 1. Res #3 had diagnoses which included dementia, overactive bladder, difficulty in walking, chronic pain, dizziness, and HTN. A quarterly assessment, dated 11/08/23, documented the resident's cognition severely impaired, always incontinent of bowel and bladder, required substantial assistance with most ADLs. On 02/14/24 at 8:10 a.m., observed the resident in bed and their call light was hanging from the wall at the end of their bed. On 02/14/24 at 1:20 p.m., observed the resident in bed and their call light was hanging from the wall at the end of their bed. On 02/15/24 at 8:06 a.m. observed the resident in bed and their call light was hanging from the wall at the end of their bed. On 02/15/24 at 10:38 a.m., the resident was asked if they were able to reach their call light. They stated there were not able to reach their call light. CNA #6 handed the Res the call light. The resident was able to demonstrate how to utilize their call light. They were asked if they knew what the call light was for. They stated to call the nurses. 2. Res #5 had diagnoses which included non-traumatic intracerebral hemorrhage, unsteadiness on feet and chronic kidney disease. A quarterly assessment, dated 12/17/23, documented the resident's cognition was moderately impaired, no impairment to their upper or lower extremities, required substantial assistance with all their ADLs, and was always incontinent of bowel and bladder. A quarterly assessment, dated 02/02/24, documented the resident's documented the resident's cognition was intact, had impairment no impairment to their extremities, required moderate assistance with their ADLs, and was always incontinent of bowel and bladder. On 02/14/24 at 8:19 a.m., observed the resident in bed and their call light was hanging from the wall between the wall and the end of their bed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/14/24 at 1:32 p.m., observed the resident in recliner and and their call light was hanging from the wall between the wall and the end of their bed. On 02/15/24 at 8:22 a.m. observed the resident in bed and their call light was hanging from the wall between the wall and the end of their bed. On 02/15/24 at 10:47 a.m., the resident was asked if they were able to reach their call light. They stated there were not. CNA # 9 handed the resident their call light. The resident was able to demonstrate how to utilize their call light. 3. Res #21 had diagnoses which included atherosclerosis heart disease, diabetes, polyneuropathy, and CHF. A significant change assessment, dated 06/05/23, documented the resident's cognition was severely impaired, had impairment to both of their lower extremities, required limited assistance with their ADLs, and was always incontinent of bowel and bladder. A quarterly assessment, dated 12/06/23, documented the resident's cognition was severely impaired, had impairment to both of their lower extremities, required limited assistance with their ADLs, and was always incontinent of bowel and bladder. On 02/14/24 at 8:12 a.m., observed the resident in bed and their call light was hanging from the wall at the end of their bed. On 02/14/24 at 1:22 p.m., observed the resident in bed and their call light was hanging from the wall at the end of their bed. On 02/15/24 at 8:08 a.m. observed the resident in bed and their call light was hanging from the wall at the end of their bed. On 02/15/24 at 10:42 a.m., the resident was asked if they were able to reach their call light. They stated there were not. The resident was able to demonstrate how to utilize their call light. They were asked if they knew what the call light was for. They stated they use it to call the CNA's and nurses. 4. Res #50 had diagnoses which included CVA, cardiomegaly, and atrial fibrillation. A quarterly assessment, dated 02/02/24, documented the resident's cognition was intact, had no impairment to their extremities, required moderate assistance with their ADLs, and was occasionally incontinent of bowel and bladder. On 02/14/24 at 8:20 a.m., observed resident in their wheelchair beside their bed and their call light was hanging from the wall between the wall and the end of their bed. On 02/14/24 at 3:35 p.m., observed resident in bed and their call light was underneath the end of the bed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/15/24 at 8:24 a.m., observed resident in bed and their call light was underneath the end of the bed. On 02/15/24 at 10:57 a.m., the resident was asked if they were able to reach their call light. They stated there were not. CNA #9 handed the resident their call light. The resident was able to demonstrate how to utilize their call light. 5. Res #64 had diagnoses which included diabetes and pain. An annual assessment, dated 11/16/23, documented the resident's cognition was moderately impaired, had no impairment to their extremities, required moderate assistance with their ADLs, and was always incontinent of bowel and bladder. On 02/14/24 at 9:19 a.m., observed the resident in bed and their call light was in the top drawer of their bedside table. The drawer was closed on the call light. On 02/14/24 at 2:32 p.m., observed the resident in bed and their call light was in the top drawer of their bedside table. The drawer was closed on the call light. On 02/15/24 at 8:39 a.m., observed the resident in bed and their call light was in the top drawer of their bedside table. The drawer was closed on the call light. On 02/15/24 at 10:51 a.m., the resident was asked if they were able to reach their call light. They stated there were not. CNA #10 handed the resident their call light. The resident was able to demonstrate how to utilize their call light. On 02/15/24 at 2:02 p.m., RN #2 was asked where the residents' call lights should be placed. They stated within their reach. They were asked how they ensured the residents' call lights were within reach. They stated when they go into a resident's room, they look to ensure the light is within the resident's reach. On 02/15/24 at 2:02 p.m., CNA #6 was asked where the residents' call lights should be placed. They stated within their reach. On 02/16/24 at 3:09 p.m., the DON was made aware of the above. They stated the call lights should be within the residents' reach at all times.