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	01/06/2025

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

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35389 Based on observation, record review and interview, the facility failed to provide incontinent care in a manner to prevent UTI's for one (#42) of four sampled residents observed during incontinent care. The DON identified 67 incontinent residents resided in the facility. Findings: A Perineal Care/Incontinent Care policy, effective 04/2012, read in parts, Staff will perform perineal/incontinent care with each bath and after each incontinent episode .Clean groin using sweeping motion .For female .Separate labia and wash downward .then downward on each side of the labia using a different peri wipe with each stroke .Wash downward toward the base of the vaginal opening .Remove gloves and wash hands or alcohol gel and re-glove hands .Turn resident on side facing staff. Roll soiled brief/incontinent pad and apply clean brief and/or incontinent pad. Turn resident away from staff. (ONLY USE ONE WIPE PER SWIPE) .Clean outer hip of buttocks going upwards towards back .Clean anal area with upward motion .Remove gloves and wash hands with alcohol gel. Resident #42 had diagnoses which included UTI. A Physician Order, dated 12/17/24, documented culture urine one time only. An Admission Resident Assessment, dated 12/18/24, documented Resident #42 had moderate cognitive impairment, was always incontinent of bowel and bladder and required substantial/maximal assistance for toilet hygiene. Urine culture laboratory results, final release 12/21/24, documented Escherichia Coli was detected low. A Physician Order, dated 12/22/24, documented ertapenem (antibiotic) one gram intramuscular every morning shift for seven days for a diagnoses of UTI. On 12/27/24 at 6:10 a.m., CNA #1 entered Resident #42's room, placed a disposable brief on the bedside table, donned gloves and adjusted the resident's bed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/24 at 6:12 a.m., CNA #1 removed the resident's linens, unlatched the disposable brief, obtained several disposable wipes, and wiped the resident's peri area front to back removing a small amount of bowel. Resident #42 was rolled to their right side, there was a large amount of bowel observed in the brief and had leaked out of the brief onto the non disposable pad. CNA #1 removed the disposable pad and rolled the non disposable pad and draw sheet under the resident. CNA #1 provided peri care, placed a clean disposable pad under the resident, rolled the resident to the left side, and pulled the soiled linens out from under the resident. CNA #1 started to attach the clean brief. There was a brown substance remaining on Resident #42's peri area. On 12/27/24 at 6:16 a.m., CNA #1 was asked to observe Resident #42's front peri area and identify if the resident still had bowel present. CNA #1 opened the brief and stated, It's like pee I think. CNA #1 wiped the resident several more times and started to close the resident's brief. A brown substance was observed on the new brief. The CNA did not offer a response when asked about it. On 12/27/24 at 6:21 a.m., CNA #1 obtained a new disposable brief from the cart on Hall 200. On 12/27/24 at 6:23 a.m., CNA #1 turned Resident #42 to their right side, and cleaned additional brown bowel off of the resident using several disposable wipes. On 12/27/24 at 6:25 a.m., CNA #1 removed the soiled brief, placed a new brief under Resident #42 and attached the brief. CNA #1 was asked to observe the resident's right thigh. There was a brown circular substance on the resident's right leg. CNA #1 stated, It wasn't BM, it looks like rice cake. CNA #1 removed the substance from Resident #42's leg. On 12/27/24 at 6:30 a.m., CNA #1 stated incontinent care was to be provided every two hours. CNA #1 was asked how they ensured incontinent care was complete before placing a clean brief. CNA #1 stated, We had some mistakes. CNA #1 stated Resident #42 was not completely clean. CNA #1 stated staff were to keep wiping until the resident was clean. On 12/27/24 at 6:40 a.m., LPN #1 stated they let staff know what residents were incontinent. They stated staff were to complete first round checks on everyone. They stated incontinent care was to be provided every two hours. On 12/27/24 at 6:41 a.m., LPN #1 stated staff were supposed to visualize the resident to ensure they were clean before placing a new brief. LPN #1 stated there had been times they observed incontinent care and had to remind staff a resident was not completely clean. On 12/31/24 at 2:34 p.m., the DON stated staff were to provide incontinent care by wiping from the perineum to the rectum using one wipe per swipe. They stated staff were to turn the resident, clean all areas of the buttock, remove gloves, perform hand hygiene, and apply new gloves before placing a new brief. On 12/31/24 at 2:37 p.m., the DON stated staff should be able to visually tell all urine and feces was removed prior to placing a clean brief on a resident.

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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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49701 On 01/03/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to follow Resident #10's minced and moist level 5 diet which resulted in the resident choking. A physician's order, dated 11/29/24, documented Resident #10 was to have a minced and moist level 5 diet. An incident report, dated 12/19/24, documented Resident #10 was eating lunch in their room when a medication aide saw that the resident was choking and alerted the nurse who performed the Heimlich maneuver. It documented the brownie was expelled. It documented the nurse practitioner was notified and a x-ray was ordered. It documented family was notified. It documented the facility investigated and determined Resident #10 was given a brownie that was not on their diet. It documented the nurse stated the resident was still moving air and coughing and was able to cough the brownie up with a gentle Heimlich maneuver. It documented the dietary manager was notified and kitchen staff were in-serviced on following the resident's diet on their diet sheet. It documented the resident would be taken to the dining room for meals as tolerated. It documented the care plan and POC had been updated. It documented the incident report was completed by the DON. On 01/02/25 at 1:15 p.m., ACMA #1 stated on the day of the incident they heard Resident #10 grunting and got ADON #1 to perform the Heimlich. ACMA #1 stated they did not know who delivered the tray that day, but if they would have noticed the rest of the food was soft, they would have checked the dietary card to make sure the brownie was OK to give to the resident. On 01/02/25 at 2:47 p.m., the CDM stated, I had a new cook on the line, and they overlooked that [Resident #10] was on a minced and moist diet. I did an in-service to dietary and the dietary aides and whoever is standing at the window. On 01/03/25 at 10:32 a.m., ADON #1 stated on the day of the incident the resident was in their room eating lunch. They stated the med aide was in the room and noticed the resident choking on their food. ADON #1 stated the resident was choking on their brownie. They stated they performed the Heimlich. ADON #1 stated the next step was to notify the nurse practitioner. They stated they received an order for a chest x-ray which was clear. ADON #1 stated they called all of the staff that was present to the nursing station and in-serviced them. They stated they were insistent that everyone was required to watch the tickets and make sure the resident was getting the right kind of diet. ADON #1 stated they encouraged the resident to go to the dining room. They stated the resident was to be supervised when eating in their room. On 01/03/25 at 12:34 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 01/03/25 at 12:47 p.m., the administrator was notified of the IJ situation and was provided the IJ template (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/06/25 at 2:03 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal documented, (1) an audit was conducted and completed by 3:12 p.m. on 01/03/25 by nursing management to verify diet cards and diet orders are correct, (2) director of nursing/designee would educate all clinical staff on checking diet cards and meals prior to serving trays to residents. Nutrition service manager/designee would educate all nutrition staff on verifying diet orders when serving, (3) director of nursing/designee would perform weekly audits to verify the accuracy of those with modified diets for a period of 4 weeks, discrepancies would be addressed immediately and pulled into the monthly QA meeting, monitoring would be extended if discrepancies were identified, (4) director of nursing/designee would audit new admission orders for diet daily during morning meetings. Nutrition service manager/designee would verify diet order accuracy for new admission on tray cards: and (5) dates of completion and/or initiation for all items 1-4. On 01/03/25 at 7:30 p.m. the items listed were completed and monitoring put into place. The IJ was lifted, effective 01/03/25 at 7:30 p.m., when all components of the plan of removal had been verified as completed. The deficient practice remained at an isolated with a potential harm. Based on record review and interview, the facility failed to follow the minced and moist level 5 diet for one (#10) of three sampled residents reviewed for diet provided accurately. ADON #1 identified 111 residents resided in the facility and 106 residents were provided food by the kitchen. Findings: Resident #10 had diagnoses which included dysphagia, motor and sensory neuropathy, and epilepsy. A hospital After Visit Summary, dated 11/24/24 through 11/29/24, read in part, patient is 1:1 feed, takes medication while in puree. Diet type diabetic healthy heart. A physician's order, dated 11/29/24, documented Resident #10 was to receive a minced and moist level 5 diet. An admission assessment, dated 12/02/24, documented Resident #10 was on a mechanically altered diet while a resident, required substantial assistance with eating, and they were severely cognitively impaired with a BIMS of 7. A Nutrition Therapy Assessment, dated 12/02/24, documented Resident #10 was at risk for dehydration related to dysphagia and swallowing difficulties. (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An incident report, dated 12/19/24, documented Resident #10 was eating lunch in their room when a medication aide saw that the resident was choking and alerted the nurse who performed the Heimlich maneuver. It documented the brownie was expelled. It documented the nurse practitioner was notified and a x-ray was ordered. It documented family was notified. It documented the facility investigated and determined Resident #10 was given a brownie that was not on their diet. It documented the nurse stated the resident was still moving air and coughing and was able to cough the brownie up with a gentle Heimlich maneuver. It documented the dietary manager was notified and kitchen staff were in-serviced on following the resident's diet on their diet sheet. It documented the resident would be taken to the dining room for meals as tolerated. It documented the care plan and POC had been updated. It documented the incident report was completed by the DON. On 12/19/24, an in-service was provided to kitchen staff by the CDM. The in-service signature page, read in part, Cooks when plating food make sure you are watching the diets, look for modified diets textures. Aide double check the cooks and watch your desserts. Very important our residents are getting the correct diet; choking could cause serious damage or even death. There were six signatures on the document. On 01/02/25 at 1:15 p.m., ACMA #1 stated on the day of the incident they heard Resident #10 grunting and got ADON #1 to perform the Heimlich. ACMA #1 stated they did not know who delivered the tray that day, but if they would have noticed the rest of the food was soft, they would have checked the dietary card to make sure the brownie was OK to give to the resident. On 01/02/25 at 2:47 p.m., the CDM stated, I had a new cook on the line, and they overlooked that [Resident #10] was on a minced and moist diet. I did an in-service to dietary and the dietary aides and whoever is standing at the window. On 01/03/25 at 10:32 a.m., ADON #1 stated on the day of the incident the resident was in their room eating lunch. They stated the med aide was in the room and noticed the resident choking on their food. ADON #1 stated the resident was choking on their brownie. They stated they performed the Heimlich. ADON #1 stated the next step was to notify the nurse practitioner. They stated they received an order for a chest x-ray which was clear. ADON #1 stated they called all of the staff that was present to the nursing station and in-serviced them. They stated they were insistent that everyone was required to watch the tickets and make sure the resident was getting the right kind of diet. ADON #1 stated they encouraged the resident to go to the dining room. They stated the resident was to be supervised when eating in their room. On 01/03/25 at 10:41 a.m., the DON stated they did not have any documentation to support an in-service was completed for all of the staff concerning the incident with Resident #10. The DON stated QAPI had been skipped the last couple of weeks because of the holidays, but would resume next Thursday. On 01/03/25 at 11:55 a.m., the DON stated, I remember we talked about having speech evaluate [Resident #10] when [Resident #10] first came in. When the resident gets here, we would assess and then possibly have speech evaluate if we had a concern. The DON also stated the ordered diet was initiated probably from report given to the receiving nurse from the hospital discharging staff. (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/03/25 at 12:31 p.m., the DON stated hospital discharges were scanned in. They stated discharging hospital staff called report to the receiving facility nurse and whatever they told the receiving nurse was what they followed. The DON stated if there was a discrepancy they took it to the nurse practitioner. They stated the diet order they used, came from the report from the hospital, to the nurse on the hall. On 01/03/25 at 1:14 p.m., the DON stated speech therapy did not evaluate Resident #10. On 01/03/25 at 2:04 p.m., after the administrator had been notified of the IJ, the RDO and administrator brought restorative aide #1 to speak with the surveyors. Restorative Aide # 1 stated, I take all the trays down every single day, that particular day [Resident #10] did not get their brownie, so they came back and said they didn't get a brownie, but I didn't have a sheet [Resident #10] is minced moist. We put milk on the brownie and wrapped it and took it down to the room. Restorative Aide #1 stated they took the brownie to the resident themselves. Restorative Aide #1 stated, I can't give random because I have to make sure it is the right diet, so we put wrap on it and I took it down to the resident. Restorative Aide #1 then identified the brownie was given on Friday 12/27/24. On 01/03/25 at 2:05 p.m., the RDO stated, So [Resident #10] did receive a minced moist brownie that day. On 01/03/25 at 2:20 p.m., the DON stated Resident #10 got the brownie from the kitchen. They stated the kitchen staff should have known, but must have just put the wrong thing on the tray. The DON stated, they talked to the CDM and minced and moist was on the ticket. The DON stated Resident #10 should not have received the brownie. On 01/06/25, a handwritten statement was received from restorative aide #1. The statement, read in part, I got the meal ticket to send a brownie to [Resident #10]. The ticket gave the consistency minced, milk was put into the brownie to soak the brownie and foil plastic was put over it. I took it to hall 500. I take all trays daily, so I know what comes and goes. An additional statement from restorative aide #1 was provided. The statement, read in part, In talks with surveyors, I gave the wrong exact date. I work Monday through Friday, so the date was wrong, but I know it was me that did that job. This was the only day that a brownie was given.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on observation, record review, and interview, the facility failed to: a. provide incontinent care in a manner which prevented cross contamination for two (#33 and #42) of four sampled residents observed during incontinent care; b. handle linens in a manner which prevented cross contamination for one (#42) of four sampled residents observed during incontinent care; c. ensure proper PPE was worn in a room with a COVID-19 positive resident for three (#46, 55 and #89) of three sampled residents observed with COVID-19; d. ensure the same PPE was not worn when assisting two different residents with COVID-19 in the same room for two (#46 and #55) of three sampled residents observed with COVID-19; and e. medications were not handled with bare hands. The DON identified 67 incontinent residents and four Covid-19 positive residents resided in the facility. ADON #1 identified 111 residents resided in the facility. Findings: A Perineal Care/Incontinent Care policy, effective 04/2012, read in parts, Staff will perform perineal/incontinent care with each bath and after each incontinent episode .Clean groin using sweeping motion .For female .Separate labia and wash downward .then downward on each side of the labia using a different peri wipe with each stroke .Wash downward toward the base of the vaginal opening .Remove gloves and wash hands or alcohol gel and re-glove hands .Turn resident on side facing staff. Roll soiled brief/incontinent pad and apply clean brief and/or incontinent pad. Turn resident away from staff. (ONLY USE ONE WIPE PER SWIPE) .Clean outer hip of buttocks going upwards towards back .Clean anal area with upward motion .Remove gloves and wash hands with alcohol gel . A Glove Use policy, reviewed 01/2022, read in parts, Gloves are worn when .Touching blood or body fluids, except sweat .Touching urine, stool .Handling items or environmental surfaces soiled with blood or body fluids .Gloves are changed between residents .Gloves are changed if contaminated with blood or body fluids before touching other parts of the same resident .Hands are washed immediately after gloves are removed, before contact with another resident or the environment .Hands are washed or decontaminated prior to donning gloves. A COVID-19 policy, revised 08/2023, read in parts, COVID-19 PPE .The required PPE for COVID-19 isolation rooms when providing care or services to a COVID-19 positive resident suspected of having COVID-19, staff should wear an N95, face shield or goggles, gown, and gloves. A Medication Administration policy, dated 01/2024, read in part, Hands are washed with soap and water and gloves applied before administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Laundry and Linen Services policy, undated, read in part, All facility staff should handle all used laundry as potentially contaminated and use appropriate precautions .Used laundry should be handled with gowns and gloves to prevent personal clothing from getting contaminated .All contaminated laundry should be bagged in the area it was used prior to transporting to the laundry area. 1. Resident #33 had diagnoses that included lack of history of cerebral infarct, lack of coordination, and muscle weakness. An Admission Resident Assessment, dated 11/14/23, documented Resident #33 required max assist with toileting and dressing. On 12/27/24 at 6:01 a.m., CNA #6 entered Resident #33's room to answer the call light. On 12/27/24 at 6:05 a.m., CNA #6 returned to Resident #33's room with brief, wipes, and trash bags. CNA #6 applied gloves, pulled the resident's covers down, and opened the resident's brief. The resident's peri area was cleaned front to back with multiple wipes. Resident #33 was then rolled to their right side and dark liquid bowel was continuously flowing from their anus. CNA #6 continued to clean the resident until the bowel movement was cleaned up. CNA #6's hair kept falling into the brief and touching the resident while care was being provided. On 12/27/24 at 6:08 a.m., CNA #6 proceeded to move Resident #33's pillow and quilt wearing the same gloves that was used during incontinent care. The CNA then removed their gloves and the remaining personal items were removed from the resident's bed. On 12/27/24 at 6:12 a.m., CNA #6 left the resident's room to get different bedding. On 12/27/24 at 6:17 a.m., CNA #6 returned to Resident 33's room with bedding. The CNA donned new gloves and cream was applied to Resident 33's buttocks. The CNAs gloves were then changed and dirty linens were bagged. On 12/27/24 at 6:24 a.m., CNA #6 completed the bed change and returned personal items to the resident's bed. The call cord was attached to the resident's blanket and dirty laundry and trash were removed from room. On 12/27/24 at 6:28 a.m., CNA #6 took the linens and trash to bins in the soiled utility and washed their hands. On 12/27/24 at 6:31 a.m., CNA #6 stated they had on new gloves when they moved the pillow and quilt, and their hair was usually tied back. They stated they were supposed to change gloves at least three times with a bowel movement and after the third time, they were to wash their hands. The CNA stated residents were to be checked and changed every two hours because most of the residents could not use the call system for assistance. 2. Resident #42 had diagnoses which included UTI. An Admission Resident Assessment, dated 12/18/24, documented Resident #42 had moderate cognitive impairment, was always incontinent of bowel and bladder and required substantial/maximal assistance for toilet hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/27/24 at 6:10 a.m., CNA #1 entered Resident #42's room, placed a disposable brief on the bedside table, donned gloves, and adjusted the resident's bed. On 12/27/24 at 6:12 a.m., CNA #1 removed the resident's linens, unlatched the disposable brief, obtained several disposable wipes, and wiped the resident's peri area front to back removing a small amount of bowel. Resident #42 was rolled to their right side, there was a large amount of bowel observed in the brief and had leaked out of the brief onto the non disposable pad. CNA #1 removed the disposable pad and rolled the non disposable pad and draw sheet under the resident. CNA #1 provided peri care, placed a clean disposable pad under the resident, rolled the resident to the left side, and pulled the soiled linens out from under the resident and threw them on the floor. CNA #1 did not change their gloves or wash/sanitize their hands when going from dirty to clean. Bowel was observed on the non disposable pad and draw sheet that were laying on the floor. CNA #1 started to attach the clean brief. There was a brown substance observed remaining on Resident #42's peri area. On 12/27/24 at 6:16 a.m., CNA #1 was asked to observe Resident #42's front peri area and identify if the resident still had bowel present. CNA #1 opened the brief and stated, It's like pee I think. CNA #1 went through several drawers in the resident's room with the same gloved hands used during incontinent care and obtained another package of disposable wipes. CNA #1 wiped the resident several more times and started to close the resident's brief. There was brown substance observed on the new brief. The CNA did not offer a response when asked about it. On 12/27/24 at 6:18 a.m., CNA #1 again went through several drawers in the room, lowered Resident #42's bed, covered the resident with a blanket, pulled a trash bag off a roll of trash bags, and sat the roll on the resident's bedside table with the same gloved hands used during incontinent care. On 12/27/24 at 6:20 a.m., CNA #1, with the same gloved hands placed the soiled linens from the floor in the trash bag, obtained the bag of trash from the trash can, tied it shut, opened the resident's door to the hallway with the same gloved hands used during incontinent care. Once out in the hall, CNA #1 removed the glove on their right hand, tossed the soiled items in the appropriate barrels, removed their left glove and threw it away. On 12/27/24 at 6:21 a.m., CNA #1 sanitized their hands and obtained a new disposable brief from the cart on hall 200. On 12/27/24 at 6:22 a.m., CNA #1 entered Resident #42's room and donned gloves. ADON #1 also entered the room and picked up the roll of trash bags CNA #1 had previously touched with contaminated gloves with gloved hands hands. ADON #1 placed a trash bag in the trash can. On 12/27/24 at 6:23 a.m., CNA #1 adjusted the bed, turned Resident #42 to their right side, and cleaned additional brown bowel off of the resident using several disposable wipes, and rolled the soiled brief under the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/27/24 at 6:25 a.m., CNA #1 removed the soiled brief, placed a new brief under Resident #42 and attached the brief. The CNA did not change their gloves or wash/sanitize their hands when going from dirty to clean. CNA #1 was asked to observe the resident's right thigh. There was a brown circular substance on the resident's right leg. CNA #1 stated, It wasn't BM, it looks like rice cake. CNA #1 removed the substance from Resident #1's leg. CNA #1 adjusted Resident #42's bed, covered them with a blanket, moved the resident's bedside table, glasses, television, and placed the roll of trash bags in their right pants pocket with the same gloved hands used during incontinent care. On 12/27/24 at 6:28 a.m., CNA #1 opened the door to the hall with the same gloved hands used during incontinent care, took the trash to the soiled utility room on the hall, removed their right glove, opened the door, placed the items in the trash, and washed their hands with soap and water. On 12/27/24 at 6:30 a.m., CNA #1 stated incontinent care was to be provided every two hours. On 12/27/24 at 6:31 a.m., CNA #1 stated staff were to make sure soiled linens were bagged before leaving the resident's room. They stated the soiled linens would be placed in the soiled linen container. CNA #1 stated they sanitized their hands every time they came out of a room. They stated by the second resident, they would wash their hands. CNA #1 stated they did not know if that was the facility's policy, but it was their policy. On 12/27/24 at 6:32 a.m., CNA #1 stated they were supposed to change gloves every time they came out of a room and between residents. CNA #1 stated they were supposed to change gloves between everything. On 12/27/24 at 6:40 a.m., LPN #1 stated they let staff know what residents were incontinent. They stated staff were to complete first round checks on everyone. They stated incontinent care was to be provided every two hours. On 12/27/24 at 6:42 a.m., LPN #1 stated staff were to either place soiled linens directly in the soiled linen container, or bag them and then place them in the container. LPN #1 stated they had seen it done both ways. On 12/27/24 at 6:44 a.m., LPN #1 stated staff were to sanitize their hands after every interaction with a resident. They stated staff were to wash their hands after they had used sanitizer twice. On 12/27/24 at 6:45 a.m., LPN #1 stated anytime staff were dealing with something dirty, they had to change their gloves before touching something clean. They stated staff were to change gloves between residents, and were not supposed to wear gloves in the hall. They stated a lot of staff did wear gloves in the hall when transporting trash. On 12/31/24 at 2:32 p.m., the DON stated staff were to wash their hands prior to providing care and after care. They stated staff were supposed to wash their hands between care if they had to go from dirty to clean. On 12/31/24 at 2:33 p.m., the DON stated anytime staff went from dirty to clean they should change their gloves. The DON stated soiled linens should be placed in a bag and placed in the hopper room. They stated they should never be on the floor. (continued on next page)

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	375256	A. Building B. Wing	01/06/2025

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/31/24 at 2:34 p.m., the DON stated staff were to provide incontinent care by wiping from the perineum to the rectum using one wipe per swipe. They stated staff were to turn the resident, clean all areas of the buttock, remove gloves, perform hand hygiene, and apply new gloves before placing a new brief. 3. Resident #89 had diagnoses which included COVID-19. COVID-19 testing logs documented Resident #89 tested positive for COVID-19 on 12/17/24. On 12/26/24 at 1:52 p.m., CMA #4 was observed placing the lid of a meal tray on the counter in Resident #89's room. CMA #4 did not have a gown, gloves, face shield, or N95 mask on while in the COVID-19 room. CMA #4 only had a standard face mask on. CMA #4 exited the room with a standard face mask on. CMA #4 stated they were delivering the meal tray to Resident #89. CMA #4 was asked to explain the COVID-19 sign on the outside of Resident #89's door. They stated, You are supposed to gown up. They stated they did not put a gown on before entering Resident #89's room. The red COVID-19 sign documented use PPE when caring for patient with COVID-19 or suspected COVID-19. It documented PPE must be donned correctly before entering patient area. 4. Resident #46 had diagnoses which included COVID-19. COVID-19 testing logs documented Resident #46 tested positive for COVID-19 on 12/23/24. A Physician Order, dated 12/23/24, documented isolation full transmission based precautions every shift, droplet precautions along with gown, gloves, N95 mask, and face shield or goggles. 5. Resident #55 had diagnoses which included COVID-19. COVID-19 testing logs documented Resident #55 tested positive for COVID-19 on 12/23/24. A Physician Order, dated 12/23/24, documented isolation full transmission based precautions every shift, droplet precautions along with gown, gloves, N95 mask, and face shield or goggles. On 12/26/24 at 12:20 p.m., CNA #5 was observed wearing two standard face masks. They donned a gown and gloves and entered room [ROOM NUMBER] where Resident #46 and #55 resided. CNA #5 did not have a N95 face mask or a face shield/goggles before entering the COVID-19 positive room. CNA #5 adjusted Resident #55's bed, rolled the resident to the right side, and placed a pillow under the resident's back. Resident #55 did not like the position so CNA #5 went to the right side of the bed, rolled the resident further to the right using the draw sheet, and placed a pillow behind their back. CNA #5 adjusted the resident's bed to the low position, pushed the bed to the wall, and lifted the head of the bed until the resident was comfortable. CNA #5 pulled the trash bag out of Resident #55's trash container, tied it shut, and placed another bag in the trash can. On 12/26/24 at 12:23 p.m., CNA #5 changed their gloves, walked over to Resident #46 with the same gown and masks used during care of Resident #55, picked up linens off of the resident's floor, placed them in a trash bag, and removed their gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/26/24 at 12:30 p.m., CNA #5 walked over to Resident #55 with the same masks and gown on, adjusted the resident's bed and handed Resident #55 a box of tissues with their bare hands. CNA #5 then washed their hands with soap and water and stated, I'm going to have to get a new gown since I'm taking care of [Resident #46] OK. CNA #5 removed their gown, placed it in the trash can, and tried to hand Resident #55 their TV remote. The resident did not take the remote. CNA #5 then handed Resident #55 their call light and bed control with their bare hands wearing no gown. On 12/26/24 at 12:34 p.m., CNA #5 entered room [ROOM NUMBER] with a new gown on and donned a pair of gloves at the door in the room. CNA #5 still had two regular face masks on and no face shield. On 12/26/24 at 12:35 p.m., CNA #5 handed Resident #55 their bed remote on request and changed their gloves. CNA #5 got a washcloth off the counter in the room, wet it, and walked over to Resident #46, sat in a chair next to the resident and washed their face and hands off with the washcloth. CNA #5 lifted the resident's head with the bed controller and offered the resident a drink of water with a straw. CNA #5 wiped down Resident #46's bedside table with a disposable wipe and lowered the resident's head back down. On 12/26/24 at 12:38 p.m., CNA #5 removed their gown and gloves, moved over to Resident #55 and moved their bedside table without a gown or gloves on. CNA #5 donned a pair of gloves, wiped off items on the bedside table with a wet wipe, handed Resident #55 their phone wearing just the two regular face masks and gloves. CNA #5 then wet a rag and wiped something off the resident's floor. On 12/26/24 at 12:44 p.m., CNA #5 washed their hands with soap and water, took the soiled linens and trash out of room [ROOM NUMBER] and placed them in the soiled utility room on hall 200. CNA #5 was still wearing both of the standard non disposable face masks. On 12/26/24 at 12:45 p.m., CNA #5 stated staff were to gown and glove before going into a COVID-19 positive room. They stated they were to use a new gown between residents. They stated they did the best they could. They stated there were a lot of needs in the COVID-19 rooms. They stated they tried to make sure the linens and areas were clean to try to stop the process of infection by changing the linens. CNA #5 stated they tried to change their gloves and gown between Resident #55 and #46, but Resident #55 was needy. CNA #5 stated they usually did not wear the same masks in and out of a COVID-19 positive room, but they did today. They stated they should have worn a N95 mask. CNA #5 stated they place COVID-19 soiled items in the regular bin on the hall as instructed. On 12/27/24 at 6:02 a.m. the call light in room [ROOM NUMBER] activated. CNA #1 donned a gown, gloves, N95 mask and face shield, and stated all of the PPE items were needed to enter a COVID-19 room. As CNA #1 approached room [ROOM NUMBER], CNA #3 was exiting and did not need anything. CNA #1 removed their PPE and disposed of it. On 12/27/24 at 6:50 a.m., LPN #1 stated complete PPE, a gown, N95 mask, face shield/goggles, and gloves were to be worn in COVID-19 rooms. On 12/27/24 at 6:54 a.m., LPN #1 stated if staff were caring for two residents in a COVID-19 room, they should change PPE between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/30/24 at 12:28 p.m., the DON stated staff were to wear a N95 mask, face shield, gown, and gloves to enter a COVID-19 room. The DON stated the trash from a COVID-19 room was to be placed in the regular trash in the resident's room. On 12/31/24 at 2:37 p.m., the DON stated staff were to switch out all PPE, wash their hands, and completely change out their PPE when caring for two residents in a COVID-19 room. 6. On 01/03/25 at 7:47 a.m., RN #1 was observed popping an unidentified pill from the blister pack that was removed from the secondary lock box inside the medication cart into their bare hands. The pill was then placed into a medication cup. Their nails had red fingernail polish on them. On 01/03/25 at 7:53 a.m., RN #1 stated the policy was to put gloves on, then get the medications out of the cart and give them to the resident, come out, then wash or sanitize their hands again. On 01/03/25 at 7:56 a.m., RN #1 stated they did not put gloves on before touching the medication. They stated the purpose of the gloves was as a safety precaution and gloves were to be used for everything. 49701