STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375285	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sand Springs Nursing and Rehabilitation	1025 North Adams Sand Springs, OK 74063

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42171 Based on observation, record review, and interview, the facility failed to maintain a clean comfortable environment for one (#33) of three residents sampled for environment. The administrator reported the census was 52. Findings: An undated facility policy titled Cleaning and Disinfecting Residents' Rooms, read in part, Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled Res #33 had diagnoses including paraplegia and diabetes mellitus. An admission assessment, dated 05/14/24, documented the resident was independent with daily decision making and was dependent on staff for transfers. On 06/17/24 at 11:00 a.m., Res #33's room was observed. The trash can was observed to be full and soiled linens were piled in two separate areas of the floor. The floor was discolored in areas and sticky to the touch. Two pairs of soiled gloves were observed near the wall by the bathroom. Food debris was observed near the resident's bed. On 06/17/24 at 11:05 a.m., Res #33 stated housekeeping came in every day but did not do a good job. On 06/18/24 at 10:00 a.m., Res #33's room was observed. Food debris was observed near the resident's bed, one pair of soiled gloves were observed near the wall by the bathroom. The floor was sticky to the touch. On 06/19/24 at 10:10 a.m., Res #33's room was observed. Food debris was observed near the resident's bed, one pair of soiled gloves were observed near the wall by the bathroom. On 06/19/24 at 10:36 a.m., the housekeeping supervisor stated the CNA's were responsible to ensure that dirty linens were not in the floor, but housekeeping should ensure the room is clean. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/21/24 at 8:42 a.m., housekeeper #1 stated they do not have enough housekeeping staff to clean the rooms like they should be cleaned. On 06/21/24 at 8:46 a.m., the housekeeping supervisor stated that the rooms are not getting deep cleaned appropriately because of lack of staff.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 42171 Based on observation, record review, and interview, the facility failed to ensure assistance with ADL's was provided for one (#33) of three residents reviewed for assistance with ADL's. The administrator reported the census was 52. Findings: Res #33 had diagnoses including paraplegia and diabetes mellitus. An admission assessment, dated 05/14/24, indicated the resident was independent with daily decision making and was dependent on staff for transfers. A physician order, dated 06/17/24, documented Per resident request: up to chair daily as tolerated to facilitate wound healing. On 06/17/24 at 11:00 a.m., Res #33 stated that they wanted to get out of bed more often, but staff didn't always help them. Res #33 also stated they had not been out of bed since the end of last week. On 06/18/24 at 10:00 a.m., Res #33 stated they still had not been out of bed. On 06/19/24 at 10:10 a.m., Res #33 stated they had an order from the doctor to get up, and they still had not been out of bed. On 06/20/24 at 9:28 a.m., CNA #3 stated they try to get Res #33 up, but they are pulled away a lot of times and they are unable to get the resident up. They also stated they are usually the only aide on the hall, and they had not seen Res #33 out of bed since last week. On 06/20/24 at 9:30 a.m., LPN #1 stated they had not seen Res #33 out of bed since late last week. On 06/21/24 at 8:30 am, Resident #1 reported they have not been out of bed since last week.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33097 Based on observation, record review, and interview, the facility failed to complete weekly skin assessments as ordered to identify impaired skin integrity for one (#27) of three residents reviewed for pressure ulcers. The DON identified two residents with pressure ulcers. Findings: Res #27 had diagnoses which included diabetes mellitus, morbid obesity, and hypertension. A care plan, dated 07/19/20, documented the resident had potential for impaired skin integrity related to fragile skin, incontinence, and/or impaired mobility. A physician order, dated 08/21/23, documented the facility was supposed to do weekly skin assessments. The staff was to examine the resident's skin from head to toe and document any new abnormalities and notify the physician for treatment every evening shift on Mondays. A weekly skin assessment, dated 05/13/24, documented the resident had redness and moisture to the groin area. A weekly skin assessment, dated 05/27/24, documented the resident had moisture associated redness to the left iliac crest and a treatment was in place. On 06/17/24 at 2:51 p.m., the Res #27 stated they had discomfort and had a wound to the right hip from lying on that side. On 06/19/24 at 10:49 a.m., LPN #2 completed a skin assessment for the resident. The LPN #2 stated the Res #27 had pressure areas to both hip areas. The LPN #2 stated the areas were discolored and could open if left untreated. On 06/20/24 at 9:54 a.m., the DON stated weekly skin assessment had not been completed the month of June 2024 to identify new skin concerns for the resident.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 33097 Based on observation, record review, and interview, the facility failed to: a. assess the resident for the use of side rails, b. ensure to mattress fit correctly for the bed frame and use of side rails, c. monitor for safety and maintenance for the use of side rails, d. obtain an informed consent prior to the use of side rails, for one (#27) of one sampled residents reviewed for side rails. The DON identified eight residents who used side rails. Findings: The policy for Bed Safety and Bed Rails documented use of bed rails were prohibited unless the criteria for use had been met. The policy documented bed frames, mattress and bed rails were checked for compatibility and size prior to use. The policy documented regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. The policy documented the maintenance staff was to routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks. Resident #27 had diagnoses which included diabetes mellitus, morbid obesity, and hypertension. The care plan, dated 06/13/19, documented the resident had an ADL self care deficit. The care plan documented the resident used a halo rail/Ubar on their bed to assist with turning and/or repositioning. A physician order, dated 07/18/22, documented the resident may use bilateral m-bars to aide with turning and repositioning. A quarterly assessment, dated 03/18/24, documented bed rails were not used. On 06/17/24 at 2:50 p.m., the Resident #27 was lying in bed on their left side. The resident's bed frame was visible three to five inches from mid mattress down. There were rolled blankets from the top of the bed to the middle positioned between the bed rail and the mattress. On 06/19/24 at 10:49 a.m., LPN #2 stated the resident's bed had quarter rails to each side. The LPN stated the mattress did not cover the metal frame of the bed from midway down and rolled blankets were used between the mattress and quarter rail. The LPN stated the mattress did not fit the resident's bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/19/24 at 11:14 a.m., the DON accompanied the survey to the resident's room. The DON stated they were unaware the resident had quarter rails. The DON stated the mattress did not fit the bed frame. The DON was unsure who was responsible for assessing and monitoring beds for safety and the use of rails. The DON stated the bed frame and rails should be assessed at least monthly. The DON stated to their knowledge the resident had the current bed since 2019. On 06/19/24 at 2:41 p.m., the DON provided a side rail consent form and a restraints: side rail utilization assessment for the resident that was completed but not dated. The DON stated to documents were most likely completed today. The DON stated at this time they could not provide assessments or monitoring for the use of bed rails for the resident.

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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. 42171 Based on record review and interview, the facility failed to provide enough staff to ensure assistance with ADL's and a clean environment was provided for one (#33) of three residents reviewed for ADL's The administrator reported the census was 52. Findings: An undated facility policy titled Staffing, Sufficient and Competent Nursing, read in part, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment Res #33 had diagnoses including paraplegia and diabetes mellitus. An admission assessment, dated 05/14/24, indicated the Res #33 was independent with daily decision making and was dependent on staff for transfers. A physician order, dated 06/17/24, documented Per resident request: up to chair daily as tolerated to facilitate wound healing On 06/17/24 at 11:00 a.m., Res #33 stated that he wanted to get out of bed more often, but staff didn't always help him. Res #33 also stated they had not been out of bed since the end of last week. The trash can in the resident's room was observed to be full and soiled linens were piled in two separate areas of the floor. The floor was discolored in areas and sticky to the touch. Two pairs of soiled gloves were observed near the wall by the bathroom. Food debris was observed near the resident's bed. Res #33 stated housekeeping did not do a good job cleaning the room. On 06/18/24 at 10:00 a.m., Res #33 stated they still have not been out of bed. Food debris was observed near the resident's bed, one pair of soiled gloves were observed near the wall by the bathroom. The floor was sticky to the touch. On 06/19/24 at 10:10 a.m., Res #33 stated they had an order from the doctor, and they still had not been out of bed. On 06/19/24 at 10:36 a.m., the Housekeeping supervisor stated the CNA's were responsible to ensure that dirty linens were not in the floor, but housekeeping should ensure the room is clean. On 06/20/24 at 9:28 a.m., CNA #3 stated that they try to get Res #33 up, but they are pulled away a lot of times and they are unable to get the resident up. They also stated they are usually the only aide on the hall, and they had not seen Res #33 out of bed since last week. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at 9:30 am, LPN #1 stated they had not seen Res #33 out of bed since late last week, they also stated staffing was an issue at times and required tasks were not always completed. On 06/21/24 at 8:30 a.m., Res #33 reported they have not been out of bed since last week. On 06/21/24 at 8:42 a.m., Housekeeper #1 stated they do not have enough housekeeping staff to clean the rooms like they should be cleaned. On 06/21/24 at 8:46 a.m., the Housekeeping supervisor stated that the rooms are not getting deep cleaned appropriately because of lack of staff. On 06/21/24 at 8:53 a.m., LPN #2 stated staff were not always available to ensure resident needs were met in a timely fashion.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 46387 Based on observation and interview, the facility failed to ensure nurse staffing information was posted on a daily basis. The administrator identified 52 residents resided in the facility. Findings: On 06/17/24 at 10:35 a.m., the nurse staffing board was not observed as posted in any high visibility area. On 06/19/24 at 12:44 p.m., a staffing board was observed posted at the nurses station near the front door. The staffing data on the posting was dated 06/18/24. On 06/20/24 at 9:36 a.m., a staffing board was observed posted at the nurses station near the front door. The staffing data on the posting was dated 06/18/24. On 06/21/24 at 8:22 a.m., a staffing board was observed posted at the nurses station near the front door. The staffing data on the posting was dated 06/18/24. On 06/21/24 at 8:26 a.m., the DON stated the staffing data was posted right up front. They pointed to the staffing data observed at the nurses station near the front door. The DON stated the staffing data was supposed to be update daily but was not.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33097 Based on record review and interview , the facility failed to administer medication as ordered by the physician for one (#51) of five sampled residents who were reviewed for unnecessary medication. The administrator identified 52 residents resided in the facility. Findings: Resident #51 had diagnoses which included acute embolism and thrombosis of unspecified deep veins of the lower extremity, cardiomyopathy, chronic systolic heart failure, hemiplegia to left nondominant side, and anemia. A five day assessment, dated 05/24/24, documented the resident was cognitively intact and was receiving an anticoagulant medication. A hospital discharge order, dated 06/12/24, documented the resident was to receive Eliquis (a anticoagulant medication) 10mg by mouth twice a day for six days then decrease to 5mg by mouth twice a day. The Resident #51's MAR for June 2024 did not document the resident received Eliquis as ordered by the physician. On 06/19/24 at 2:15 p.m., LPN #2 stated they admitted the resident to the facility on [DATE] from the hospital. The LPN #2 stated physician orders were put in the computer and a copy was faxed to the pharmacy. The LPN #2 was unsure why the medication was not on the MAR or why the Eliquis had not been given. On 06/20/24 at 2:06 p.m., the DON reviewed the resident's hospital physician orders. The DON stated the resident had not received the Eliquis as ordered by the physician. The DON stated some education needed to be given.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46387 Based on record review and interview, the facility failed to ensure a PRN order for an antianxiety had a 14 day stop date and an antipsychotic had an appropriate diagnosis for one (#53) of five sampled residents reviewed for unnecessary medications. The administrator identified 52 residents resided in the facility. Findings: Res #53 had diagnoses which included dementia. A physician order, dated 04/04/24, documented to administer Seroquel (an antipsychotic) 200 mg at bedtime for dementia. A MAR for April 2024 documented Seroquel was received by the resident 25 times. A physician order, dated 05/05/24, documented to administer Ativan (an anti-anxiety) 0.5 mg every six hours as needed for agitation. A MAR for May 2024 documented Seroquel was received by the resident 31 times, and Ativan was received by the resident 16 times. A MAR through 06/19/24, documented Seroquel was received by the resident 18 times, and Ativan was received by the resident 9 times. On 06/19/24 at 2:41 p.m., the DON stated it was the responsibility of the DON to ensure the end date for the PRN and the diagnosis for the psychotropic medication.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46387 Based on record review and interview, the facility failed to ensure resident records were accurate for one (#49) of four sampled residents reviewed for accidents. The administrator identified 52 residents resided in the facility. Findings: Res #49 had diagnoses which included dementia. A progress note dated 04/30/24 at 10:08 a.m., documented the resident's hand was deep purple, swollen, and painful. The note documented the physician was notified. On 06/20/24 at 1:51 p.m., the medical director stated the report they received did not include pain or discoloration. An observation of a text message documented the staff reported to the doctor the hand was swollen and not painful. The message to the doctor included a photograph. The photograph did not show the resident's hand was discolored.

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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. 33097 Based on observation, record review, and interview, the facililty failed to maintain an infection control program for enhanced barrier precautions for three (#29, 46, and #51) of three reviewed for infection control. The DON identified eight residents who currently had EBP. Findings: A policy titled Enhanced Barrier Precautions documented in parts .EBPs employ targeted gown and glove use during high contact resident care activitites when contact precautions do not otherwise apply .Examples of high-contact resident care activitites requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing) . 1. Res #29 had diagnoses which included obstructive and reflux uropathy, diabetes mellitus, atrial fibrillation, polyneuropathy, and depressive disorder. On 06/17/24 at 10:20 a.m., signage was noted at the door for Res #29 and documented enhanced barrier precautions gown and gloves required. On 06/17/24 at 10:24 a.m., LPN #2 stated they were unsure what the signage on the door meant. The LPN #2 stated they were not aware of the resident requiring special precautions with care at this time. On 06/21/24 at 8:50 a.m., the DON stated an in-serviced regarding enhanced barrier precautions had been provided for staff. The DON stated the signage on the door documented staff were to wear a gown and gloves when providing resident personal care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Res #51 had diagnoses which included neuromuscular dysfunction of bladder, vesical tenesmus, tubuloinerstitial nephritis, and left nondominant hemiplegia. On 06/17/24 at 10:46 a.m., the Res #51 was lying in bed with a catheter hanging from the bedside. A sign posted at the resident's door documented enhanced barrier precautions. On 06/17/24 at 10:54 a.m., LPN #2 stated the resident had ESBL in the urine and staff must wear gown, gloves, mask, and shoe protectors with resident care. PPE was available at door entrance. On 06/20/24 at 9:35 a.m., Res #51's door was observed with signage indicating the resident required enhanced barrier precautions. On 06/20/24 at 9:37 a.m., Res #51 was observed during foley catheter care. On 06/20/24 at 9:40 a.m., CNA #1 was observed donning gloves and pulling back the covering of Res #51. Res #51 stopped the CNA and asked if the CNA #1 should be wearing a gown. On 06/20/24 at 10:17 a.m., CNA #1 was observed emptying the resident's foley catheter drainage bag, and placing a new brief and gown without wearing PPE. On 06/20/24 at 10:33 a.m., CNA #1 stated they should have donned a gown to empty the foley catheter and assist the resident with dressing. On 06/20/24 at 11:01 a.m., the DON stated the CNA should have been wearing PPE during care for the resident as part of enhanced barrier precautions. 3. 42171 3. Res #46 had diagnoses which included a stage four pressure ulcer and diabetes mellitus. A sign on Res #46's door documented they required EBP. On 06/19/2024 at 12:13 p.m., LPN #1 and the ADON were observed providing ordered wound care to Res #46, they were not wearing gowns. On 06/20/24 at 8:25 a.m., LPN #1 stated they should have been wearing a gown because Res #46 required EBP. On 06/20/24 at 9:00 a.m., the ADON stated they should have been wearing a gown while providing direct patient care for Res #46.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 33097 Based on observation, record review, and interview, the facility failed to inspect the bed frame, mattress, and bed rails as part of a regular maintenance program for one (#27) of one sampled residents reviewed for side rails. The DON identified eight residents who used side rails. Findings: The policy for Bed Safety and Bed Rails documented use of bed rails were prohibited unless the criteria for use had been met. The policy documented bed frames, mattress and bed rails were checked for compatibility and size prior to use. The policy documented regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. The policy documented the maintenance staff was to routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks. Res #27 had diagnoses which included diabetes mellitus, morbid obesity, and hypertension. The care plan, dated 06/13/19, documented the resident had an ADL self care deficit. The care plan documented the resident used a halo rail/Ubar on their bed to assist with turning and/or repositioning. A physician order, dated 07/18/22, documented the resident may use bilateral m-bars to aide with turning and repositioning. A quarterly assessment, dated 03/18/24, documented bed rails were not used. On 06/19/24 at 11:41 a.m., the Res #27 was lying in bed on their left side. The Res #27 bed frame was visible three to five inches from mid mattress down. There were rolled blankets from the top of the bed to the middle positioned between the bed rail and the mattress. On 06/19/24 at 10:49 a.m., LPN #2 stated the resident's bed had quarter rails to each side. The LPN #2 stated the mattress did not cover the metal frame of the bed from midway down and rolled blankets were used between the mattress and quarter rail. The LPN #2 stated the mattress did not fit the resident's bed. On 06/19/24 at 11:14 a.m., the DON accompanied the survey to the resident's room. The DON stated they were unaware the resident had quarter rails. The DON stated the mattress did not fit the bed frame. The DON was unsure who was responsible for assessing and monitoring beds for safety and the use of rails. The DON stated the bed frame and rails should be assessed at least monthly. The DON stated to their knowledge the resident had the current bed since 2019.