STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375290	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Health Center	1153 Cherokee Street Wakita, OK 73771

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on record review and interview, the facility failed to ensure informed consent was obtained for the use of an psychotropic medication for one (#29) of five sampled residents reviewed for unnecessary medications. The DON identified 27 residents were prescribed psychotropic medication. Findings: The facilty's Initiation of a Psychotropic Drug policy policy, dated 11/21/22, read in part, The family is to be notified .Explain our effects and inquire about their feeling toward the use if a psychotropic medication and explain the risk involved. Resident #29 was admitted on [DATE] with diagnoses which included major depressive disorder and dementia unspecified with other behavioral disturbances. A physician order, dated 12/26/23, documented Resident #29 was prescribed buspirone HCl oral tablet 15 mg .Give one tablet by mouth two times a day .Citalopram Hydrobromide Oral Tablet 10 mg. Give one tablet in the morning. A quarterly assessment, dated 4/9/24 documented Resident #29's cognition was significantly impaired. The clinical health record did not contain documentation an informed consent had been signed for the use of buspirone and citalopram. On 07/09/24 at 2:26 p.m., the IP was asked if they could provided consents for psychotropic medications for Resident #29. The IP stated they had a form they previously used, cant locate consents and education in the clinical health record. On 07/09/24 at 2:27 p.m., the DON was asked what psychotropic medications Resident #29 was prescribed. The DON stated the Resident#29 was prescribed buspirone and citalopram. The DON was asked to provide the consents and education for the prescribed psychotropics. The DON stated, No, I cant find them at this time. I don't think they had been doing them.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 48344 Based on observation, record review, and interview, the facility failed to ensure a resident who was physically restrained has a physician order, was assessed, and monitored for one (#1) of one sampled resident reviewed for the use of physical restraints. The Administrator identified 35 residents resided in the facility. Findings: An undated facility policy titled Restraint Policy, read in part, All residents will have an assessment performed to determine the safety and protective needs of the resident prior to the application of the restraints. The policy also read, .restraints may be applied only on a physician's written order and shall identify the type and reason for the restraint .A restrained resident shall have their restraints released every two hours for at least ten minutes. Resident #1 had diagnoses which included cerebral palsy and dystonia. An annual resident assessment, dated 05/06/24, documented Resident #1 had severe cognitive impairment and required extensive assistance with ADL's. On 07/09/24 at 8:51 a.m., Resident #1 was observed in their wheelchair. There was a black belt around their waist with a quick release buckle. On 07/10/24 at 9:56 a.m., Resident #1 was observed sitting in the common area. There was a black belt around their waist with a quick release buckle. On 07/10/24 at 9:57 a.m., RN #1 stated Resident #1 has a lap belt on their wheelchair because they moved a lot and they were fidgety. On 07/10/24 at 10:01 a.m., RN #1 stated there was no physician order for the use of the lap belt and no documentation Resident #1's wheelchair lap belt use was monitored. On 07/10/24 at 10:05 a.m., Admin stated Resident #1 can undo the wheelchair seat belt on their own. On 07/10/24 at 10:06 a.m., the DON and Infection Preventionist instructed Resident #1 to undo the seat belt. Resident #1 was unresponsive to the instructions given. On 07/10/24 at 10:16 a.m., the DON was unable to locate a resident assessment for the use of the wheelchair seat belt.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 48344 Based on observation, record review, and interview, the facility failed to ensure physical restraints were coded accurately on MDS assessments for one (#1) of one sampled resident reviewed for the use of physical restraints. The Administrator identified 35 residents resided in the facility. Findings: Resident #1 had diagnoses which included cerebral palsy and dystonia. An annual resident assessment, dated 05/06/24, did not document Resident #1's use of chair restraint. On 07/09/24 at 8:51 a.m., Resident #1 was observed in their wheelchair. There was a black belt around their waist with a quick release buckle. On 07/10/24 at 9:56 a.m., Resident #1 was observed their wheelchair in the common area. There was a black belt around their waist with a quick release buckle. On 07/10/24 at 10:06 a.m., the DON and Infection Preventionist instructed Resident #1 to undo the seat belt. Resident #1 was unresponsive to the instructions given. On 07/10/24 at 10:20 a.m., MDS Coordinator #1 stated it was considered a restraint if a resident is not able to undo their wheelchair seat belt. On 07/10/24 at 10:23 a.m., the DON stated the use of the wheelchair seat belt was not coded in Resident #1's annual resident assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was labeled and dated, per the facility policy and professional standards of care, for one (#20) of one resident sampled for respiratory care. The DON identified one resident used supplemental oxygen. Findings: The facility's OXYGEN THERAPY policy, undated, read in part, Change device tubing every 30 days on the 15 th of the month on night shift and store the tubing in a bag when not in use. Tubing is to be dated. Resident #20 was admitted on [DATE] with diagnoses which included acute respiratory failure and major depressive disorder. A annual assessment, dated 04/01/24, documented Resident #20's cognition was intact. A physician order, dated 05/07/24, read in part, O2 via nasal cannula PRN to keep sats above 89% every shift. On 07/08/24 at 2:17 p.m., Resident #20 observed in bed wearing O2 with a nasal annual. There was no date observed on the O2 tubing or O2 saturator. On 07/10/24 at 1:39 p.m., CNA #1 went in Resident #20's room. They were asked to observe the date the O2 tubing was changed. They stated there was no date on the tubing or saturator. On 07/10/24 at 1:42 p.m., RN#1 was asked to look at the Resident #20s O2 tubing and saturator. They stated there was no date and have an order to change it monthly. They stated the tubing should be labeled with date. On 07/10/24 at 1:50 p.m., the DON was aked what the policy was when changing O2 tubing and humidifier on the O2 saturator. The DON stated the O2 tubing needed to be labeled with the date it was changed and put in a bag when not in use.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46702 Based on record review and interview, the facility failed to ensure a medication regimen review gradual dose reduction was responded to timely for one (#35) of five sampled residents reviewed for unnecessary medications. The administrator identified 35 residents resided in the facility and received medication. Findings: The facility's Drug Regimen Review policy, dated 11/21/22, read in part, The consultant pharmacist documents potential or actual medication therapy problems, and communicates them to the primary physician and the Director of nursing. A written report is provided to the physician within seven working days. Resident #35 had diagnoses which included major depressive disorder and peripheral vascular disease. A physician order, dated 05/17/24, documented to administer tramadol 50 mg HCl oral tablet every 6 hours as needed for pain. A monthly medication review, dated 05/22/24, documented the pharmacist request to attempt a gradual dose reduction of the residents tramadol 50 mg every six hours as needed. The medication review was not documented as sent to the physician or responded to by the physician in the clinical health record. On 07/10/24 at 10:40 a.m., the Medical records personal was shown the GDR attempt dated 05/22/24 and asked to locate the physician response. They stated it was never sent to the physician due to finding it in a stack of paperwork. They were asked what the policy was when a GDR from a monthly medication regimen review was received . They stated the staff give them to me and I send them to the doctor. When they come back signed, we review and update chart. On 07/10/24 at 11:22 a.m., the DON was asked what the policy was when a monthly medication pharmacy review GDR was requested. The DON stated the GDR should of been sent sent to the physician within 7 days and nursing personnel should of provided a response within two weeks. The DON stated the physician should of provided a report to the facility within one month after the report was sent. The DON was asked if the policy was followed. They stated the policy was not followed.