

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/11/2024
NAME OF PROVIDER OR SUPPLIER  Colonial Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1320 Northeast 1st Place Pryor, OK 74362	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>33148</p> <p>Based on observation, record review, and interview, the facility failed to promote resident dignity by staff standing over residents while assisting them to eat for two (#9 and #11) of three sampled residents reviewed for dignity.</p> <p>The administrator identified 38 residents resided in the facility.</p> <p>Findings:</p> <p>1. Res #9 had diagnoses which included achondroplasia.</p> <p>A significant change assessment, dated 03/15/24, documented the resident's cognition was severely impaired and they required partial/moderate assistance with eating.</p> <p>On 04/10/24 at 8:18 a.m., CNA #3 was observed standing over the resident in the dining room while assisting them to eat their breakfast.</p> <p>On 04/10/24 at 8:31 a.m., CNA #3 was asked asked what was the protocol for assisting residents with eating. They stated they should sit next to the residents while assisting them with their meals. They were asked if they sat while assisting Res #9 with their breakfast. They stated they did not sit.</p> <p>2. Res #11 had diagnoses which included CHF, SOB, diabetes, and seizures.</p> <p>A quarterly assessment, dated 01/17/24, documented the resident's cognition was moderately impaired and they required substantial/maximal assistance with eating.</p> <p>On 04/10/24 at 8:12 a.m., the DON was observed standing over the resident in the dining room while assisting them to eat their breakfast.</p> <p>On 04/10/24 at 8:47 a.m., the DON was asked what was the protocol for assisting residents with eating. They stated they should have sat down next to Res #11 while assisting them with their breakfast.</p>

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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