STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375299	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Terrace Care Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35474 Based on record review and interview, the facility failed to ensure resident representatives were notified of change for one (#32) of one sampled resident reviewed for notification of change. The administrator identified 39 residents who resided in the facility. Findings: The undated Notification of Change policy, read in parts, .The nurse will immediately notify the resident . resident representative for the following [list is not all inclusive]: A need to alter treatment significantly [a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment] .Document the notification and record any new orders in the resident's medical record . Resident #32 had diagnoses which included dementia, recurrent depressive disorders, and constipation. The Medication Administration Record, dated 01/01/24 through 01/31/24, documented the resident's Zoloft was increased from 25 mg daily to 50 mg daily for depression on 01/18/24 and had been ordered Namenda 5mg twice daily for dementia on 01/19/24. A Progress Note, dated 01/19/24, documented Resident #32 had new orders for Namenda and the Zoloft had been increased. The note did not reveal the resident's representative had been notified of the medication changes. The Medication Administration Record, dated 05/01/24 through 05/31/24, documented the resident was ordered a Fleets enema once daily, as needed, on 05/09/24. A Progress Note, dated 05/09/24, documented Resident #32 had been administered an enema for complaints of constipation with positive results. Review of the progress notes did not reveal the resident's representative had been notified of the order for the Fleets enema. The quarterly assessment, dated 05/21/24, documented the resident was severely impaired in cognition for daily decision making. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/19/24 at 2:53 p.m., the resident's representative stated they would like to be notified of medication changes and new orders. On 06/21/24 at 9:52 a.m., RN #1 stated they were to notify residents and/or resident representatives of medication order changes and document the notification in the progress notes. On 06/21/24 at 10:15 a.m., Corporate nurse #1 stated they did not have documentation the representative for Resident #32 had been notified of the medication changes.

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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. 35474 Based on observation, record review, and interview, the facility failed to ensure indwelling urinary catheter tubing was placed to maintain infection control for one (#16) of one sampled resident who had an indwelling urinary catheter. Corporate nurse #1 identified one resident who had an indwelling urinary catheter. Findings: Resident #16 had diagnoses which included neuromuscular dysfunction of the bladder, retention of urine, and history of urinary tract infection. The quarterly assessment, dated 05/03/24, documented the resident had an indwelling urinary catheter and required maximal assistance for transfers to the chair. On 06/18/24 at 9:15 a.m., Resident #16 was observed in the hall in their wheel chair. The catheter tubing was observed to touch the floor. On 06/19/24 at 8:42 a.m., Resident #16 was observed in their room sitting in their wheel chair. They stated they were totally dependent on staff for transfers. The catheter tubing was observed to touch the floor. On 06/19/24 at 11:29 a.m., Resident #16 was observed by the nurses station in their wheel chair. The catheter tubing was observed to drag on the floor under the wheel chair. On 06/20/24 at 8:26 a.m., CNA #1 stated indwelling urinary catheter tubing was not to touch the floor. On 06/20/24 at 10:02 a.m., RN #1 stated indwelling urinary catheter tubing was not to touch the floor. They stated they would need to set up monitoring to ensure infection control was maintained regarding the placement of catheter tubing.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 35474 Based on record review and interview, the facility failed to ensure pain medication was administered per the physician's order for one (#1) of six sampled residents whose medications were reviewed. Corporate nurse #1 identified 29 residents on routine pain medication. Findings: Resident #1 had diagnoses which included neuropathy. The Care Plan, dated 02/21/24, documented to administer pain medication as ordered by the physician. The Prescription Order, dated 03/16/24, documented the resident had been ordered diclofenac sodium 1% (a pain reliever) topically to bilateral feet twice daily. The Treatment Administration History, dated 04/01/24 through 04/30/24, did not contain documentation the diclofenac had been administered on 04/08/24 for the a.m. shift or 04/11/24 for the a.m. or p.m. shift. The Treatment Administration History, dated 05/30/24, did not contain documentation the diclofenac had been administered on the a.m. or p.m. shift. The Treatment Administration History, dated 06/10/24, did not contain documentation the diclofenac had been administered on the p.m. shift. Review of the progress notes for April, May, and June 2024 did not reveal documentation regarding the missing documentation of the diclofenac. On 06/19/24 at 10:17 a.m., Resident #1 stated some days they did not receive the medication for their feet and they wanted the medication to be provided twice daily as ordered for pain management. On 06/20/24 1:27 p.m., Corporate nurse #1 stated they had no documentation as to why the diclofenac was not documented as administered per the physician's order. On 06/21/24 at 7:52 a.m., RN #1 stated the Resident # 1 would usually remind the nurses about the diclofenac gel for their feet. RN #1 stated the lack of documentation related to administration was an oversight and did not know why the pain medication was not documented as administered per the physician's order.

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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. 34270 Based on observation, record review, and interview, the facility failed to ensure residents were administered the correct doses of medications ordered by their physician for two (#19 and #93) of six sampled residents reviewed for medication administration. A facility resident roster, dated 06/17/24, documented 39 residents resided at the facility. Findings: An Adverse Consequences and Medication Errors policy, dated 2001, read in part, A medication error is defined as the preparation or administrator of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 1. Resident #19 had diagnoses which included acute kidney failure and diabetes mellitus with diabetic neuropathy. A Medications Administration Record for Resident #19, dated 06/01/24 - 06/18/24, documented the resident was to be administered five units of lispro insulin from a 200 unit per milliliter strength insulin pen before each meal. The order had a start date of 01/09/24 and an open end date. The record documented the resident had 52 doses of the medication between 06/01/24 and 06/18/24. On 06/18/24 at 11:21 a.m., RN #1 was observed administering insulin to Resident #19. RN #1 set the dose on an insulin pen and showed it to the surveyor. The pen was observed to be lispro 100 units per milliliter and was set to administer 5 units. RN #1 was then observed administering the medication. On 06/18/24 at 12:15 p.m., RN #1 and the surveyor reviewed Resident #19's medication orders in the resident's electronic medical record and then the insulin pen that had been used. RN #1 stated the pen that was used at 11:21 a.m. had a strength of 100 units per milliliter but the order was to use a pen with the strength of 200 units per milliliter. RN #1 stated the resident had been under-dosed. They stated the insulin pens in the medication cart had not been replaced since the order was change in January. 2. Resident #93 had diagnoses which included paroxysmal atrial fibrillation. A prescription order form, dated 06/07/24, documented Resident #93 was to be administered one Sotalol [an oral medication use to treat atrial fibrillation]120 mg tablet every morning. A Medication Administration Record form for Resident #93, dated 06/01/24 - 06/20/24, documented the resident had received 12 doses of Sotalol 120 mg tablets between 06/07/24 and 06/19/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/19/24 at 8:00 a.m., RN #1 was observed administering medications to Resident #93. RN #1 removed a tablet from a container and presented the container to the surveyor. The container label documented the medication was Sotalol 80 mg tablets and one was to be administered to the resident. RN #1 was observed administering the medication. On 06/19/24 at 9:04 a.m., RN #1 and the surveyor reviewed Resident #93's medication orders in the resident's electronic medical record and then the container of Sotalol that had been administered that morning. RN #1 stated the order for Sotalol was for one 120 mg tablet but the container read 80 mg tablets. RN #1 stated the resident had been under-dosed. They stated they had since looked in the medication cart and the correct dose was there. They stated they had not looked close enough and had given the 80 mg tablet instead of the 120 mg tablet. They stated there was a problem with communication amongst the nursing staff and discontinued meds have been left in the carts instead of moved to the DON's office. On 06/20/24 at 10:24 a.m., Regional Nurse stated that when RN #1 had administer the insulin to Resident #19 and Sotalol to Resident #93, they had not followed facility policy or the standards of care when they did not check the actual medications on hand against the physician's order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 34270 Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than five percent. A facility resident roster, dated 06/17/24, documented 39 residents resided at the facility. Findings: An Adverse Consequences and Medication Errors policy, dated 2001, read in part, A medication error is defined as the preparation or administrator of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. A Treatments Administration History form for Resident #19, dated 06/01/24 - 06/19/24, read in part, Humalog KwikPen Insulin (insulin lispro) Insulin pen; 200 unit/mL (3 mL); Amount to administer: 5 units; subcutaneous . The form further documented the resident received the afternoon dose of the medication on 06/18/24. A Medication Administration Record form for Resident #93, dated 06/01/24 - 06/20/24, read in part, sotalol tablet; 120 mg; Amount to Administer: 1 tab; gastric tube . The form further documented the resident received the morning dose of the medication on 06/19/24. On 06/18/24 at 11:21 a.m., RN #1 was observed administering insulin to Resident #19. RN #1 set the dose on an insulin pen and showed it to the surveyor. The pen was observed to be lispro 100 units per milliliter and was set to administer 5 units. RN #1 was observed administering the medication. On 06/18/24 at 12:15 p.m., RN #1 and the surveyor reviewed Resident #19's medication orders in the resident's electronic medical record and then the insulin pen that had been used. RN #1 stated the pen uses was 100 units per milliliter but the order was to use a pen with the strength of 200 units per milliliter. RN #1 stated the resident had been under-dosed. On 06/19/24 at 8:00 a.m., RN #1 was observed administering medications to Resident #93. RN #1 removed a tablet from a container and presented the container to the surveyor. The container label documented the medication was Sotalol [an medication to treat atrial fibrillation] 80 mg tablets and one was to be administered to the resident. RN #1 was observed administering the medication. On 06/19/24 st 9:04 a.m., RN #1 and the surveyor reviewed Resident #93's medication orders in the resident's electronic medical record and then the container of Sotalol that had been administered that morning. RN #1 stated the order for Sotalol was for one 120 mg tablet but the container read 80 mg tablets. RN #1 stated the resident had been under-dosed. On 06/20/24 at 10:24 a.m., Regional Nurse stated that when RN #1 had administer the insulin to Resident #19 and Sotalol to Resident #93, they had not followed facility policy or the standards of care when they did not check the actual medications on hand against the physician's order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35474 Based on observation, record review, and interview, the facility failed to ensure the ice machine was maintained in a sanitary manner for one of one ice machines observed. Corporate nurse #1 identified 38 residents who received nourishment from the kitchen. Findings: The untitled, undated policy, read in parts, .It is the policy .that ice machines will be cleaned weekly and as needed. Maintenance will clean ice machine at a minimum of weekly . The Ice Machine Log, dated June 2024, documented the ice machine had been cleaned on 06/03/24, 06/10/24, and 06/17/24. On 06/17/24 at 9:02 a.m., the ice machine was observed with the dietary manager. The deflector panel on the inside of the ice machine was observed to contain a black/brown substance that was easily wiped off with a paper towel. The dietary manager stated the maintenance supervisor was responsible to clean the ice machine. The coil cover in the top portion of the ice machine was observed to contain a orange/yellow substance that was easily wiped with a paper towel. On 06/17/24 at 9:05 a.m., the maintenance supervisor stated the ice machine was cleaned weekly. The maintenance supervisor observed the ice machine and stated it looked like it needed to be cleaned more often due to the buildup.