STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375304	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coweta Care & Rehab Center	30049 East 151st Street South Coweta, OK 74429

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accurate assessments were completed for 2 (#5 and 81) of 28 sampled residents reviewed for accuracy of assessments. The administrator identified 75 residents resided in the facility. Findings: A facility MDS 3.0 policy, revised [DATE], read in part, Everyone completing a portion of the assessment must sign and certify the accuracy of the portion of the assessment they completed. 1. A physician's order for Resident #5, dated [DATE], showed to administer Clopidogrel Bisulfate (an antiplatelet) 75 mg one time a day for blood clot prevention. A quarterly assessment, dated [DATE], showed a BIMS of 10 which indicated Resident #5 had moderate cognitive impairment for daily decision making and diagnoses which included non-Alzheimer's dementia, traumatic brain injury, depression, anemia, and asthma. Section N of the assessment showed an anticoagulant was taken during the look back period and an antiplatelet was not taken. On [DATE] at 9:31 a.m., the MDS coordinator stated they obtained information for the MDS assessment from interview with residents, assessments, and other documentation. The MDS coordinator was asked why the quarterly assessment, dated [DATE], showed Resident #5 had taken an anticoagulant. They stated they would have to check and left the room. On [DATE] at 9:33 a.m., the MDS coordinator returned and stated they had miss coded it. They stated they tried to make sure the assessment was correct while they were going through it. 2. An admission assessment for Resident #81, dated [DATE], showed a BIMS of 13 which indicated the resident was cognitively intact for daily decision making. The assessment showed diagnoses which included anemia, urinary tract infection in the last 30 days, and arthritis. A discharge assessment, dated [DATE], showed Resident #81 died in the facility. A progress note, dated [DATE] at 2:55 a.m., showed Resident #81 was hypoxic, pallor, and short of breath with retractions. The note showed Resident #81 was sent to the hospital at 2:50 a.m. with emergency medical service. A progress note, dated [DATE], showed the emergency room called and informed Resident #81 had a pulmonary embolism and requested a copy of the Do Not Resuscitate (DNR) for Resident #81. On [DATE] at 1:36 p.m., the representative of Resident #81 was called and stated Resident #81 had a blood clot. They reported the facility informed it all happened very quickly. The representative stated a nurse called them early in the morning and informed them they thought Resident #81 had aspirated because they were a green color. The representative stated the facility called an ambulance who took Resident #81 to the hospital where a blood clot was found. They stated Resident #81 died at the hospital. On [DATE] at 10:34 a.m., the MDS coordinator after reviewing the clinical record of Resident #81 stated Resident #81 died in the facility and that sometimes the MDS did not give an option that fit the situation better. They stated it looked like they should have discharged Resident #81 out to the hospital and did a death in facility instead.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to make a referral to the OHCA after a newly identified serious mental health disorder and a significant change in status assessment for 1 (#13) of 2 sampled residents reviewed for PASRR.The administrator identified 32 residents with mental health diagnoses. Findings: A PASRR level I form, dated 04/25/25, showed Resident #13 did not have a diagnosis of a mental health disorder and a PASRR level II referral was not needed. An undated medical diagnosis tab in Resident #13's electronic medical record showed a diagnosis of bipolar disorder was added on 06/26/25. A significant change assessment, dated 07/29/25, showed Resident #13 had a BIMS score of 15 which indicated their cognition was intact. The assessment showed the resident was not currently considered by the state PASRR level II process to have a serious mental illness and/or intellectual disability. On 09/22/25 at 4:41 p.m., the MDS coordinator stated they could not find documentation a referral was made to the OHCA for a PASRR level II when the resident received the diagnosis of bipolar disorder.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to store drugs and biologicals in a locked compartment and permit only authorized personnel to have access for 1 of 3 nurse medication carts observed. The administrator identified 75 residents resided in the facility.Findings:Findings: On 09/17/25 at 8:27 a.m., an observation of a medication cart on the Southwest corridor was made. The cart was unlocked with a set of keys hanging from the lock. There were no staff present in the hall. Three residents were moving in the hallway independently. On 09/17/25 at 4:16 p.m., LPN #1 was observed during a medication pass on the Southwest corridor. LPN #1 obtained Pyridostigmine Bromide (a reversible acetylcholinesterase inhibitor medication) 60 mg and Pepcid (a H2 receptor which decreases gastric acid) 40 mg for Resident #31. LPN #1 removed the medication from the multi-dose pharmacy prepared package, placed the medication in a cup, and entered the resident's room to administer the medication. LPN #1 did not place the multi-dose medication packages back in the locked cart before leaving the medication cart unattended. When LPN #1 returned to the medication cart a resident was sitting in a wheelchair by the medication cart. An undated facility policy titled Medication Storage in the Facility, read in part, Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g. medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.On 09/17/25 at 8:31 a.m., LPN #1 stated they were in a hurry, forgot the lock the cart, and left the keys hanging in the lock. On 09/17/25 at 4:17 p.m., LPN #1 stated they were not aware they had left the multi-dose medication packages unlocked and unattended on the medication cart in the hall. On 09/23/25 at 10:00 a.m., the DON stated medication should be stored and medication carts should always be locked when unattended. The DON stated as needed narcotic medications were stored in the nurses' medication carts on the halls.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation and interview, the facility failed to ensure pureed food was free of chunks and of a consistency to meet the needs of the residents for 1 of 1 observation. The administrator identified four residents who ate pureed food from the kitchen. Findings: On 09/16/25 at 11:25 a.m. cook #1 was observed to prepare puree for the noon meal. The meatloaf was placed in the food processor with a low sodium beef base paste and hot water. When cook #1 thought the puree was finished, they asked the dietician to check the puree. This surveyor tasted the puree, and it was chunky with bits that required chewing. The dietician was not observed to taste the meatloaf puree and informed cook #1 it was good to serve. [NAME] #1 poured the puree into a container and placed it on the steam table to serve. On 09/16/25 at 11:55 a.m., the pureed meat was observed to be placed in a bowl with gravy added and placed on tray. On 09/16/25 at 11:57 a.m., this surveyor stopped the serving of puree. On 09/16/25 at 11:58 a.m., the dietary manager stated the puree was grainy and not smooth. They pulled the pureed meat off the line. On 09/16/25 at 11:59 a.m., the dietician stated they would have to blend the meat until it was smooth.