

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Ruth Wilson Hurley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 7 North Covington Coalgate, OK 74538	
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 33097 Based on record review and interview, the facility failed to accurately complete a level I PASARR for one (#20) of one sampled resident reviewed for PASARR. The administrator identified 29 residents resided in the facility. Findings: Resident #20 had diagnoses which included dementia with other behavioral disturbances, delusional disorders, and mood affective disorder. A level I PASARR assessment, dated 01/23/19, documented resident #20 did not have a diagnosis of a serious mental illness. On 12/06/24 at 2:56 p.m., the ADON reviewed the resident's level I PASARR form and stated the question regarding a diagnosis of serious mental illness was answered incorrectly. The ADON stated a level II PASARR referral should have been made to Oklahoma Health Care Authority.		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 30267 Based on record review and interview, the facility failed to care plan a resident's weight loss for one (#9) of one sampled resident whose care plan was reviewed for weight loss. The DON identified three residents with weight loss. Findings: Resident #9 had diagnoses which included dementia. The registered dietician's note, dated 11/19/24, documented the resident had weight loss of 12.5% in the last three months and 11.6% in the last six months. The note documented the resident received Megace, an appetite stimulant, as a physician ordered intervention for weight loss. On 12/06/24 at 4:40 p.m., Resident #9's clinical record was reviewed. There was no documentation weight loss was care planned. On 12/06/24 at 6:00 p.m., the MDS coordinator stated the resident's weight loss should have been care planned.		

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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. 30267 Based on observation and interview, the facility failed to maintain a clean ice machine. The administrator identified 29 residents who received ice from the kitchen. Findings: On 12/03/24 at 10:38 a.m., the DM stated the kitchen staff cleaned the storage chest of the ice machine weekly and removed all the ice and cleaned/sanitized the storage chest of the ice machine monthly. The DM stated the kitchen staff did not clean the mechanical workings of the ice machine. The DM stated there was a company which came and ran sanitizer through the ice machine, but did not know how often the company did so. On 12/06/24 at 2:21 p.m., the internal mechanics of the ice machine was observed to have a moist green and black substance along the edges of the water reservoir, covers, inlets, and tubing. On 12/06/24 at 2:22 p.m., the administrator observed the internal mechanics of the ice machine and stated the ice machine needed to be cleaned.		