STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375330	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Gibson Care & Rehab Center	205 East Poplar Street Fort Gibson, OK 74434

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 49701 Based on record review and interview, the facility failed to complete a significant change assessment for a resident with a decline in ADLs due to an above knee amputation for one (#7) of 13 sampled residents reviewed for assessments. The administrator identified 51 residents resided in the facility. Findings: An annual MDS assessment, dated 04/21/24, documented Res #7 had no functional impairments in range of motion. The MDS documented Res #48 required setup/cleanup assistance with upper body dressing. The MDS documented Res #7 used both a walker and a wheelchair for mobility, and required supervision with walking 10 feet. A quarterly MDS assessment, dated 09/18/24, documented Res #7 had declined in range of motion and had impairments of upper and lower extremities on both sides. The MDS documented Res #7 required supervision with walking 10 feet. A progress note, dated 11/25/24, documented Res #7 was being sent to the hospital due to possible gangrene to their left heel. The facility census report documented Res #7 went to the hospital on 11/25/24 and returned on 12/02/24. A progress note, dated 12/02/24, documented the nurse observed eight sutures and 20 staples to the left side above the knee amputation. A review of the record identified a significant change assessment had not been completed. On 01/15/25 at 10:51 a.m., the MDS coordinator stated a significant change should have been completed within 14 days of recognizing a significant change had taken place. On 01/15/25 at 11:00 a.m., the DON stated a significant change should have been completed.

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. 33097 Based on record review and interview, the facility failed to ensure a referral was made to the LOCEU for one (#3) of three sampled residents reviewed for PASSARs. The DON identified eight residents with a level II PASSAR. Findings: Resident #3 had diagnoses which included hypertension, dementia, and hallucination. A level I PASSAR, dated 08/30/18, documented the resident did not have a diagnosis of a serious mental illness. A level I PASARR, dated 06/10/19, documented the resident did not have a diagnosis of a serious mental illness. On 01/11/24 the resident received a diagnosis of psychosis not due to a substance or known physiological condition. The annual assessment, dated 08/28/24, documented the resident was not currently considered by the state level II PASSAR process to have serious mental illness and/or intellectual disability or a related condition. On 01/14/25 at 12:35 p.m., the ADON reviewed the resident's diagnoses and stated they were not aware of the diagnosis of psychosis for the resident. The ADON stated when the resident received the psychosis diagnosis a referral should have been made to the LOCEU for consultation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49701 Based on observation, record review and interview, the facility failed to ensure a care plan was updated for one (#7) of thirteen resident care plans reviewed for accuracy. The administrator identified 51 residents resided in the facility. Findings: 1. Resident #7 had diagnoses which included surgical amputation of left lower leg. The resident's care plan was reviewed and did not document the amputation of the left lower leg. On 01/15/25 at 10:51 a.m., the MDS coordinator stated the care plan should have been updated to include the amputation and any other changes to their abilities that resulted from the amputation. On 01/15/25 at 11:00 a.m., the DON stated the care plan should have been updated.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 33097 Based on observation, record review, and interview, the facility failed to ensure a resident received restorative services to maintain or improve their ability to carry out activities of daily living for one (#26) of one sampled resident reviewed for activities of daily living. The DON identified nine residents who were currently receiving restorative services. Findings: A document titled Policy and Procedure Range of Motion, read in parts, To exercise the resident's joints and muscles as required and/or clinically indicated .Verify exercise to be completed with physician's orders or treatment plan. Unless otherwise specified, repeat each exercise (3) times. There was no policy regarding restorative services provided. Resident #26 had diagnoses which included muscle weakness, lack of coordination, muscle wasting and atrophy, abnormalities of gait and mobility, and Parkinson's. The care plan, revised 08/07/23, documented the resident had muscle strength/muscle atrophy, weakness, and deconditioning. The care plan documented the staff were to encourage the resident to participate in activities that promoted exercise, physical activity for strengthening and improved mobility. The care plan documented the staff were to refer the resident to PT/OT/restorative PRN indication/ordered. A physician order, dated 02/08/24, documented to discontinue part B physical therapy services and resident may have restorative nursing services. A physician order, dated 06/05/24, documented PT/OT/ST to evaluate and treat as indicated. A physical therapy discharge summary, dated 06/05/24 through 08/09/24, documented discharge recommendations for the restorative program. The summary documented range of motion program established with resident. The summary documented the resident was able to move their feet up and down, raise their arms above their head, chin to chest, and tier was functional and with restorative nursing program. The summary documented a transfer program was established with resident and they were currently able to perform stand pivot transfers, perform wheelchair transfers, and tier was functional with restorative nursing program. The annual assessment, dated 01/01/25, documented the resident was cognitively independent and was dependent assist with transfers and most ADLs. The assessment documented the resident had limited ROM with one side of the upper body. The assessment documented the resident was not receiving physical therapy, occupational therapy, or restorative services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/12/25 at 2:36 p.m., the resident was observed lying in bed and was wearing an incontinent brief. The resident stated they just laid in bed because it took more than one staff member for transfers. The resident stated they had not received restorative services since their physical therapy had ended in August of last year. The resident stated they were walking in the hall with assistance when receiving physical therapy. On 01/14/25 at 2:47 p.m., the DON could not provide documentation the resident ever received restorative services. The DON stated they were responsible for ensuring restorative services were provided when therapy made a recommendation. The DON stated they were not aware of the recommendation for restorative services for the resident. On 01/14/25 at 3:10 p.m., the resident was observed for ROM and a transfer. The resident stated they were still able to complete ROM and transfers as when receiving physical therapy, but they were just weaker now.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33097 Based on observation, record review, and interview, the facility failed to update and implement individualized fall interventions in the care plan for a resident who fell and sustained a head injury for one (#47) of one sampled resident reviewed for falls. The DON identified 17 residents who had fallen in the past three months. Findings: A policy titled FALL MANAGEMENT, read in parts, To provide an environment that remains as free of accident hazards as possible. The Facility will complete a Morse Fall Scale Evaluation on Residents to determine who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent to minimize further Falls and/or reduce injuries .Identified risk factors should be addressed in the Resident's Care-Plan to ensure individualized interventions to reduce the risk are implemented .The Care Plan should be reviewed after every fall and updated with a new intervention . Revise/Modify Care Plan/Kardex; Implement Interventions according to Treatment approach to minimize further Falls & reduce injury. Resident #47 had diagnoses which included psychosis, hallucinations, and dementia. A fall risk evaluation, dated 01/14/24, documented the resident was at risk for falls. A fall log for the resident documented the resident had three falls in February 2024, one fall in April 2024, one fall in May 2024, two falls in June 2024, one fall in July of 2024, two falls in August 2024, two falls in September 2024, and six falls in October of 2024. An incident report, dated 11/08/24, documented the resident was found sitting on the floor in their room by the bathroom. The report documented a moderate amount of blood was noted to the floor and on the resident's clothes. The report documented the resident had a vertical laceration to the forehead about 3.5 cm long. The report documented the resident was sent to the emergency room for treatment. The care plan intervention for fall risk, dated 11/08/24, documented to place the resident on every hour toileting program while awake. The care plan documented the resident had an injury fall on 11/08/24 sustaining a laceration with sutures to the forehead. An incident report, dated 11/14/24, documented the resident was on the floor in the lobby. The report documented the resident stated they were going to the bathroom. The care plan intervention for fall risk, dated 11/14/24, documented the pharmacist was to review the resident's medications. An incident report, dated 11/18/24, documented the resident was found in their room sitting on the floor in front of the toilet. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The care plan intervention for fall risk, dated 11/18/24, documented the staff was to continue with the resident's plan of care. An incident report, dated 12/05/24, documented the resident was found in their room sitting on the floor by the bathroom door. The resident stated they had a nosebleed. The care plan intervention for fall risk, dated 12/05/24, documented the staff was to keep Kleenex within reach. The quarterly assessment, dated 12/12/24, documented the resident was severely impaired cognitively and had two or more non-injury/injury (not major) falls since admission. An incident report, dated 12/14/24, documented the resident was found in their room laying on the floor. The care plan intervention for fall risk, dated 12/14/24, documented neuro checks were initiated. An incident report, dated 12/16/24, documented the resident was found sitting on the floor in front of their recliner. The report documented the resident stated they were going to smoke a cigarette. The care plan did not document a new intervention for the incident which occurred on 12/16/24. An incident report, dated 12/17/24, documented the resident was found lying on the floor near the mens bathroom door with their wheelchair not locked. The care plan intervention for fall risk, dated 12/17/24, documented staff were to initiate neuro checks per protocol. A fall log for the resident documented the resident had falls on 12/19/24 and 12/20/24. There were no incident reports provided. The care plan intervention for fall risk did not document a new intervention for the fall which occurred on 12/19/24. The care plan intervention for fall risk, dated 12/20/24, documented visitors were to be educated on notification of staff if the alarm was sounding while the door was closed and visitor was caring for the roommate. An incident report, dated 12/22/24, documented the resident was found lying on the floor in their room with their brief saturated and complaining of being cold. The care plan intervention for fall risk, dated 12/22/24, documented staff were to do frequent checks at night due to the alarm not working correctly. An incident report, dated 12/24/24, documented the resident was assisted by staff to the bathroom per resident request. The report documented staff left the resident sitting on the toilet to obtain a new brief and clothing. The report documented the resident slid off the toilet to the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The care plan intervention for fall risk, dated 12/24/24, documented staff were not to leave the resident's side when they were not able to sit up straight on the toilet and to obtain assistance with dressing the resident. A fall log for the resident documented the resident had a fall on 12/26/24 and 12/30/24. There were no incident reports provided. The care plan did not document new interventions for the falls which occurred on 12/26/24 and 12/30/24. An incident report, dated 01/01/25 at 12:00 a.m., documented the resident was found lying on the floor in their room by the bed. The report documented incontinent care was provided and the resident was assisted back to bed. The care plan did not document an intervention for the fall which occurred on 01/01/25 at 12:00 a.m. An incident report, dated 01/01/25 at 1:55 a.m., documented the resident was found lying on the floor in their room. The report documented the resident had been incontinent of bowel and bladder and incontinent care was provided. The report documented the resident sustained a small abrasion to their left knee. The care plan intervention for fall risk, dated 01/01/25, documented the resident was to have wound care to the left knee abrasion until resolved. The care plan intervention for fall risk, dated 01/02/25, documented to change the resident's mattress to a wide mattress. On 01/12/25 at 4:16 p.m., the resident was in the dining room sitting in a wheelchair for the evening meal. The resident's wheelchair had a anti-tip back bar. No alarm was noted. The resident's room had floor mats covering the entire floor area of the resident's side of the room. On 01/14/25 at 4:06 p.m., the ADON reviewed the resident's plan of care and stated new interventions were no implemented with each fall occurrence. The ADON stated some interventions were repeat interventions or not appropriate fall interventions for the resident. On 01/15/25 at 8:14 a.m., the resident was sitting in the dining room in a wheelchair with their head down and their eyes closed. The wheelchair had a anti-tip back bar. The wheelchair did not have a chair alarm. The resident was wearing tennis shoes. On 01/15/25 at 8:28 a.m., CNA #4 stated the resident had a low bed, was observed every two hours, had a anti roll back attachment on their wheelchair, and was toileted every two hours. The CNA stated the resident was usually in common areas or near the nurse station during the day for visual site. The CNA stated the resident usually slept through the night, but was still checked on every two hours. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/15/25 at 10:54 a.m, the DON stated the staff were aware of resident's toileting program and documented in the task records. The DON reviewed the resident's plan of care and stated there were repeat interventions and not appropriate interventions for the resident. The DON stated the staff needed education regarding falls and fall interventions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49701 Based on record review and interview, the facility failed to ensure medications were administered as ordered for one (#21) of five sampled residents reviewed for unnecessary medications. The administrator identified 51 residents resided in the facility. Findings: The Medication Administration policy, dated 01/2024, read in part, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Resident #21 had diagnoses which include hypertension, hypothyroidism, and bipolar disorder. A November 2024 Medication Administration Record was blank on November 28th, 29th, and 30th for Resident #21's order for levothyroxine (thyroid hormone medication) 50 mcg to be given twice daily for hypothyroidism. A December 2024 Medication Administration Record was blank on December 7th, 8th, 11th, and 16th for Resident #21's order for levothyroxine 50 mcg to be given twice daily for hypothyroidism. A January 2025 Medication Administration Record was blank for the 2:00 p.m. dosage of metoprolol (beta blocker) 50 mg to be given three times daily for hypertension on January 4th and 9th. The MAR was also blank for the 2:00 p.m. dosage of protriptyline (antidepressant medication) 20 mg to be given three times a day for bipolar on January 4th and 9th. On 01/14/25 at 2:12 p.m., CMA #1 stated they were unable to verify if the medications were given if the medication administration was blank. On 01/14/25 at 2:25 p.m., the ADON stated the blanks meant the medication administration was not documented, so there would be no way to know it the medication was administered or not.

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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. 33097 Based on observation, record review, and interview, the facility failed to ensure: a. the ovens were clean; b. foods were labeled and dated in the refrigerator; and c. the ice scoop was maintained in a sanitary manner. The administrator identified 51 residents resided in the facility. Findings: A policy titled Ice Machine, read in parts, The ice machine, scoop, and storage container will be maintained in a clean and sanitary condition .The scoop and storage container will be cleaned once per day. A policy titled Refrigeration, read in part, Foods shall be stored in an organized manner and shall be maintained in their original containers unless they are considered a leftover. All leftovers shall be labeled and dated with an expiration date of no more than three (3) days. On 01/12/25 at 11:55 a.m., a tour of the kitchen was conducted. The ice scoop was observed lying on top of the ice machine uncovered and not in a bag. Three ham sandwiches were in the refrigerator in sandwich bags unlabeled and undated. On 01/12/25 at 12:05 p.m., the ovens were observed to have a thick black substance on the bottom and sides of the oven. On 01/12/25 at 12:07 p.m., cook #1 stated the ovens needed to be cleaned. The cleaning schedule posted on the wall documented the oven had been cleaned a week ago. The cook stated the ovens did not look like they had been cleaned a week ago. The cook stated the ice scoop should be kept in a plastic bag and the bag changed daily. On 01/13/25 at 3:45 p.m., the DM stated the ovens had not been cleaned per the cleaning schedule and staff education had been provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49701 Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions were utilized during resident care for one (#32) of one sampled resident observed during care. The administrator identified 11 residents that required enhanced barrier precautions. Findings: An Enhanced Barrier Precautions (EBP) policy, last reviewed on 05/15/24, read in part, enhanced barrier precautions refer to the use of gowns and gloves during high-contact resident care provides opportunities for transfer of multidrug resistant organisms to hands or clothing. EBP should be used during these high contact areas: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or toileting for people with central lines, urinary catheters, enteral tubes, tracheostomy/ventilator, and wound care for skin openings that require a dressing. On 01/13/25 at 8:02 a.m., Resident #32 had EBP signage on the door. CNA #1 was observed in Resident #32's room assisting with toileting and dressing. CNA #1 was observed wearing gloves and a mask, but no gown. Resident #32 had a dressing over their right foot. CNA #1 was observed placing a sock over the dressing and assisting resident to place a boot on the right foot. CNA #1 then assisted Resident #32 with applying deodorant. CNA #1 then proceeded to change the bed linen that had a yellow stain that was darker around the edges on the bottom sheet. On 01/13/25 at 4:07 p.m., CNA#3 was asked what EBP or enhanced barrier precautions meant. CNA #3 stated EBP was lantiseptic and you were supposed to use gloves at all times with all residents. On 01/13/25 at 4:13 p.m., CNA#2 stated they were not told about enhanced barrier precautions or what it meant. On 01/14/25 at 11:29 a.m., LPN #1 was observed providing wound care to Resident #32. LPN#1 cleaned the bed side table appropriately, applied clean gloves, removed Resident #32's boot, sock, and dressing from their left foot. On 01/14/25 at 11:34 a.m., LPN #1 donned clean gloves and washed wound, the wound was patted dry and measured. Santyl was applied followed by calcium alginate, 4x4 abdominal pad, stretch gauze, Kerlix, and secured with Coban. On 01/14/25 at 11:48 a.m., LPN #1 stated they provided wound care five days a week. LPN #1 stated EBP were to be used for wounds, urinary catheter care, peg tube care, and breathing treatments to prevent cross contamination. LPN #1 stated they were trained and magnets were placed on the side of the door to indicate EBP were to be used and the supplies were supposed to be on the back of the door inside the rooms. LPN #1 stated they used an app that reported what residents required EBP when providing high contact direct care. LPN#1 stated they were not wearing a gown and should have been. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/25 at 2:25 p.m., the ADON stated they had started re-educating staff when it was brought to their attention that some of the staff's understanding was incomplete or inaccurate.