STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375335	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windridge Nursing and Rehabilitation Center	2530 North Elm Street Miami, OK 74354

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. 47453 Based on record review and interview, the facility failed to ensure Resident Assessments were accurately coded for one (#13) of 12 residents reviewed for assessments. The Administrator identified 36 residents resided in the facility. Findings: An Assurance Of Professional Accuracy policy, undated, read in part, this facility will insure the accuracy of each resident's assessment. Resident #13 had diagnoses which included dementia, bipolar, depression, and anxiety. An Order Summary report, documented Resident #13 did not received the Antipsychotic medication Depakote and a review of discontinued orders documented Depakote was discontinued on 05/24/24. An Quarterly Resident Assessment, dated 07/12/24, document Resident #13 received a Antipsychotic medication daily. On 08/22/24 at 11:40 a.m., the ADON was asked to review the quarterly assessment for 07/12/24. The ADON reviewed and was then asked if Resident #13 received a Antipsychotic medication Depakote daily. They stated they mistook the Depakote level lab as the order for Depakote and marked the MDS inaccurately. On 08/22/24 at 12:01 p.m., the ADON was asked what the facility policy was for accuracy of resident assessments. They stated the assessments should be accurately 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47453 Based on record review and interview, the facility failed to ensure RN coverage for eight consecutive hours seven days per week. The Administrator identified 36 residents resided in the facility. Findings: On 08/22/24 at 1:52 p.m., Administrator, provided the requested RN hours for January, February, and March 2024. On 08/22/24 at 2:18 p.m., review of the RN time punch details and floor schedule for nurses documented, the facility did not have RN coverage for eight consecutive hours on the following dates: a. 01/06/24 - No RN hours worked, b. 01/07/24 - No RN hours worked, c. 01/20/24 - No RN hours worked, d. 01/21/24- No RN hours worked, e. 02/04/24- No RN hours worked, f. 02/20/24- No RN hours worked, and g. 02/27/24- No RN hours worked. On 08/22/24 at 2:52 p.m., Administrator was asked what the facility policy is for RN coverage 7 days a week. They stated the facility needed RN coverage 7 days a week. They were then asked were the dates above covered by RN's, they stated No.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41809 Based on observation and interview, the facility failed to ensure equipment was maintained in a manner to prevent growth and equipment was not left in food bins. The administrator identified 36 residents who ate from the kitchen. Findings: On 08/20/24 at 10:39 a.m., scoops were observed in food bins of cake mix, sugar, flour, brown sugar and pinto beans. On 08/02/24 at 10:50 a.m., the ice machine was observed to have pink and black substances on the deflector plate which ice was observed to touch. The maintenance supervisor was asked to open the top of the ice machine. The area where ice was formed was observed to have a dark substance scattered across the plastic and along the sides of the machine. Observation of the ice revealed dark specks frozen inside of the ice. The maintenance supervisor stated the ice machine was cleaned by a contracted company every six months. On 08/21/24 at 12:46 p.m., the holding temperature of beef roast was 135.9 degrees Fahrenheit. DA #1 stated the holding temperature should be 170 degrees Fahrenheit. On 08/22/24 at 2:06 p.m., the DM stated the holding temperature of meat was to be 140 degrees Fahrenheit or higher and the food should have been reheated until it reached the proper temperature. They stated no resident had signs or symptoms of food borne illness. The DM stated the scoops should have been placed on the hook inside of the bins to prevent them from touching the food products/ingredients.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41809 47453 Based on observation, record review, and interview the facility failed to ensure proper infection control techniques when providing catheter care for one (#1) of one sampled residents who were reviewed for catheter care and failed to ensure enhanced barrier precautions were utilized for PEG tube care for one (#20) of one sampled residents who were reviewed for PEG tubes. The ADON identified one resident resided in the facility with a urinary catheter and one resident in the facility with a peg tube. Findings: An undated Catheter Care policy, read in part, use gloves, basin of warm water, soap or peri wash, washcloth, towel .Routine to be followed unless specific orders direct otherwise. An Enhanced Barrier Precautions policy, undated, read in part, the expanded use of PPE and refer to the use of gown and gloves during high-contact care activities that provide opportunities for transfer of Multi-Drug Resistant Organisms (MDRO) to or from staff hands or clothing or indirectly transferred. 1. Resident #1 had diagnoses which included urinary retention, neuropathy, and cellulitis. An Order Summary report documented catheter care was to be completed every shift. On 08/22/24 at 9:15 a.m., CNA #1 was observed to obtain wash cloths from a handrail in the hallway outside the room of Resident #1 to provide peri care. CNA #1 wet the wash cloths in the sink, a hospice aide assisted CNA #1 to remove the incontinent brief of Resident #1. CNA #1, using same gloves, re-wet the wash cloths in the sink. CNA #1 was observed to wipe the peri area of Resident #1 multiple times with the same wash cloth. CNA #1 returned to sink, wearing the same gloves and re-wet another cloth, returned to Resident #1 then wiped the catheter tube multiple times with the same cloth, doffed their gloves, and was not observed to sanitize their hands. On 08/22/24 at 9:43 a.m., the ADON was asked what the facility policy was on peri care with or without a catheter. They stated to use soap and water, wipe from front to back, rinse well, and clean around catheter. They were then asked if wash cloths hanging off of handrails in the hallway were considered clean. They state No. 2. Resident #20 had diagnoses which included brain cancer, dysphagia, and seizures. A physician order, dated 12/15/23, documented to change PEG tube PRN for obstruction or displacement only. A physician order, dated 12/15/23, documented to cleanse PEG tube stoma and around area with wound cleanser, pat dry with 4x4's, then secure a spilt sponge dressing daily and prn. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/24 at 9:30 a.m., no signage was posted for EBP precautions, no PPE was observed near Resident #20's or Resident #1 door. On 08/22/24 at 9:36 a.m., the administrator was asked what the facility policy was regarding Enhanced Barrier precautions. They stated the policy was included with the infection control policy and procedure. On 08/22/24 at 9:41 a.m. the ADON was asked what residents in the facility were on EBP. They stated no residents were on EBP at this time.