STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375350	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seminole Pioneer Nursing Home	1705 Boren Blvd Seminole, OK 74868

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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 43023 Based on record review and interview, the facility failed to ensure a significant change assessment had been completed after a resident admitted to hospice for one (#30) of 17 sampled residents reviewed for assessments. The administrator identified 50 residents in the facility. Findings: Resident #30 admitted to the facility with diagnoses which included dementia. A physician's order, dated 06/06/24, documented the resident was admitted to hospice. The resident's record was reviewed and contained no documentation a significant change assessment had been completed. On 11/04/24 at 1:31 p.m., MDS Coordinator #1 reported a significant change assessment should have been completed when the resident admitted to hospice.

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on record review and interview, the facility failed to accurately complete a level I PASARR for a new admit resident for one (#48) of one sampled resident reviewed for a PASARR. The administrator identified 50 residents in the facility. Findings: Res #48 admitted to the facility on [DATE] with diagnoses which included schizophrenia. A level I PASARR assessment, dated 10/10/24, documented Res #48 did not have a diagnosis of a serious mental illness. On 11/04/24 at 11:20 a.m., the administrator stated they were unaware of the diagnosis at admit and did not accurately complete the form.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on record review and interview, the facility failed to complete a baseline care plan for one (#48) of two sampled residents reviewed for pressure ulcers. The administrator identified 50 residents in the facility. MDS Coordinator #1 identified three residents with pressure ulcers. Findings: Res #48 admitted to the facility on [DATE] with diagnoses which included depression and schizophrenia. A record review did not document a baseline care plan was completed. On 11/04/24 at 1:54 p.m., MDS Coordinator #1 stated there was no baseline care plan completed for Res #48.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on observation, record review, and interview, the facility failed to develop a care plan for smoking for one (#32) of one sampled resident reviewed for smoking and failed to develop a care plan for a wound for one (#48) of two sampled residents reviewed for pressure ulcers. The administrator identified eight residents who smoked. MDS Coordinator #1 identified three residents with wounds. Findings: 1. Res #32 had diagnoses which included history of stroke and hypertension. On 11/04/24 at 9:06 a.m., Res #32 was observed on the front porch of the facility smoking a cigarette during the facility designated smoking time. A record review did not document a smoking care plan was developed for Res #32. On 11/04/24 at 3:20 p.m., MDS Coordinator #1 stated Res #32's care plan should have included smoking. 2. Res #48 admitted to the facility on [DATE] with diagnoses which included schizophrenia. A physician's order, dated 10/16/24, documented to cleanse wound to left upper buttocks with wound cleanser, pat dry, apply calcium alginate, and cover with dressing. A record review did not document a wound care plan. On 11/04/24 at 2:22 p.m., MDS Coordinator #1 stated there should have been a wound care plan, but there was not.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on record review and interview, the facility failed to assess a pressure ulcer upon admission for one (#48) of two sampled residents reviewed for pressure ulcers. MDS Coordinator #1 identified three residents with pressure ulcers. Findings: Res #48 admitted to the facility on [DATE] with diagnoses which included schizophrenia. A record review did not document a wound assessment upon admission. A progress note, dated 10/16/24, documented the nurse was informed the resident had a pressure ulcer that was not assessed on admission. It was documented the physician was notified and treatments were ordered. On 11/04/24 at 12:40 p.m., the ADON stated Res #48 admitted to facility a wound to the buttock. They stated they were out of town when the resident admitted and the charge nurse should have completed the assessment, but did not.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43023 Based on observation, record review, and interview, the facility failed to obtain a physician's order for a catheter for one (#14) of one sampled resident reviewed for catheters. The administrator identified 50 residents resided in the facility. Findings: Res #14 was admitted with diagnoses which included chronic kidney disease, Parkinson's without dyskinesia, COPD, and personal history of UTIs. On 11/03/24 at 1:49 p.m. Resident #14 was observed resting in their bed with their eyes open. The resident's catheter was observed draining to gravity at bedside. The resident's record was reviewed and did not contain a physician's order for the catheter. On 11/05/24 at 10:25 a.m., LPN#1 reported the resident had a catheter since May 2022 due to a wound that had to be surgically repaired. On 11/05/24 at 10:52 a.m., MDS Coordinator #1 was informed there was no order for a catheter. They reported there should have been an order for the catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43023 Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was dated for one (#52) of one resident sampled for oxygen. The administrator identified 50 residents resided in the facility. Findings: Res #52 admitted to the facility with diagnoses which included COPD. On 11/04/24 at 1:58 p.m., Resident #52's oxygen tubing was observed with no date. On 11/05/24 at 12:05 p.m., the DON reported the tubing was supposed to be changed weekly and dated.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 46387 Based on observation and interview, the facility failed to ensure census information was posted with the daily staffing roster. The administrator identified 50 residents resided in the facility. Findings: On 11/05/24 at 9:14 a.m., the staffing roster was observed posted next to the nurses station. The census was not included in the posted information. On 11/05/14 at 9:16 a.m., the administrator stated they were unaware the census had to be posted.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46387 Based on record review, and interview, the facility failed to ensure residents were free of significant medication errors for one (#49) of five sampled residents reviewed for unnecessary medications. The administrator identified 50 residents resided in the facility. Findings: Res #49 had diagnoses which included mood disorders. A physician's order, dated 10/21/24, documented to administer Zyprexa (an antipsychotic) 5 mg at bedtime for mood disorder. An October 2024 MAR documented blanks for the PM doses of Zyprexa on 10/22/24 and 10/30/24. A behavior monitoring tracker for October 2024 documented Res #49 had behaviors on 10/22/24 and 10/30/24. On 11/05/24 at 9:22 a.m., CMA #1 stated the blanks on the MAR meant the medication was not given. On 11/05/24 at 9:24 a.m., the DON stated there was no way to prove the medications were administered if the administration record was blank. They were made aware of the resident's behaviors on the days the medication was not given. They shrugged and had no additional comment regarding the behaviors.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43023 Based on observation and interview, the facility failed to ensure foods in the kitchen were dated and labeled. The administrator reported 50 residents resided in the facility. Findings: On 11/03/24 at 8:45 a.m, a tour of kitchen was conducted. A commercial refrigerator was observed to contain a pitcher of brown liquid, a pitcher of yellow liquid, 11 cups of different colored liquids, and a pitcher of fruit. There were no dates or labels on the food products. On 11/03/24 at 9:21 a.m., [NAME] #1 reported everything in the refrigerator should have been dated and labeled.

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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. 46582 Based on observation, record review, and interview, the facility failed to maintain an infection control program for enhanced barrier precautions for one (#33) of one sampled resident reviewed for wound care. MDS Coordinator #1 identified three residents with pressure ulcers. Findings: An Enhanced Barrier Precautions policy, undated, read in parts, Enhanced Barrier Precautions refer to an infection designated to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions .An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers .and/or indwelling medical devices (e.g., urinary catheters) .PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .High-contact resident care activities include: wound care: any skin opening requiring a dressing .Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Res #33 had diagnoses which included stage III left heel pressure ulcer, dementia, and cerebral infarction. An admission assessment, dated 02/20/24, documented the resident was cognitively intact, required setup to partial assistance with mobility, and had one stage III pressure ulcer present upon admission. A physician's order, dated 09/11/24, documented to cleanse left heel with normal saline, apply five tobramycin eye drops to wound bed, apply Medihoney, then apply calcium alginate to wound bed, apply Exudry pad and secure with kerlix and tape one time a day for open wound. On 11/03/24 at 12:08 p.m., Res #33 was observed lying in bed. A gauze dressing was observed wrapped around Res #33's left heel. Res #33 stated they had a wound on the back of their heel and the staff provided wound care daily. On 11/05/24 at 10:52 a.m., LPN #1 was observed performing wound care on Res #33. LPN #1 was observed to have worn gloves during the treatment. LPN #1 was not observed to have worn a personal protective gown during the wound care treatment. No personal protective equipment was observed outside or near Res #33's room. On 11/05/24 at 12:15 p.m., the DON stated they had never heard of enhanced barrier precautions. They stated the IP was responsible for infection control and the facility had not implemented enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/05/24 at 12:30 p.m., CNA #1 stated they had not been educated on the use of enhanced barrier precautions during high-risk activities for residents with pressure wounds. On 11/05/24 at 12:56 p.m., LPN #1 stated they should have donned a gown prior to providing wound care on Res #33. They stated the facility had not implemented the use of enhanced barrier precautions. On 11/05/24 at 1:07 p.m., the IP stated the facility had not implemented the use of enhanced barrier precautions.