

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Nowata Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 436 South Joe Nowata, OK 74048	

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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to provide accurate CMS-10055 forms to residents who discharged from part A services for two (#31 and #32) of three sampled residents reviewed for accurate skilled services beneficiary notices.</p> <p>The ADON reported four residents had discharged from skilled services in the previous six months.</p> <p>Findings:</p> <p>An undated facility document titled, Form Instructions Skill Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 (2024), read in part, The SNF ABN provides information to the patient so that [they] can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility.</p> <p>A CMS-10055 form, dated 02/16/24, documented it was for Resident #31 and had been approved via telephone by the resident's representative. The document did not document the estimated costs to the resident if they wished to continue the identified skilled services. The form did not document the resident representative's choice whether they wished to continue the services and bill Medicare for an official decision, continue services and bill the resident, or end the services.</p> <p>A CMS-10055 form, dated 08/31/24, documented it was for Resident #32 and included the resident's signature. The form did not include what type of skilled services that were to be billed to Medicare.</p> <p>On 11/19/24 at 11:41 a.m., ADON stated they must have forgotten to include the information on the forms for Residents #31 and #32. They stated the reason for this document was to inform the residents about the type of services to be provided and the residents financial responsibility if any. They stated not filling out the forms completely was an error on their part.</p>

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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to provide a written notice of transfer to a resident prior to a transfer to an acute care hospital for one (#32) of two sampled residents reviewed for hospitalizations and discharges.</p> <p>The ADON reported that seven residents had transferred to a hospital in the previous six months.</p> <p>Findings:</p> <p>A facility Transfer or Discharge Notice policy, dated December 2016, read in part, Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility.</p> <p>A progress note, dated 08/27/24 at 7:50 a.m., documented Resident #32 had been sent to an acute care hospital for confusion and a low blood oxygen saturation rate. The note documented a family member of the family was notified of the situation.</p> <p>A progress note, dated 08/31/24 at 2:45 p.m., documented Resident #32 was returned to the facility from the hospital by a family member.</p> <p>On 11/21/24 at 9:35 a.m., Resident #32 stated they had been sent to the hospital earlier that year because of breathing problems.</p> <p>ON 11/21/24 at 9:50 a.m., RN #1 and LPN #1 stated they did not give a written notice of transfer to Resident #32 when they went to the hospital. They stated they had not heard of a written notice of transfer before.</p> <p>On 11/21/24 at 10:02 a.m., the ADON stated Resident #32 were not given a written notice of transfer when they had been sent to the hospital on 08/27/24. They stated they were unaware of the requirement for the written notice.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to provide a written notice of the bed hold policy when a resident was sent to a hospital for one (#32) of two sampled residents reviewed for hospitalization s and discharges.</p> <p>The ADON reported that seven residents had transferred to a hospital in the previous six months.</p> <p>Findings:</p> <p>A facility Bed-Hold and Returns policy, dated March 2017, read in part, Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy.</p> <p>A progress note, dated 08/27/24 at 7:50 a.m., documented Resident #32 had been sent to an acute care hospital for confusion and a low blood oxygen saturation rate.</p> <p>On 11/21/24 at 9:35 a.m., Resident #32 stated they had been sent to the hospital earlier that year because of breathing problems.</p> <p>On 11/21/24 at 9:50 a.m., RN #1 and LPN #1 stated they did not give a written notice of the bed hold policy when Resident #32 was sent to the hospital on 08/27/24.</p> <p>On 11/21/24 at 10:02 a.m., the ADON stated after review of Resident #32's records, they found no documentation of a bed hold policy having been given to the resident. They stated Resident #32 had not been given a written notice of the bed hold policy when they were sent to the hospital on 08/27/24.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270</p> <p>Based on record review and interview, the facility failed to ensure:</p> <p>a. an antianxiety medication was not prescribed on an as needed basis without a 14-day limit or a physician's explanation why it should be used beyond 14 days for one (#24); and</p> <p>b. gradual dose reductions were recommended or attempted for antidepressants for two (#17 and #30) of five sampled residents reviewed for unnecessary medications.</p> <p>The ADON reported 27 residents at the facility were prescribed psychotropic medications.</p> <p>Findings:</p> <p>A facility policy titled Policy for the Management of Resident Medication, dated 10/2017, read in part, For resident who require the use of these medications, gradual dose reductions will be attempted unless contraindicated, and behavioral interventions implemented in an effort to discontinue the medication.</p> <p>1. Resident #17 had diagnoses of recurrent depressive disorder.</p> <p>A medication administration record, dated 11/01/24 through 11/30/24, documented Resident #17 had been ordered citalopram hydrobromide (SSRI) 40mg one time daily for recurrent depressive disorder on 12/01/23. The record documented the resident had received the medication routinely.</p> <p>2. Resident #24 had diagnoses of anxiety disorder.</p> <p>A medication administration record, dated 11/01/24 through 11/30/24, documented Resident #24 had been ordered lorazepam (benzodiazepine) 0.5mg one tablet to be given as needed only once daily for restlessness and agitation. The order was dated 10/07/24. The record documented the resident had received a dose of that medication on 11/17/24.</p> <p>3. Resident #30 had diagnoses of major depressive disorder.</p> <p>A review of Resident #30's medication order history found a medication order for trazodone ([NAME]) 50mg once daily with a start date of 12/13/24 and a discontinue date of 06/07/24. A second order for trazadone 50mg once daily had a start date of 06/07/24 and was active at the date of the review which was 11/20/24.</p> <p>A medication administration record, dated 06/01/24 through 06/30/24, documented two orders for trazodone 50mg to have been given once daily. One order's last documented dose was given on 06/06/24 and the other's first documented dose was given on 06/07/24. The record documented the resident received trazadone 50mg once daily each day of that month.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/19/24 at 2:13 p.m., the ADON stated they recalled PRN antipsychotics need a reason for the order to go beyond 14 days, but they did not catch this one.</p> <p>On 11/20/24 at 9:52 a.m., the ADON stated they had reviewed pharmacy records and found no gradual dose reduction had been recommended by the pharmacy or attempted by the physician for Resident #30's trazadone order.</p> <p>On 11/20/24 at 10:54 a.m., the ADON stated they reviewed Resident #17's medical record and pharmacy records, but did not find any documentation of a gradual dose reduction having been recommended or attempted for the resident's citalopram. They stated they were unable to locate a policy that specifically speaks to PRN psychotropics.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>34270</p> <p>Based on observation and interview, the facility failed to ensure kitchen staff with beards wore beard guards while preparing food for the resident.</p> <p>The ADON stated 34 residents at the facility routinely ate meals provided by the facility kitchen staff.</p> <p>Findings:</p> <p>On 11/18/24 at 8:10 a.m., the facility's dietary manager and dietary aide #1 were observed working in the kitchen where food items were being prepared. Each had a beard and were not wearing beard guards.</p> <p>On 11/18/24 at 11:03 a.m., the facility's dietary manager and dietary aide #1 were observed in the food preparation area. They were not wearing beard guards. The dietary manager stated they did not have any beard guards in the facility.</p> <p>On 11/19/24 at 9:35 a.m., the administrator stated they were unaware there were not beard guards in the facility and would immediately obtains some. They stated the beard guards were required in the facility when preparing food.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to provide staffing data to CMS for the third quarter of 2024.</p> <p>The ADON stated 34 residents resided at the facility.</p> <p>Findings:</p> <p>A PBJ Staffing Data Report for the third quarter of 2024 (04/01/24 through 06/30/24) documented the facility had failed to submit the mandated staffing data for that quarter.</p> <p>On 11/20/24 at 1:50 p.m., the administrator stated they were the person who put in the data for the third quarter. They stated they had not followed up to ensure the data have been uploaded to CMS. They stated the person who usually uploaded the data had been out ill and they had put in the data remotely. They stated the business office manager would put in the data in the future.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42171</p> <p>Based on observation and interview, the facility failed to implement a policy related to enhanced barrier precautions to prevent the spread of MDROs in the facility.</p> <p>The ADON reported 34 residents resided in the facility.</p> <p>Findings:</p> <p>A facility Enhanced Barrier Precautions policy, revised 07/21/22, read in part, The expanded use of PPE . 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 from resident/client to resident/client during high-contact activities Use Enhanced Barrier Precautions when providing care to any resident/client with an indwelling medical device or colonized infection with an MDRO.</p> <p>On 11/18/24 at 8:30 a.m., a tour of the facility was conducted. No signage was noted on resident doors indicating EBP was implemented for at risk residents.</p> <p>On 11/21/24 at 12:35 p.m., CMA #1 stated to their knowledge enhanced barrier precautions were not in place in the facility.</p> <p>On 11/21/24 at 12:49 p.m., CNA #1 stated they were unaware what EBP was or how they were supposed to be used.</p> <p>On 11/21/24 at 1:15 p.m., the ADON stated they were still in the process of implementing EBP and they were not consistently using EBP in the facility.</p>