

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2024
NAME OF PROVIDER OR SUPPLIER  Glenhaven Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE  3003 Iowa Chickasha, OK 73023	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46387</p> <p>On 10/07/24 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure staff followed proper procedure for the use of a mechanical lift to prevent accidents. The failure resulted in a fractured hip for Res #1.</p> <p>An undated facility Hydraulic Lift policy documented to check to be sure hooks are secure.</p> <p>A care plan intervention, dated 11/03/23, documented Res #1 required two staff assistance with a Hoyer (full body mechanical lift) for transfers.</p> <p>On 09/08/24, Res #1 had a fall due to the strap on the transfer sling failing to remain attached to the Hoyer lift. The resident was sent to the hospital and diagnosed with a closed hip fracture.</p> <p>Staff were in-serviced on 09/08/24 regarding lift safety and operation, but no ongoing monitoring was completed to ensure staff compliance with safe utilization of mechanical lifts.</p> <p>During interviews with staff conducted on 10/07/24, the staff stated lift sling straps were to be checked to ensure placement prior to lifting a resident.</p> <p>On 10/07/24 an observation was made of Res #3 being transferred from the wheelchair to the bed. The middle strap on the left side of the resident did not remain secured to the hook on the lift. A loud pop was heard, and the middle strap could be seen hanging below the resident.</p> <p>On 10/07/24 at 2:10 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.</p> <p>On 10/07/24 at 2:21 p.m., the administrator was notified of the IJ situation.</p> <p>On 10/07/24 at 5:40 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented:</p> <p>[Name withheld]</p> <p>CC2606</p> <p>(continued on next page)</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>PTAN 375359</p> <p>NPI 1740313048</p> <p>On October 7, 2024, we immediately inserviced nursing staff that was present on 7-3 and 3-11 shifts with demonstration and return demonstration of newly rented lift, with option to buy.</p> <p>New lift arrived by 3:30 pm by local DME company.</p> <p>All other nursing staff are projected to be inserviced by 9 am on October 8, 2024. If staff is not inserviced they cannot clock in to work until they have been inserviced.</p> <p>Root cause analysis is unknown. Therefore, it was agreed that due to age of current Hoyer lift and recent events a new lift would be obtained and all nursing staff inserviced on the proper use of lift and slings to ensure safety.</p> <p>The IJ was lifted, effective 10/08/24 at 9:00 a.m., when all components of the plan of removal had been completed. The deficient practice remained at an isolated with a potential for harm.</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff followed proper procedure for the use of a Hoyer (full body mechanical lift) to prevent accidents for two (#1 and #3) of three sampled residents reviewed for mechanical lift safety. The failure resulted in a fractured hip for Res #1.</p> <p>The DON identified 52 residents resided in the facility. Eight residents required use of a mechanical lift for transfers.</p> <p>Findings:</p> <p>An undated facility Hydraulic Lift policy, read in part, Attach S hooks of the chain to the loops on the seat hanger. BE SURE TO INSERT THE OPEN END OF THE HOOKS AWAY FROM RESIDENT TO THE OUTSIDE OF THE SLING FOR SAFETY .Attach S hooks of the back rest if seat has a back rest. NOTE: AT THIS POINT, CHECK TO BE SURE THAT ALL HOOKS ARE SECURE AND EVENLY PLACED SO RESIDENT IS BALANCED.</p> <p>1. Res #1 had diagnoses which included muscle weakness and history of stroke.</p> <p>A care plan intervention, dated 11/03/23, documented Res #1 required two staff assistance with a Hoyer for transfers.</p> <p>A progress note, dated 09/08/24 at 6:21 p.m., documented Res #1 had fallen out of the lift sling. It read in part, Upon further investigation it is apparent that one of the hooks on the sling was not seated properly, therefore allowing that side to slip off when maneuvering the resident from above the bed to above the wheelchair, and ultimately causing the resident to fall out of the sling. Res #1 was sent to the hospital for evaluation due to complaints of pain to their hip.</p> <p>A hospital record dated 09/08/24, documented Res #1 sustained a closed fracture of the left hip.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An annual MDS, dated [DATE], documented Res #1 was totally dependent on staff for transfers and severely cognitively impaired.</p> <p>On 10/07/24 at 11:32 a.m., Res #1 was observed resting in their bed. The resident was unable to participate in an interview. Their representative did not return contact attempts for interview.</p> <p>On 10/07/24 at 12:05 p.m., RN #1 stated the DON had completed an inservice with the staff to address Res #1's fall.</p> <p>On 10/07/24 at 12:13 p.m., the DON stated there was no documented monitoring for effectiveness of training or ongoing compliance regarding lift safety.</p> <p>2. Res #3 had diagnoses which included dementia, weakness, and cognitive deficits.</p> <p>A car plan intervention, dated 01/09/23, documented Res #3 required two people assist with transfers using a Hoyer lift.</p> <p>A quarterly MDS, dated [DATE], documented Res #3 was severely cognitively impaired and was totally dependent on staff for transfers.</p> <p>On 10/07/24 at 11:27 a.m., CNA #3 stated straps on lift slings were to be double checked to ensure the strap was on the hook prior to transferring the resident.</p> <p>On 10/07/24 at 11:35 a.m., CNA #1 stated staff were to ensure the sling was properly secured on the lift prior to a transfer.</p> <p>On 10/07/24 at 12:08 p.m., Res #3 was observed being assisted from the wheelchair to the bed using a Hoyer lift. The lift was operated by CNA #1 and CNA #2. The CNAs were observed placing three straps on each side of the resident onto the hooks of the lift. When the resident's body was approximately six inches in the air above the wheelchair a loud pop was heard. The middle strap on the left side of Res #3 was observed hanging below them and no longer was attached to the lift. CNA #2 was heard stating, You're ok, it sounds scarier than it is. The CNAs continued to transfer the resident from the wheelchair to the bed using the lift with one of the sling straps not attached. While lowering the resident onto the bed CNA #2 was heard stating this came off, that's my fault.</p> <p>On 10/07/24 at 12:17 p.m., CNA #2 stated they were unsure how the strap to the sling came off of the lift.</p>