STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375360	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Nursing Center	1100 Oak Ridge Drive Durant, OK 74701

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48344 Based on observation, record review, and interview, the facilty failed to ensure residents were assisted with eating in a dignified manner for one (#4) of four sampled residents observed during meal service. The administrator identified 65 residents in the facility. Findings: The Accommodation of Needs policy, revised 01/2020, read in part, Our facility's environment and staff behaviors are directed toward assisting the resident in maintain and/or achieving safe independent functioning, dignity and well-being. Resident #4 had diagnoses which included muscle weakness and history of falling. Resident #4's quarterly resident assessment, dated 11/30/24, documented Resident #4 had severe cognitive impairment and required staff assistance with ADLs. On 01/23/25 at 8:26 a.m., CNA #2 offered Resident #4 breakfast. CNA #2 set up the breakfast and elevated the resident's head of the bed. They stated the resident was able to feed themselves. On 01/23/25 at 8:35 a.m., CNA #2 and LPN #3 were standing over Resident #4. LPN #3 told CNA #2 they would assist the resident with feeding. LPN #3 put a bite of scrambled eggs in Resident #4's mouth while standing by the foot of bed. On 01/23/25 at 8:39 a.m., LPN #3 continued to feed Resident #4 while standing by the foot of bed. On 01/23/25 at 8:55 a.m., LPN #3 fed Resident #4 cereal while standing by the foot of bed. On 01/23/25 at 9:04 a.m., LPN #3 asked Resident #4 if they would like to lay down. They wiped the resident's face, adjusted the resident in bed, and put their bedside table within reach. On 01/23/25 at 3:02 p.m., LPN #3 stated there was no chair in the resident's room to sit next to the resident and assist them with feeding. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/25 at 3:04 p.m., LPN #3 stated they were standing while feeding Resident #4.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48344 Based on observation, record review, and interview, the facility failed to ensure a call light was within reach of a resident for one (#4) of 24 sampled residents observed for call lights in reach. The administrator identified 65 residents resided in the facility. Findings: Resident #4 had diagnoses which included muscle weakness and history of falling. Resident #4's quarterly resident assessment, dated 11/30/24, documented Resident #4 had severe cognitive impairment and required staff assistance with ADLs. Resident #4's care plan for falls, dated 11/01/24, documented to keep call light within the resident's reach. On 01/23/25 at 8:21 a.m., Resident #4 stated their call light was somewhere as they looked towards the foot of the bed. They stated they sometimes they screamed for help if the call light was not in reach. Resident #4's call light was observed out of reach by the foot of the bed. On 01/23/25 at 8:26 a.m., CNA #1 came in to offer Resident #4 breakfast and assisted with set up. On 01/23/25 at 8:34 a.m., LPN #3 came into the resident's room. They assisted the resident with feeding. CNA #1 left the resident's room. On 01/23/25 at 9:04 a.m., LPN #2 wiped the resident's face, adjusted the resident in bed, and put the bedside table within reach. On 01/23/25 at 9:10 a.m., LPN #2 left the resident's room and turned of the lights. Resident #4's call light was out of the reach. LPN #2 stated they were done with the task in Resident #4's room. On 01/23/25 at 9:11 a.m., LPN #2 stated the process for call light was to keep them within reach of the resident either in bed or chair. They stated Resident #4 could use their call light and liked to hold their call light across their chest. They stated the resident sometimes yelled out for help. On 01/23/25 at 9:12 a.m., LPN #2 retrieved the resident's call light and handed it to the resident. On 01/23/25 at 9:13 a.m., LPN #2 stated Resident #4's call light was not in reach.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 45583 Based on observation, record review, and interview, the facility failed to ensure: a. privacy was provided during care for one (#31) of four sampled residents reviewed for privacy; and b. protected health information was secured for three (#10, 170, and #173) of four sampled residents observed during medication pass. The administrator identified 65 residents resided in the facility. Findings: The Confidentiality of Information and Personal Privacy policy, revised 10/2017, read in part, Our facility will protect and safeguard resident confidentiality and personal privacy. 1. Resident #31 had diagnoses which included dementia and generalized edema. A quarterly assessment, dated 11/09/24, documented the resident had moderately impaired cognition. On 01/23/25 at 8:23 a.m., CNA #3 and CMA #2 were observed to pull Resident #31 up in the bed. The privacy curtain was not pulled. On 01/23/25 at 8:58 a.m., LPN #3 asked Resident #31 when their last Poop was while they were standing at the bedside of Resident #4. On 01/23/25 at 8:59 a.m., LPN #3 asked Resident #31 if they could listen to their tummy and see if there were any bowel sounds. The privacy curtain was not pulled and the door was wide open with the resident's abdomen exposed. On 01/23/25 at 9:03 a.m., LPN #3 told Resident #31 they would fix them a brown cow. The privacy curtain was not pulled and the door was open. Resident #4 was in the room. On 01/23/25 at 2:57 p.m., LPN #3 stated to ensure privacy during resident care or assessments they would knock on the door and pull the curtain between them if there were two in the room to ensure privacy between the patients. They stated the door needed to be shut so other people could not hear what you were talking about or see anything. LPN #3 stated they should have pulled the curtain between the resident. LPN #3 stated they did not pull the curtain when they did the assessment on their belly. They also stated they did not remember if the door was open or shut at the time. On 01/23/25 at 2:59 p.m., LPN #3 was asked if confidential information regarding a resident's assessment be obtained while taking care of another resident. They stated if they were standing by another resident they should have left their bedside, pulled the curtain, and then should have gone to the other resident to be able to see what was going on and do the assessment. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/23/25 at 3:01 p.m., CMA #2 stated to ensure privacy during resident care they were to make sure the door was shut and there was not another resident. They stated they pulled the curtain. They stated the curtain should only be pulled when you are discussing private information or giving care like when you are dressing the resident. On 01/23/25 at 3:12 p.m., the DON stated staff needed to shut the door and pull the curtain for privacy during care. They stated the curtain should be pulled between residents when receiving incontinent care, toileting, an if there was a bed side commode. The DON further stated they should pull the curtain if there was a resident assessment being done and they should utilize the curtain if the resident was a two person assist and being pulled up in the bed. The DON was asked should confidential information regarding a resident's assessment be obtained from a resident while taking care of another resident. They stated as long as the curtain was pulled. I am not sure. On 01/24/25 at 8:06 a.m., LPN #1 was observed to prepare medication for Resident #10. On 01/24/25 8:29 a.m., LPN #1 left their computer screen on and entered Resident #10's room to administer their medication. The screen had Resident #10's medication profile visible. There were two staff members observed at the nurse's station. On 01/24/25 at 8:43 a.m., LPN #1 was observed to prepare medication for Resident #173. On 01/24/25 at 8:54 a.m., LPN #1 left their computer screen on and entered Resident #173's room to administer their medication. The screen had Resident #173's medication profile visible. A staff member was observed at the nurse's station and an unknown resident by the nurse's station. On 01/24/25 at 9:02 a.m., LPN #1 was observed to prepare medication for Resident #170. On 01/24/25 at 9:07 a.m., LPN #1 left their computer screen on and entered Resident #170's room to administer their medication. The screen had Resident #170's medication profile visible. On 01/24/25 at 9:14 a.m., LPN #1 stated they did not lock their screen during medication pass observation and should have. 48344 51977

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34460 Based on record review and interview, the facility failed to ensure restorative therapy was provided to residents with limited ROM for two (#33 and #51) of two sampled residents reviewed for restorative services. The regional survey consultant identified 27 residents who received restorative therapy resided in the facility. Findings: The Restorative Nursing Services policy, revised 07/2017, read in part, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. 1. Resident #33 had diagnoses which included congestive heart failure, Parkinson's, COPD, and atrial fibrillation. The MDS, dated [DATE], documented Resident #33 needed substantial/maximum assistance from staff. On 01/28/25 at 11:01 a.m., two staff provided resident care. They used a sling and Hoyer lift and transferred the resident from the bed to the shower chair for bathing. On 01/28/25 at 2:15 p.m., the DON stated the resident had three restorative care orders for bed mobility, ROM, and ADLs. The physician order documented a start date of 11/29/24 two days a week on Tuesday and Thursday. On 01/28/25 at 2:20 p.m., the DON stated the CNAs probably did not chart it. There were eleven opportunities for restorative ROM missed from the order date 11/29/24 until 01/28/25 (12/03/24, 12/10/24, 12/12/24, 12/17/24, 12/19/24, 12/24/24, 12/26/24, 12/31/24, 01/02/25, 01/07/25 and 01/09/25). On 01/29/25 at 8:35 a.m., CMA #1 demonstrated using matrix care how staff would know restorative care was ordered and the different restorative care to provide and document. CMA #1 stated documentation was important because it helped residents with their contractures or flaccid limbs because they did not want them to get worse. 2. Resident #51 had diagnoses which included chronic obstructive pulmonary disease and heart failure. Resident #51's quarterly resident assessment, dated 11/15/24, documented Resident #51 had moderate cognitive impairment and was dependent on staff assistance for ADLs. It documented the resident had an impairment on one upper extremity. A physician's order, dated 12/06/23, documented refer to restorative nursing program to address ROM: AAROM exercises to BUEs; AROM/stretching to BLEs with focus on knees (abduction, adduction, flexion and extension) x 15 minutes, once a day on Monday and Wednesday. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/22/25 at 10:29 a.m., Resident #51 stated they should be getting restorative therapy. They stated they got it two to three times and the person quit. The November 2024 POC History Report documented Resident #51 received restorative therapy on 11/06/24. There was no documentation for Resident #51's December 2024 restorative therapy. The January 2025 POC History Report documented Resident #51 received restorative therapy on 01/22/25. On 01/28/25 11:35 a.m., the DON provided restorative therapy documentation for Resident #51. They stated that was all they had. On 01/28/25 at 1:31 p.m., LPN #2 stated the nurses were responsible for restorative therapy. They stated it included ROM, grip strength, and getting the residents out of bed. On 01/28/25 at 1:35 p.m., LPN #2 stated if a resident refused restorative therapy, they would document the refusal in a progress note. They stated Resident #51 had refused restorative therapy. On 01/28/25 at 1:43 p.m., LPN #2 reviewed Resident #51's EHR record. They stated they could not locate documentation the resident refused on scheduled days for the months of November 2024, December 2024, and January 2025. On 01/28/25 at 1:59 p.m., the DON stated all refusals were to be documented in the EHR. 48344

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 48344 Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than five percent during the medication pass observation. The medication error rate was 15.38%. The administrator identified 65 residents resided in the facility. Findings: The Medication Administration policy, dated 06/21/17, read in part, Medications will be administered by legally-authorized and trained persons in accordance to applicable State, Local and Federal laws and consistent with accepted standards of practice. 1. Resident #10 had diagnoses which included chronic obstructive pulmonary disease with acute exacerbation. A physician's order, with a start date of 01/22/25, documented prednisone (a corticosteriod) 5 mg one tablet oral daily times three days for chronic obstructive pulmonary disease. It documented an end date of 01/24/25. A physician's order, with a start date of 01/24/25, documented azithromycin (an antibiotic) 500 mg one tablet oral once a day for chronic obstructive pulmonary disease with acute exacerbation. It documented an end date of 01/24/25. On 01/24/25 at 8:06 a.m., LPN #1 was observed to prepare medication for Resident #10. They were observed to prepare and administer azithromycin 250 mg one tablet by mouth to the resident. On 01/24/25 at 8:17 a.m., LPN #1 stated they could not locate the resident's prednisone 5 mg. They stated they would document not available and informed the charge nurse. On 01/24/25 at 8:25 a.m., LPN #2 stated today was the last day for the prednisone. On 01/24/25 at 8:53 a.m., LPN #2 stated they could not locate the prednisone and there was none in the emergency kit. They stated they would have the medication sent to the local pharmacy. On 01/28/25 at 2:31 p.m., the DON provided a progress note by LPN #1. It documented Resident #10's prednisone was administered at 3:00 p.m. on 01/24/25. 2. Resident #173 had diagnoses which included essential hypertension A physician's order, with a start date of 01/23/25, documented aspirin (NSAID) 81 mg one tablet oral delayed released once a day for essential hypertension. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/24/25 at 8:43 a.m., LPN #1 was observed to prepare medication for Resident #173. They stated they would find out if they could administer the house stock aspirin 325 mg. They had instructed CMA #1 to find out if they could administer the aspirin 325 mg in place of the 81 mg. The nurse had set the bottle aside. On 01/24/25 at 9:01 a.m., after Resident #173's medications were administered, LPN #1 was asked what they would do about the aspirin. They stated they had already administered the aspirin 325 mg when CMA #1 researched and informed them aspirin 81 mg and aspirin 325 mg were the same. 3. Resident #170 had diagnoses which included long term current use of antithrombotic/antiplatelets. A physician's order, with a start date of 01/22/25, documented aspirin 81 mg chewable one tablet oral once a day. On 01/24/25 at 9:02 a.m., LPN #1 was observed to prepare medication for Resident #170. They were observed to prepare and administer aspirin 325 mg one tablet by mouth. On 01/28/25 at 9:23 a.m., the DON stated they had 81 mg and 325 mg house stock aspirin. They stated if a resident had an order for aspirin 81 mg, they expected the staff to administer the 81 mg. They stated an aspirin dose of 325 mg was different from 81 mg.

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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. 45583 Based on observation, record review, and interview, the facility failed to ensure: a. the required PPE was worn when providing care to a resident on transmission based precautions for one (#46) of four sampled residents who were reviewed for transmission based precautions; and b. infection control practices were maintained during medication administration observation. The administrator identified 65 residents resided in the facility. The infection preventionist identified 19 residents were on transmission based precautions. Findings: The Facility COVID-19 Plan, dated 05/16/23. read in part, The objective of this plan is to mobilize the facility's resources to prevent the acquisition, spread, and transmission of COVID-19 (formerly Novel Coronavirus) infection, caused by SARS-CoV-2 virus, within the facility and safely care for residents who may be infection while protecting the safety of other residents and staff. The policy also read, All team members will receive education on identification, prevention, transmission .Direct care providers will receive additional education to include but not limited to identification of residents/staff ill with acute respiratory symptoms and fever, prevention, transmission, and Personal Protective Equipment (PPE). 1. Resident #46 had diagnoses of COVID-19. A physician's order, dated 01/17/25, documented droplet precautions every shift. A progress note, dated 01/17/25 at 1:51 p.m., read in part, Resident tested positive for Covid during routine testing-Dr [name withheld] notified and standing Covid orders implemented. -MARS updated. On 01/24/25 at 9:14 a.m., transport #1 was observed to go into Resident #46's room while stating to another staff member they were working with Resident #46. Transport #1 did not have on any PPE except a mask. The sign on the door read droplet precautions. On 01/24/24 at 9:17 a.m., transport #1 was observed exiting Resident #46's room. They were asked what the precaution was for Resident #46's room. They stated it was for when doing personal care. Transport #1 was asked if droplet precautions were for the COVID residents. They then stated after confirming with the nurse next to them, they stated,Yes. They stated droplet precautions required a mask, goggles, and gown. They stated they did not have on a gown when they went back into the COVID resident's room. On 01/24/25 at 9:45 a.m, the administrator was asked if they were aware of the COVID isolation room breech concern that occurred while they were down the same hall. They stated they were aware. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 01/24/25 at 8:10 a.m. LPN #1 was observed to touch a trash can bag to adjust it. They did not use ABHR (alcohol based hand rub) prior to proceeding with med pass. The only thing in the trash bag were white gloves. LPN #1 did not have gloves on. On 01/24/25 at 9:13 a.m., LPN #1 stated they needed to look up what the policy and procedure was for infection control during med pass. LPN #1 stated infection control was not maintained when they adjusted the trash bag. 48344