STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375362	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shanoan Springs Nursing and Rehabilitation	2500 South 12th Street Chickasha, OK 73018

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34945 Based on observation, record review, and interview, the facility failed to ensure residents were free from abuse and neglect for two (#35 and #40) of three residents sampled for abuse. a. On 10/19/23, an initial Incident Report documented CNA #1 did place their hand over the mouth and nose of the Res #35 on 3 different occasions during a shower. It was also reported that CNA #1 told the resident to shut up. All those involved were suspended until the investigation was complete. CNA #1 was separated from employment immediately and CNA #2 was educated one-on-one related to reporting abuse immediately. On 10/24/23 an in-service and training was initiated by management to all staff members at the facility on abuse, neglect, dementia, reporting abuse, rights of residents, and bathing residents. On 10/26/23 management completed the in-service and training for all staff members at the facility. The facility was in past non compliance after completing a QAPI meeting, dated 03/20/24, which discussed the outcome of the State Reportable Incident(s) interventions. b. On 02/11/24 at 11:15 a.m., the administrator was notified by RN #3 that Res #40 had squirted Purell Surface Disinfectant cleaner into their mouth when the cleaner was not in direct control of dietary #4 aide who was to have been using the product. The dietary aide was reported to the Nontechnical Service Worker registry and suspended during the investigation. Immediate measures were instituted and the staff were in-serviced on chemical storage. Monitoring of chemical storage was conducted and documented for 30 days. A QAPI meeting, dated 03/20/24, discussed the outcome of the State Reportable Incident(s) interventions. The facility was in past non compliance after completing the final measure to correct the deficiency on 02/21/24. The administrator reported seven incidents of abuse or neglect had occurred in the previous six months. Findings: 1. Res #40 had diagnoses which included dementia, Alzheimer's disease, and unspecified symbolic dysfunction. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A significant change assessment, dated 01/05/24, documented the resident was severely impaired in cognition and required supervision or touch assistance with eating and had no restrictions in range of motion of their extremities. A care plan, dated 01/07/24, documented the resident had poor impulse control and to provide interventions to mitigate their behaviors such as anticipate their possible needs for food and thirst. A nurse note, dated 02/11/2024 at 11:06 a.m., documented that another resident reported that Res #4 was spraying the Purell surface disinfectant into their mouth in the dining room. The note documented RN #3 Res #3 was in their wheelchair sitting near the kitchen cleaning cart and dietary aide #4 was removing the bottle from the resident's hands. The note documented dietary aide #4 stated that although they had not seen the resident squirting the disinfectant into their mouth, they had the bottle pointed facing them with their hands on the trigger of the spray bottle. The note documented the resident was assessed and Poison Control was contacted and interventions were put in place recommended by them. The note documented the on call provider, the DON, and Res #40's family were also contacted. A care plan update, dated 02/23/24, documented the resident was at risk for injury related to cognitive deficit. The care plan documented to monitor the residents whereabouts and to keep all chemicals or any products that have warning labels documenting ingestion could cause harm stored behind locked doors in the departments in which they were to be used. An Incident Report Form, dated 02/11/24, included documentation of an in-service for staff to keep all chemicals which could cause harm to residents behind locked doors. The in-service form documented residents were not to have access to these storage areas at any time. Monitoring forms, dated 02/11/24 through 03/12/24, to ensure no chemicals were in a place residents could access them were provided for review. A form titled Shanoan Springs Monthly QA Minutes, dated 03/20/24, documented under number 10., Reportables reviewed to ensure investigations completed immediately, intervention implemented, and reporting timely to proper agencies. On 04/15/24 at 11:48 a.m., Res #40 was observed sitting in the dining room at a table with another resident. Res #40 was unable to be interviewed. On 04/16/24 at 12:57 p.m., the DON stated the facility did audits after the incident to ensure all chemicals were not left out. The DON stated they also included this incident and the results of the monitoring at the next QA committee meeting. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/24 at 8:52 a.m., the DM reported the product Res #40 had squirted into their mouth was Purell Professional Surface Disinfectant. At that time a bottle of the product was retrieved by the DM from the kitchen area where they stated it was locked up. The DM stated the product was used to sanitize hard surfaces in the dining room tables after meal service. The DM stated on the day of the incident, the product had been left unattended on the cart in the dining room. They stated when the dishwasher looked out of the kitchen pass and into the dining room they witnessed the resident squirting the product into their mouth. The DM stated the dishwasher came out of the kitchen, removed the product from Res #40's hands, and took them to the nurse and reported what had happened. The DM stated the product is stored in a locked cabinet in the kitchen when not in use. On 04/17/24 at 9:20 a.m., the administrator was asked why this incident had been identified as neglect. The administrator stated the incident occurred due to a staff member left the sanitizer unattended in the dining room when they knew or should have known it was on the cart and there were residents in the area. 46909 2. Res #35 had diagnoses which included dementia with behavioral disturbance, epilepsy unspecified, and anxiety disorders. A quarterly MDS assessment, dated 08/09/23, documented the resident was cognitively impaired, required extensive assistance with all ADLs. On 10/19/23, an initial incident report documented that CNA #1 and CNA #2 were showering Res #35 with the assistance of hospitality aide. The hospitality aide reported CNA #1 placed their hand over the mouth and nose of Res #35 on three different occasions during the shower. It was also reported that CNA #1 told the resident to shut up. The incident report documented CMA #1 heard Res #35 screaming in the shower room. The incident report documented all those involved were suspended until the investigation was complete. On 10/23/23 a final incident report documented the investigation had been completed and CNA #1 was separated from employment immediately and CNA #2 was educated one-on-one related to reporting abuse immediately. On 10/24/23 an in-service and training was initiated by management to all staff members at the facility on abuse, neglect, dementia, reporting abuse, rights of residents, and bathing residents. On 10/26/23 management completed the in-service and training for all staff members at the facility. On 04/15/24 at 09:27 a.m., the DON stated the facility had immediately reported the incident to the OSDH on 10/19/23 and started an initial investigation. They stated a thorough investigation on the incident was conducted and completed the investigation on 10/23/24. The DON stated all entities of authority were contacted as well as the family members of the resident. They stated all staff members were provided policy and procedure on abuse and neglect and everything was faxed to OSDH. The DON stated the all staff members involved in the abuse were terminated after the investigation was completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34945 Based on record review and interview, the facility failed to ensure residents who were unable to carry out activities of daily living received the services to maintain grooming and personal hygiene. The Long-Term Care Facility Application for Medicare and Medicaid form documented 50 residents resided in the facility. Findings: Res #102 was admitted on [DATE] and had diagnoses which included laceration without foreign body of right eyelid and periocular area, need for assistance with personal care, and intellectual disabilities. A care plan, dated 02/06/24, documented the resident required extensive assistance of one staff member with showering or bathing. A medicare five day assessment, dated 02/08/24, documented the resident required substantial to maximal assistance with bathing. The resident was discharged on [DATE]. On 04/17/24 at 1:33 p.m., the ADON brought bathing sheets and after review confirmed that documentation verified the resident was showered twice while a resident, on 02/09/24 and 02/10/24 out of four opportunities for a shower. The DON stated the resident was scheduled to be showered on the 7 p.m. to 7 a.m. shower schedule. The ADON stated if the resident refused or the staff were unable to shower the resident they should have informed the nursing staff. The ADON stated per the documentation the resident had not received their showers as scheduled.

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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. 38495 Based on observation, record review, and interview, the facility failed to ensure: a. wound care was provided in a sanitary manner for one (#20) of four residents observed for wound care, b. residents' catheters were not dragging on the floor for two (#8 and #26) of four sampled resident who had catheters, and c. a water management program was implemented to prevent the growth of Legionella and other opportunistic waterborne pathogens in the buildings water system. The facility identified a census of 50 residents who resided in the facility. Findings: 1. Res #8 had diagnoses which included diabetes mellitus, personal history of urinary tract infections, and neuromuscular dysfunction of the bladder. A care plan, last revised 10/18/23 documented the resident has a suprapubic catheter for neurogenic bladder. The care plan documented to keep the catheter bag below the bladder level and monitor for sign and symptoms of UTI. The care plan documented the resident was on enhanced precautions required due to Res #8 was at an increased risk for infection and MDRO related to indwelling medical device. A quarterly assessment, dated 03/27/24, documented the resident had a indwelling catheter. On 04/15/24 at 11:07 a.m., observed Res #8's catheter under the wheelchair in a bag but the catheter tubing was on the floor. On 04/15/24 at 2:39 p.m., Res #8 was observed in a chair in their room. The catheter tubing was on floor and the bag was hung on on plastic three drawer storage unit. On 04/15/24 at 2:50 p.m., Res #8 stated they had the catheter since 2012 because they could not empty their bladder. Res #8 stated they did not realize the tubing was on the floor. On 04/16/24 at 3:00 p.m., the resident was observed in the dining room with the catheter tubing dragging the floor. On 04/16/24 at 3:45 p.m., Res #8 was observed with staff member assisting them to their room and the catheter tubing was dragging on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/24 at 2:03 p.m., CNA #3 stated the catheter bag should be covered and placed under the residents wheelchair. CNA #3 stated they would make sure the catheter was not leaking and not crimped. They stated they tried to make sure the tubing was not dragging on the floor. CNA #3 stated the catheter tubing on the floor was an infection control issue. On 04/17/24 at 2:20 p.m., the IP stated the catheter tubing absolutely should not have been dragging on the floor. 2. Res #26 had diagnoses which included neuromuscular dysfunction of bladder and cystostomy status. A quarterly assessment, dated 04/01/24, documented the resident had a catheter. On 04/15/24 at 11:21 a.m., an observation was made of the resident in the dining area with the catheter tubing dragging on the floor. On 04/17/24 at 12:06 p.m., an observation was made of the resident in the dining area with catheter tubing touching the sole of the resident's tennis shoe and then dragging the floor. On 04/17/24 at 2:21 p.m., the IP stated the catheter should not have been dragging on the floor at any time. 3. A facility policy, dated April 2013, titled Dressings, dry/clean read in part, .Personal protective equipment (e.g., gowns, gloves, mask, ect,, as needed) .clean bedside stand. Establish a clean field .wash and dry hands thoroughly . Res #20 had diagnoses which included pressure ulcer of right heel stage 3, PVD, non-pressure chronic ulcer to right thigh, lymphedema, and non-pressure chronic ulcer of the other part of left lower leg with unspecified severity. A care plan, revised 03/09/24 documented the resident had actual impairment to their right lateral thigh, bilateral buttocks, left heel, left great toe, left shin, right lateral foot, and scabs to left toes/foot/shin. A quarterly assessment, dated 03/24/24, documented the resident had two unhealed stage three pressure ulcers. On 04/15/24 at 10:45 a.m., Res #20 stated they had wounds to their left shin, lipedema that developed into a sore, and a right thigh pressure ulcer. Res #20 stated it was on an old scar from road rash and the wound would come and go. Res #20 stated the facility provided daily wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/16/24 at 01:16 p.m., wound care was observed with LPN #1. LPN #1 used hand sanitizer, gathered supplies on a sheet of wax paper, sanitized hands and put on gloves. The LPN placed the wax paper on the resident's overbed table but had not cleaned the table first. The LPN removed the resident's nonskid sock from their right foot, cleaned the right foot, wrapped it with ace wrap, and placed the sock back on the resident's foot. The LPN moved to the left foot, removed the sock, cleaned the foot and shin, applied the dressings, wrapped the area with Kerlix and ace wrap, and replaced the sock back on the resident foot. The nurse then applied Triad cream to the resident's right thigh area. LPN #1 then removed their gloves and disposed of the supplies and gloves. The LPN did not change gloves, or perform hand hygiene, during the entire wound care observation. On 04/16/24 at 1:33 p.m., LPN #1 stated they forgot something. LPN #1 stated she did not gown up before wound care was performed as the resident was on EBP. LPN #1 was asked when should they do hand hygiene during wound care. LPN #1 stated before it was started and when they finished the wound care. On 04/16/24 at 3:38 p.m., the IP stated hand hygiene should have been performed before staff entered the room, after the field was set up, and before wound care was started. The IP stated glove changes and hand hygiene should have been performed between each wound. The IP stated the overbed table should have been cleaned before setting the wax paper on it. 34945 4. A facility policy titled Legionella Water Management Program, revised in September of 2022, read in part, . 2. The water management team consists of at least the following personnel a. The infection preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance; and e. the director of environmental services .5. The water management program included the following elements: a. An interdisciplinary water management team (see above); b. A detailed description and diagram of the water system in the facility, including the following: (1) Receiving (2) Cold water distribution; (3) Heating; (4) Hot water distribution; and (5) waste . The facility provided a book which was to document the water management program to review. The book documented the Legionella Water Management Program and documented a water sample was obtained from the facility in March of 2023 and the results. The rest of the book did not document any other aspects of the program had been instituted. On 04/18/24 at 1:33 p.m., the IP was asked about the Water Management Program. The IP stated they thought the facility was doing something about the water program but was not sure as they were not involved. The IP stated they thought it was the administrator and the maintenance man who took care of this program. On 04/18/24 at 1:59 p.m., the administrator stated all the staff members on the Legionella Water Management Program were on the team. They stated they had not had a meeting for more than a year. The administrator did not provide meeting minutes for the team meeting. The administrator stated they did not think they had obtained a diagram of the plumbing in the facility. They stated they would get with the maintenance man to have them answer questions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/24 at 2:11 p.m., the maintenance man stated the facility had not obtained any plumbing schematics but could contact a plumber to obtain them. The maintenance man stated they remembered the meeting and it consisted of themselves, the administrator, and several corporate people. There were no other staff in the meeting to their recollection. The maintenance man stated they had only one meeting to their recollection. They stated there were aerators in all the sinks and shower heads and they cleaned them monthly but they did not have documentation of these activities. The maintenance man stated they cleaned the ice machine monthly and did check the water temperatures on a regular basis. On 04/18/24 at 2:25 p.m., the administrator stated, based on these conversations, the water management program had not been fully put in action.