STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375366	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Nursing Center	1503 West Har-Ber Road Grove, OK 74344

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 34270 Based on record review and interview, the facility failed provide residents or their representatives a written notice of transfer or discharge prior to residents departing the facility for two (#28 and #49) of three sampled resident reviewed for transfer and discharges. A Long Term Care Facility Application for Medicare and Medicaid form, dated 07/14/24, documented 58 resident resided in the facility. Findings: A facility Transfer or Discharge Documentation policy, dated 12/2016, was reviewed. The policy did not contain a requirement to provide a written notice of transfer or discharge to a resident or their legal representative prior to the resident departing the facility. A review of the facility's Transfer or Discharge Documentation policy found the document did not include instructions to provide written notices of transfer or discharge to residents or their representatives prior to facility initiated transfers and discharges. 1. Resident #28 had diagnoses which included diabetes mellitus. A progress note, dated 06/04/24 at 5:36 p.m., documented the resident was transferred by facility staff to a community emergency room following a fall. 2. Resident #49 had diagnoses which included diabetes mellitus. A progress note, dated 03/22/24 at 10:25 a.m., documented the resident was transferred to an acute care hospital by facility staff for behaviors. On 07/16/25 at 1:15 p.m., the DON stated the residents were not given written notices of tranfers before being sent to other facilities for treatment.

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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NAME OF PROVIDER OR SUPPLIER Grove Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1503 West Har-Ber Road Grove, OK 74344	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42171 Based on record review and interview, the facility failed to implement a comprehensive care plan for one (#53) of five sampled residents reviewed for unnecessary medications. The Don reported the census was 57. Findings: Resident #53 had diagnoses which included paroxysmal atrial fibrillation and hypertension. A physician order, dated 04/16/24, documented the resident was to receive 2.5 mg of apixaban (an anticoagulant) twice every day. An admission assessment, dated 04/23/24, documented Resident #53 had received an anticoagulant medication during the look back period. A review of Resident #53's care plan did not address the use of an anticoagulant. On 07/16/24 at 9:20 am, LPN #1 stated anticoagulants should be included in a resident's care plan. At 9:35 am, LPN #2 stated the use of anticoagulant should be included on the care plan and the resident should be observed for signs of bleeding and bruising. At 9:50 am, the DON stated the use of an anticoagulant should be addressed on the care plan.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 34270 Based on observation, record review, and interview, the facility failed to ensure: a. alternatives to the use of bed rails were attempted prior to the use of bed rails; b. bed rails were inspected for proper fit and condition prior to use of the bed rails; c. residents and their representatives were educated on the risks and benefits of bed rails prior to the use of bed rails; and d. informed consent from the resident or their legal representative was obtained prior to attaching a bed rails to the bed for three (#19, 28, and #49) of four sampled resident reviewed for accident hazards. The Administrator identified 25 resident that had bed rails attached to their beds. Findings: The facility's Proper Use of Side Rails policy, dated 12/2016, documented consent would be obtained from the resident or legal reprentative after being informed of the benefits and risks of the use of bed rails. It further documented that specific alternatives to bed rails would be care planned and gave a list of the six interventions that would be used. The facility's Bed Safety policy, dated 12/2007, documented the facility would ensure bed rails were properly installed according to the manufacturer's instructions and pertinent safety guidance to ensure they fid correctly. 1. Resident #19 had diagnoses which included Alzheimer's Disease and abnormalities of gait and resided on the 200 hall. 2. Resident #28 had diagnoses which included weakness and abnormalities of gait and resided on 200 hall. 3. Resident #111 had diagnoses which included anthropathy (a joint disease) and repeated falls and resided on 300 hall. On 07/14/24 at 11:27 a.m. Resident #11 was observed to have bed rails attached to their bed. On 07/15/24 at 8:57 a.m., Resident #19 was observed to have bed rails attached to their bed. At 9:02 a.m., Resident #28 was observed to have bed rails attached to their bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Residents #19, 28, and #111 did not find signed consents for the use of bed rails, documentation that bed inspections were conducted prior to the use of bed rails, or documentation that alternatives to the use of bed rails had been attempted prior to the use of bed rails. At 10:51 a.m., DON stated they had not attempted alternatives to the use of bed rails prior the use of the bed rails for any of the residents. They stated they had not obtained written consent from the residents or their representatives prior to the use of bed rails for any of the residents. At 11:11 a.m., the Maintenance Supervisor stated they inspect and repair resident beds if housekeeping or nursing staff find an issue. They stated otherwise the company that sold them the beds perform an annual inspection of each bed. They stated the beds and bed rails were not inspected prior to first use by residents. At 11:14 a.m., the Administrator stated the staff did not inspect bed rails to see if they were the proper type for each bed as they purchase all beds and accessories from the same retail company and they assumed they were compatible . They stated they had not inspected the beds and bed rails prior to use by the residents.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to ensure a resident being administered Furosemide (a diuretic medication) was monitored for electrolyte levels for one (#28) of five sampled resident reviewed for unnecessary medications. The DON stated 12 residents residing at the facilty had been prescribed diuretics. Findings: A review of Resident #28's medical records did not find the resident's electrolyte levels had been assessed or reviewed by a facility healthcare professional prior to or since admission to the facility. Further, no order for lab work to obtain those levels were found in the medical record. Resident #28 was admitted to the facility on [DATE] and readmitted on [DATE]. They had diagnoses which included chronic systolic congestive heart failure. An Admission Minimum Data Set assessment, dated 03/14/24, documented in Section N that the resident had been administered diuretic medication. A Quarterly Minimum Data Set assessment, dated 06/14/24, documented in Section N that the resident had been administered diuretic medication. A physician order dated, 07/05/24, documented Resident #28 had been ordered Furosemide (a diuretic medication) 20 mg once daily for congestive heart failure. On 07/16/24 at 9:50 a.m., DON stated they had reviewed the resident medical record and did not find documentation of electrolyte level having been ordered by a physician. They stated there was no documentation electrolyte levels had been assessed prior to or since admission. They stated the facility did not use routine orders for lab work but instead defer to the physicians to order labs as they see fit. They stated they did not find a facility policy regarding lab work when administering diuretic medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34270 Based on observation, record review, and interview the facility failed to ensure a CNA (certified nurse aide) changed gloves and cleaned their hand between dirty and clean surfaces for one (#19) of one resident reviewed for pressure ulcers. Findings: A facility Handwashing/Hand Hygiene policy, dated 09/2015, read in part The facility considers hand hygiene the primary means to prevent the spread of infections. On 07/15/24 at 1:41 p.m., LPN #3 and CNA #1 were observed providing wound care and perineal care to Resident #19. Prior to wound care the resident's disposable undergarment was found to be soiled and CNA #1 was observed to provide perineal care. CNA #1 was gloved when they began the care making contact with the soiled undergarment then cleaning the peri area without changing gloves or cleaning hands. Following perineal care CNA was observed placing their hands on the resident's skin, clothing, repeatedly without changes gloves or washing their hands. They were observed moving the resident's television remote control with the dirty gloves and placing it closer to the resident. At 2:15 p.m., following completion of wound care LPN #3 was asked how they felt the care had gone. They stated they believed it went well. They were asked how they felt CNA #1 had performed perineal care. They stated CNA had not changed their gloves during the care and that everything they had touched was considered dirty. At 2:40 p.m. CNA #1 stated they had been nervous and forgotten to change gloves and clean their hands after perineal care. On 07/16/24 at 11:59 a.m., DON stated CNA #1 should have changed gloves and cleaned their hands between steps of the perineal care and after it was over. They stated they give staff training on hand hygiene several times during the year. They stated CNA #1 had not followed facility policy.