

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/06/2024
NAME OF PROVIDER OR SUPPLIER  Perry Green Valley Nursing Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1103 Birch Street Perry, OK 73077	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35474</p> <p>Based on observation and interview, the facility failed to ensure chemicals were secured for three of five halls observed.</p> <p>The DON identified five halls in which residents resided.</p> <p>Findings:</p> <p>On 11/04/24 at 11:39 a.m., the utility room door on hall eight was observed to be unlocked. A bottle of bleach was observed in the unlocked utility room. LPN #4 stated the door was to be closed and locked due to chemicals.</p> <p>On 11/04/24 at 2:44 p.m., a can of disinfectant spray and a tube of Calmoseptine was observed to be unattended on hall seven by the shower room. The disinfectant spray label documented to store the product in an area inaccessible to small children. The Calmoseptine label was observed to document to keep out of reach of children. The door to the shower room was observed to be open. A four ounce bottle of derma daily moisturizing lotion and a box of 50 germicidal disposable wipes were observed to be unsecured and unattended. The labels on the bottle of lotion and the germicidal wipes documented to keep out of reach of children.</p> <p>On 11/04/24 at 2:51 p.m., LPN #3 stated they were supposed to keep the door to the shower room closed and locked and the cart with disinfectant spray was not to be unsecured.</p> <p>On 11/05/24 at 8:05 p.m., the shower room door on hall one was observed to be ajar, unattended, and the key in the door knob. The following items were observed to be unsecured and unattended in the shower room:</p> <ul style="list-style-type: none"> <li>a. one, four ounce bottle of ultra sure antiperspirant and deodorant. The label documented to keep out of reach of children;</li> <li>b. two, 11 ounce cans of shaving cream. The label documented to keep out of reach of children; and</li> <li>c. four, four ounce bottles of derma daily moisturizing lotion The label documented to keep out of reach of children.</li> </ul> <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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/05/24 at 8:08 p.m., the utility room on hall one was observed to be unlocked and unattended. Two, 3.78 liter bottles of bleach were observed unsecured in the utility room.</p> <p>On 11/05/24 at 8:21 p.m., LPN #1 walked by and closed the door. The key to the door was observed to remain in the door knob.</p> <p>On 11/05/24 at 8:28 p.m., LPN #2 stated the door to the utility room was to be kept closed and locked.</p> <p>On 11/05/24 at 8:34 p.m., the utility room on hall seven was observed to be unlocked. The following items were observed to be unsecured in the utility room:</p> <ul style="list-style-type: none"> <li>a. one gallon bottle of disinfectant cleaner; and</li> <li>b. one bottle of disinfectant with approximately half an inch of liquid.</li> </ul> <p>On 11/05/24 at 8:38 p.m., LPN #2 arrived to the utility closet and stated the utility closet was to be closed and locked.</p> <p>On 11/06/24 at 4:57 p.m., the DON stated utility rooms and shower rooms were to be locked to ensure chemicals were secured.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>35474</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were assessed for the use of bed rails prior to installation for four (#17, 30, 115, and #55) of four sampled residents who were reviewed for bed rails.</p> <p>The DON identified 24 residents who utilized bed rails.</p> <p>Findings:</p> <p>1. Resident #17 had diagnoses which included Parkinson's disease.</p> <p>A physician order, dated 11/02/23, documented half side rails bilaterally for bed mobility.</p> <p>The Care Plan, dated 10/03/24, read in part, 1/2 side rails bilat upper bed for self repositioning.</p> <p>On 11/04/24 at 11:35 a.m., Resident #17's bed was observed to contain half side rails bilaterally.</p> <p>Review of the electronic clinical record did not reveal a consent had been completed for the use of bed rails.</p> <p>2. Resident #30 had diagnoses which included muscle weakness.</p> <p>A physician order, dated 09/18/24, documented the resident may use half bed rails for position/mobility.</p> <p>Review of the care plan did not reveal the use of the bed rails.</p> <p>Review of the clinical record did not reveal a consent had been completed for the use of bed rails.</p> <p>On 11/04/24 at 11:31 a.m., Resident #30 was observed in bed with half side rails in the up position bilaterally.</p> <p>3. Resident #115 had diagnoses which included atrial fibrillation.</p> <p>The Baseline Care Plan, dated 10/28/24, did not document the use of half bed rails.</p> <p>Review of the electronic clinical record did not reveal a physician order or consent for the use of bed rails.</p> <p>On 11/04/24 at 1:12 p.m., Resident #115 was observed in bed with half side rails in the up position bilaterally.</p> <p>4. Resident #55 had diagnoses which included chronic kidney disease.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the care plan did not reveal the use of the bed rails.</p> <p>Review of the clinical record did not reveal a consent had been completed for the use of bed rails or a physician's order had been obtained.</p> <p>On 11/04/24 at 2:43 p.m., the resident's bed was observed to have bilateral half bed rails.</p> <p>On 11/06/24 at 11:37 a.m., the DON stated they obtained physician's orders for the use of bed rails, bed rails were applied to the bed, and residents were then assessed for the use of the bed rails. The DON stated they did not obtain consents for the use of bed rails because they were not used as a restraint. The DON stated orders for bed rails for Resident #115 and Resident #55 had not been obtained.</p> <p>41809</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were offered snacks for one (bedtime) of one snack time observed.</p> <p>The DON identified 63 residents who received nourishment from the kitchen.</p> <p>Findings:</p> <p>The undated Resident Meals/Snacks policy, read in part, Staff will pass out optional snacks to residents in-between meals. Residents may also request snacks or simple meals (soups, sandwich, etc.) after dining room hours.</p> <p>On 11/05/24 at 1:37 p.m., seven residents in the resident council meeting stated they were not offered bedtime snacks.</p> <p>On 11/05/24 at 8:04 p.m., the dietary staff were observed in the kitchen. A tour of the facility's nurses stations and resident rooms did not reveal snacks had yet been provided.</p> <p>On 11/05/24 at 8:13 p.m., cook #1 was observed to take a bowl with snacks in it to hall eight.</p> <p>On 11/05/24 at 8:39 p.m., Resident #18 requested a sandwich, chips, and a snack cake from a CNA. Resident #18 stated staff did not offer snacks, but they would ask for them for themselves and their roommate.</p> <p>On 11/05/24 at 8:43 p.m., CMA #1 stated they usually passed out snacks after evening medications were administered. CMA #1 was asked what snacks they had to offer to residents. They stated they had been provided five sandwiches, five bags of chips, and five snack cakes for hall eight.</p> <p>On 11/05/24 at 8:45 p.m., LPN #1 stated they had 24 residents on hall eight.</p> <p>On 11/05/24 at 8:47 p.m., Resident #9 was watching television in their room. They stated they were not offered snacks at bedtime and had not been offered a snack tonight.</p> <p>On 11/05/24 at 8:51 p.m., LPN #1 stated they no longer had access to the kitchen. They stated the other charge nurse may have a key.</p> <p>On 11/05/24 at 8:56 p.m., LPN #2 stated they did not have a key to access the kitchen.</p> <p>On 11/06/24 at 12:23 p.m., cook #1 stated they made approximately six sandwiches, six bags of chips, and six snack cakes for the overnight snacks. They stated they had thought the nurses could get into the kitchen for additional snacks if needed after the kitchen was closed.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/06/24 at 12:34 p.m., the dietary manager stated they provided hearty snacks at 8:00 p.m. They stated they had a snack list they followed. They stated they made six sandwiches, six bags of chips, and six cookies in case a resident wanted something overnight. The dietary manager stated if additional food was needed they kept bread and peanut butter in the pantry on the hall. They stated the nursing staff did not have access to the kitchen once it was closed.</p> <p>On 11/06/24 at 12:47 p.m., the DON stated the CMAs were responsible to pass out the snacks provided by the dietary department. The DON stated some residents have scheduled snacks and some residents requested snacks from the staff.</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure arbitration agreements documented a location agreed upon by both parties.</p> <p>The administrator identified 63 residents who had signed binding arbitration agreements.</p> <p>Findings:</p> <p>The Mediation and Arbitration Agreement, dated 02/05/1951, read in part, Such mediation will be held in Tulsa or Oklahoma County, Oklahoma in a place agreed to by the parties</p> <p>On 11/06/24 at 3:36 p.m., the administrator stated arbitration would take place in either Tulsa or Oklahoma county. The administrator stated if Tulsa or Oklahoma county was not agreed upon by both parties they thought they could change to another location. The administrator stated they did not know why the arbitration agreement did not indicate arbitration could occur in a location agreeable to both parties.</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>41809</p> <p>Based on observation, record review, and interview, the facility failed to:</p> <p>a. ensure control measures and testing protocols were in place for monitoring for the potential presence of water-borne pathogen such as Legionella; and</p> <p>b. follow the enhanced barrier precautions policy for a resident on precautions for one (#6) of 16 sampled residents reviewed for infection control.</p> <p>The administrator identified 63 residents resided in the facility.</p> <p>Findings:</p> <p>An Infection prevention and control program policy, revised July 2024, read in part, Water Management: a. Control measures and testing protocols are in place to address potential hazards associated with the facility's water system.</p> <p>An Enhanced Barrier Precautions policy, revised April 2024, read in part, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The policy also read, 'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The policy also read, All staff receive training on enhanced barrier precautions and high-risk activities upon hire and at least annually. The policy also read, Enhanced barrier precautions (EBP) are indicated for residents with any of the following: wounds .Indwelling medical devices . Infection or colonization.</p> <p>1. On 11/05/24 at 4:32 p.m., the DON stated they did not know what was in place for prevention of Legionella.</p> <p>On 11/05/24 at 4:40 p.m., the DON stated they spoke with maintenance and they did not know about Legionella.</p> <p>On 11/06/24 at 8:36 a.m., the maintenance director stated they did not check for waterborne pathogens or bacteria. They stated they were not aware of any water testing being done. They stated they did not monitor the water system. They stated the only thing they checked was the water temperature and they knew where the shut off valves were. They stated they did not have a map of the water system. They stated they did not know if any areas of stagnant water concern. They stated they know where to look for leaks based on the location of the valves.</p> <p>2. Resident #6 had a diagnosis of pressure ulcer stage 3 to left elbow.</p> <p>On 11/06/24 at 9:35 a.m., the wound care nurse was observed during provision of wound care to Resident #6's elbow. The nurse had a nursing student present to assist during the treatment. There was signage on the door for EBP.</p> <p>(continued on next page)</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>On 11/06/24 at 9:45 a.m., the wound care nurse was observed to remove the dressing from the residents elbow. They did not have on a gown.</p> <p>On 11/06/24 at 9:46 a.m., the wound care nurse put on the gown after removing the dressing. The nursing student was instructed to hold the resident's arm up while the wound care nurse performed the treatment. The nursing student was not observed to wear a gown.</p> <p>On 11/06/24 at 9:51 a.m., the wound care nurse stated gown and gloves were required for EBP. They stated the requirements for EBP were for anybody that would have close contact with the wound. They stated close contact meant dressing changes, clothing changes, or anything that could get drainage on them. They stated the nursing student did not have on the required PPE and should have since they held the resident's arm. The wound care nurse also stated they should have put on the gown before starting the treatment.</p> <p>45583</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>35474</p> <p>41809</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident beds were maintained and monitored for the use of bed rails for four (#17, 30, 115, and #55) of four sampled residents who were reviewed for bed rails.</p> <p>The DON identified 24 residents who utilized bed rails.</p> <p>Findings:</p> <p>The Bed Safety and Bed Rails policy, dated August 2022, read in part, Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks.</p> <p>1. Resident #17 had diagnoses which included Parkinson's disease.</p> <p>On 11/04/24 at 11:35 a.m., Resident #17's bed was observed to contain half side rails bilaterally.</p> <p>2. Resident #30 had diagnoses which included muscle weakness.</p> <p>On 11/04/24 at 11:31 a.m., Resident #30 was observed in bed with half side rails in the up position bilaterally.</p> <p>3. Resident #115 had diagnoses which included atrial fibrillation.</p> <p>On 11/04/24 at 1:12 p.m., Resident #115 was observed in bed with half side rails in the up position bilaterally.</p> <p>4. Resident #55 had diagnoses which included muscle weakness and history of falling.</p> <p>On 11/04/24 at 2:43 p.m., the resident's bed was observed to have bilateral half bed rails.</p> <p>On 11/06/24 at 11:38 a.m., the maintenance supervisor stated they installed bed rails as directed by the DON. They stated they repaired bed rails as needed based on staff reports, but did not provide routine safety inspections of the residents' beds or bed rails.</p>