STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375374	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Nursing Home of Guthrie, LLC	419 East Oklahoma Guthrie, OK 73044

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to prevent accidents for 1 (#54) of 3 residents sampled for accident hazards. The DON identified three residents ambulated with wheelchairs independently. Findings: On 05/13/25 at 9:00 a.m., Resident #54 was observed ambulating in a wheelchair. Resident #54's hands were observed to have bruising on their right and left knuckles and the back of their hands. A facility policy titled Accident and Incidents -Investigating and Reporting, dated 07/2017, read in part, All accidents or incidents involving residence, employees, visitors, vendors, etc. [et cetera], Occurring on premises shall be investigated and reported to the administrator.Incident/accident reports will be reviewed for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. Resident #54's admission record, dated 07/05/22, showed they were admitted with diagnoses which included edema, muscle weakness, and hyperlipidemia. Resident #54's care plan, dated 03/25/25, read in part, Approach: Xarelto [anticoagulant] Use - Many drugs interact with Xarelto to affect clotting time: most antibiotics, antifungals, anticonvulsants, anti-ulcer drugs, SSRI [selective serotonin reuptake inhibitors] antidepressants, various other drugs. Use caution when starting, changing, or discontinuing any medications on residents taking Xarelto. Monitor for S/S of bleeding. Notify Physician of any change in condition. Resident #54's quarterly MDS assessment, dated 04/05/25, showed their BIMS score was 15 indicating their cognition was intact for decision making. The assessment showed they ambulated with the assistance of a wheelchair independently and was prescribed and taking an anticoagulant. Resident #54's physician orders, dated 04/28/25, read in part, Xarelto (rivaroxaban) tablet; 20 mg; amt: 1 tab; oral at Bedtime. On 05/13/25 at 9:01 a.m., Resident #54 stated they bumped and hurt their hands while ambulating with a wheelchair and bruised easily due to taking an anticoagulant. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/25 at 9:42 a.m., LPN #1 was asked to discuss the bruising observed on Resident #54's hands. They stated the resident self propelled in their wheelchair and bumped into things and bruised because they were prescribed an anticoagulant. LPN #1 was asked what was done to prevent the injury. LPN #1 stated they had not done anything and did not document the bruising to the hands in the TAR for side effect monitoring of anticoagulants and did not complete an incident report. On 05/14/25 at 9:52 a.m., the ADON stated Resident #54's hands had several bruises on the backs of both hands due to Resident #54's hands on the doors while ambulating with a walker and a wheelchair. They stated the injuries had occurred since admission. They were asked what interventions were in place to prevent injury to the resident's hands. They stated the last intervention was educating the resident on 07/18/22. The ADON stated they needed to do an incident report and care plan and intervention to prevent further injury. On 05/14/25 at 10:19 a.m., the DON stated Resident #54 was not assessed after they reported the injuries to their hands and nursing should of assessed the resident and completed an incident report . The DON stated there were no interventions to prevent the bruising of the hands related to the resident ambulating with a wheelchair or walker.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure: a. a resident had a physician's order for oxygen administration for 1 (#98); and b. oxygen was administered as ordered for 1 (#11) of 2 sampled residents reviewed for respiratory services. The DON identified 28 residents received oxygen in the facility. Findings: 1. On 05/12/25 at 11:25 a.m., Resident #98 was observed to be on four liters of oxygen via nasal cannula. The oxygen tubing was dated 04/28. There was no documentation Resident #98 had an order for the use of oxygen. A policy titled Oxygen Administration, revised 10/10, read in part, Oxygen is administered under orders of physician, except in the case of resident with shortness of breath or respiratory distress, as needed. In such cases, oxygen is administered and orders for oxygen are obtained as soon as practicable. Resident #98's physician order report, dated 05/2025, showed the resident had diagnoses which included unspecified combined systolic and diastolic congestive heart failure and dementia. Resident #98's quarterly resident assessment, dated 05/08/25, showed the resident had severe cognitive impairment with a BIMS score of 04. A progress note, dated 05/13/25 at 3:06 p.m., read in part, resident has been complaining of shortness of breath most of the day, lungs clear in all quads, 02 sats 98-96% room air. heart rate 90 -100 .02 2 liters given at 2 liters per n/c [nasal cannula], resident was able to calm down. A progress note, dated 05/09/25 at 3:28 p.m., read in part, Resident complained of shortness of breath, around 3:15, this nurse checked on them. 02 Sat-97%. Placed on 02 at 2 liters, encouraged to take deep breaths. On 05/12/25 at 11:25 a.m., Resident #98 stated they started using oxygen occasionally about a week or two ago. On 05/12/25 at 11:26 a.m., Resident #98 stated they did not know how much oxygen they were receiving. On 05/14/25 at 8:36 a.m., Resident #98 stated they did not need oxygen this morning. They stated the nasal cannula tubing was changed yesterday on 05/13/25. On 05/14/25 at 9:48 a.m., CNA #2 stated Resident #98 used oxygen every night. They stated they cared for the resident last week and this morning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/14/25 at 9:49 a.m., CNA #2 stated the resident had on oxygen this morning on 05/14/25, but took it off when they got up. On 05/14/25 at 9:55 a.m., LPN #3 stated they were not aware the resident used oxygen. On 05/14/25 at 9:57 a.m., LPN #3 stated there was no order for the use of oxygen. On 05/14/25 at 9:59 a.m., LPN #3 stated if a resident had low oxygen saturation, they would call the doctor and get an order. On 05/14/25 at 10:07 a.m., the DON stated if a resident had shortness of breath, or in respiratory distress, they would administer oxygen and notified the provider for orders. 2. On 05/12/25 at 11:39 a.m., Resident #11 was observed to be on five liters oxygen via a nasal cannula. On 05/14/25 at 1:19 p.m., Resident #11 was observed to be on five liters of oxygen via a nasal cannula. A physician's order, dated 01/26/24, showed oxygen at three liters via nasal cannula continuously related to chronic obstructive pulmonary disease. Resident #98's physician order report, dated 04/14/25 to 05/14/25, showed the resident had diagnoses which included chronic obstructive pulmonary disease with acute exacerbation. Resident #11's discharge assessment-return anticipated, dated 05/01/25, showed the resident's memory was ok with some difficulties in cognitive skills for daily decision making. On 05/14/25 at 1:29 p.m., LPN #4 stated they last checked the resident's oxygen saturation at 9:11 a.m. on 05/14/25 and it was 98% on three liters. On 05/14/25 at 1:33 p.m., LPN #4 stated Resident #11's oxygen was set at five liters on the concentrator. On 05/14/25 at 1:34 p.m., LPN #4 stated the oxygen rate was incorrect. They stated it should be three liters as ordered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interview, the facility failed to ensure a resident received pain medication in a timely manner for 1 (#315) of 2 sampled residents reviewed for pain management. The administrator identified 115 residents resided in the facility Findings: A policy titled Administering Pain Medications, revised 10/2022, read in part, Administer pain medications as ordered. Resident #315's medications administration history, dated 05/2025, showed the resident had diagnoses which included displaced intertrochanteric fracture of right femur, sequela and unspecified pain. Resident #315's physician's order, dated 05/05/25, showed tramadol (opioid pain medication) 50 mg oral, may take one tablet every four hours as needed by mouth for pain and diagnosis of displaced intertrochanteric fracture of right femur, sequela. A baseline care plan, dated 05/06/25, showed Resident #315's cognition was intact. Resident #315's medications administration history, dated 05/12/25, showed the resident received tramadol at 9:06 a.m. Resident #315's medications administration history, dated 05/12/25, showed the resident received tramadol at 2:09 p.m. On 05/12/25 at 1:03 p.m., Resident #315 asked CNA #1 for their pain medication. On 05/12/25 at 1:08 p.m., Resident #315 stated they had right hip surgery. They stated it took a long time to receive their pain medicine when they asked for it. On 05/12/25 at 1:10 p.m., Resident #315 stated their pain rating was a 10 out of 10 on the numerical pain scale because they wheeled themselves back to their room from the dining room. They stated their pain was all over. On 05/13/25 at 2:28 p.m., CNA #1 stated if a resident request pain medication, they would inform the nurse as soon as they were through and the nurse would inform the CMA. On 05/13/25 at 2:29 p.m., CNA #1 stated they informed LPN #2 and LPN #2 informed CMA #1 that Resident #315 needed pain medication. They stated CMA #1 stated it was not time for the resident to received their pain medication. CNA #1 stated they could not recall the time they told the nurse. On 05/13/25 at 2:36 p.m., CMA #1 stated if a resident request pain medication, they would inform the nurse and the nurse would assess the resident and tell the CMA what to give. On 05/13/25 at 2:37 p.m., CMA #1 stated they offered residents pain medication right away to keep their pain under control. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/25 at 2:38 p.m., CMA #1 stated Resident #315's tramadol order was for every four hours as needed. On 05/13/25 at 2:41 p.m., CMA #1 stated they administered the tramadol twice on 05/12/25. They stated at 9:06 a.m. and 2:09 p.m. CMA #1 stated Resident #315 did not receive any pain medication between 1:00 p. m. and 2:00 p.m. On 05/13/25 at 2:42 p.m., CMA #1 stated LPN #2 informed them of the resident's request for pain medication some time after 2:00 p.m. on 05/12/25. On 05/13/25 at 2:44 p.m., CMA #1 stated they did not remember discussing with CNA #1 about the resident's request of pain medication. They stated they did not remember telling CNA #1 and LPN #2 that it was not time for the resident to have their pain medication on 05/12/25. On 05/13/25 at 2:45 p.m., CMA #1 stated it was not acceptable for the resident to wait an hour for their pain medication. On 05/13/25 at 2:53 p.m., the DON stated it was not acceptable for the resident to wait an hour for the pain medication if the resident could have it.

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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. Based on observation, record review, and interview, the facility failed to document side effect monitoring for the use of anticoagulants for 1 (#54) of 5 residents sampled for side effect monitoring of anticoagulants. The DON identified 22 residents were prescribed anticoagulants. Findings: On 05/13/25 at 9:00 a.m., Resident #54 was observed ambulating in a wheelchair. Resident #54's hands were observed to have bruising on their right and left knuckles and back of their hands. A facility policy titled High Risk Medications-Anticoagulants, read in part, The facility recognizes that some medication's, including anticoagulant, are associated with greater risk of adverse consequences than other medications.The residents plan of care shall alert staff to monitor for adverse consequences. Resident 54's admission record, dated 07/05/22, showed they were admitted with diagnoses which included edema, muscle weakness, and hyperlipidemia. Resident #54's TAR, dated 02/01/25 through 05/13/25, did not document bruising on the resident's hands related to side effect monitoring of anticoagulants and/or in the skin inspections. Resident #54's care plan, dated 03/25/25, read in part, Approach: Xarelto [anticoagulant] Use - Many drugs interact with Xarelto to affect clotting time: most antibiotics, antifungals, anticonvulsants, anti-ulcer drugs, antidepressants, various other drugs. Use caution when starting, changing, or discontinuing any medications on residents taking Xarelto. Monitor for S/S, of bleeding. Notify Physician of any change in condition. Resident #54's quarterly MDS assessment, dated 04/05/25, showed their BIMS score was 15 indicating their cognition was intact for decision making. The assessment showed they ambulated with the assistance of a wheelchair independently and was prescribed and taking an anticoagulant. Resident #54's physician orders, dated 04/28/25 read in part, Xarelto (rivaroxaban) tablet; 20 mg; amt: 1 tab; oral at Bedtime. On 05/13/25 at 9:01 a.m., Resident #54 stated they bumped and hurt their hands while ambulating with a wheelchair and bruised easily due to taking an anticoagulant. On 05/14/25 at 9:42 a.m., LPN #1 was asked to discuss the bruising observed on Resident #54's hands. They stated the resident self propelled in their wheelchair and bumped into things and bruised easily because they were prescribed an anticoagulant. LPN #1 stated they did not document the bruising to the hands in the TAR for side effect monitoring of anticoagulants or in the the skin inspections in the TAR. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/25 at 10:19 a.m., the DON stated Resident #54's TAR from 02/01/25 through 05/13/25 did not document the reported bruising observed on Resident #54's hands in the anticoagulant side effect monitoring or the skin inspections.