

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Lakeland Manor, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 604 Lake Murray Drive Ardmore, OK 73401	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure the physician and/or the resident's representative were notified after a change in the resident's condition for one (#1) of three sampled residents reviewed for notification.</p> <p>The DON identified 42 residents resided in the facility.</p> <p>Findings:</p> <p>An Assessing Falls and Their Causes policy, dated 11/23/20, documented to notify the resident's attending physician and family in an appropriate time frame after a fall.</p> <p>Res #1 had diagnoses which included Alzheimer's disease and psychosis.</p> <p>A witnessed fall report, dated 06/25/24, documented the resident was walking and grabbed onto the nurses' station, slid down the wall, and went to the ground. It was documented the resident was assessed and there were no injuries.</p> <p>There was no documentation the resident's representative was notified.</p> <p>An incident note, dated 07/02/24 at 5:28 a.m., documented the aide was going to get Res #1's roommate up. It was documented Res #1 appeared to have fallen going to the restroom. It was documented the resident had a small laceration to their upper left brow area. It was documented the fall was not witnessed by staff.</p> <p>An incident note, dated 07/02/24 at 5:37 a.m., documented the laceration was over the resident's right brow area and not the left.</p> <p>A health status note, dated 07/02/24 at 7:36 a.m., documented the nurse received report the resident had fallen and had a laceration to their eyebrow. It was documented when the nurse entered the room the resident had significant bleeding from the laceration. It was documented blood was present on the resident's forehead where they had been wiping the blood. It was documented vitals were obtained, the resident's forehead was cleaned, gauze applied over the laceration, wrapped, and taped. It was documented the physician and resident's representative was notified.</p> <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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documentation the physician and the resident's representative were notified of the incident until report had been provided to the oncoming nurse.</p> <p>On 07/17/24 at 1:09 p.m., Corporate Nurse Consultant #1 was asked to locate documentation the resident's representative was notified of their fall on 06/25/24. They were asked when was the physician and resident's representative notified of their fall on 07/02/24. They stated they should have been notified at the time of the fall.</p> <p>On 07/17/24 at 1:35 p.m., Corporate Nurse Consultant #1 stated there was no documentation the resident's representative was notified regarding the incident on 06/25/24.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to assess and monitor a resident after an unwitnessed fall for one (#1) of three sampled residents reviewed for accident hazards.</p> <p>The DON identified 42 residents resided in the facility.</p> <p>Findings:</p> <p>Res #1 had diagnoses which included Alzheimer's disease and psychosis.</p> <p>An annual assessment, dated 05/17/24, documented the resident's cognition was severely impaired. It was documented the resident required supervision or touching assistance with transfers and was independent with walking.</p> <p>An incident note, dated 07/02/24 at 5:28 a.m., documented the aide was going to get Res #1's roommate up. It was documented Res #1 appeared to have fallen going to the restroom. It was documented the resident had a small laceration to their upper left brow area. It was documented the fall was not witnessed by staff. It was documented neurological checks were to be started.</p> <p>There was no documentation neurological checks began at the time of the resident's fall.</p> <p>An incident note, dated 07/02/24 at 5:37 a.m., documented the laceration was over the resident's right brow area and not the left.</p> <p>A health status note, dated 07/02/24 at 7:36 a.m., documented the nurse received report the resident had fallen and had a laceration to their eyebrow. It was documented when the nurse entered the room the resident had significant bleeding from the laceration. It was documented blood was present on the resident's forehead where they had been wiping the blood. It was documented vitals were obtained, the resident's forehead was cleaned, gauze applied over the laceration, wrapped, and taped.</p> <p>There was no documentation the resident was assessed after they had fallen until report had been provided to the oncoming nurse.</p> <p>A neurological flow sheet, initiated 07/02/24, documented neurological checks began at 7:36 a.m.</p> <p>On 07/17/24 at 11:14 a.m., the COO was asked to provide documentation the resident was assessed after they had fallen.</p> <p>On 07/17/24 at 12:51 p.m., Corporate Nurse Consultant #1 stated neurological checks were not started until 7:36 a.m. They stated neurological checks should have been started at the time of the resident's fall. They stated neurological checks were to be conducted every 15 minutes X one hour, every 30 minutes X one hour, every one hour X four hours, then every four hours X 24 hours.</p> <p>On 07/17/24 at 1:09 p.m., Corporate Nurse Consultant #1 stated there was no documentation the resident was assessed by the nurse until 7:36 a.m.</p>		