STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375379	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Manor, Inc	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)
F 0804 Level of Harm - Actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34333 Based on observation, record review, and interview, the facility failed to ensure food was served at a safe temperature to prevent a burn for 1 (#10) of 1 resident sampled for food related burns. The DON reported 51 residents received food from the facility kitchen. Findings: On [DATE] at 12:09 p.m., Resident #10 was observed sitting in the dining room eating lunch. The resident was observed to eat independently with set-up supervision. An Assistance with Meals policy, dated [DATE], read in part, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity. A Hospitality Aide Qualifications and Training Requirements policy, dated [DATE], read in part, Hospitality aides must undergo a state-approved training program .Applicants who meet the qualifications for a hospitality aide and are in training will have a minimum of 16 hours of training in the following areas prior to direct contact with residents .Assisting with eating and hydration .Proper feeding techniques. Resident #10 had diagnoses which included encephalopathy, chronic obstructive pulmonary disease, atrial fibrillation, protein-calorie malnutrition, dysphagia, and adult failure to thrive. An minimum data set admission assessment, dated [DATE], showed the resident was moderately cognitively impaired. The assessment showed the resident required supervision with eating. (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 0804 Level of Harm - Actual harm Residents Affected - Few	An incident progress note, dated [DATE] at 10:00 a.m., showed CNA #1 reported to LPN #1 they entered Resident #10's room to assist with feeding the resident. CNA #1 reported they observed another unidentified aide feeding the resident oatmeal with a spoon and steam was observed coming off the oatmeal. CNA #1 reported they attempted to stop the aide from feeding the resident the hot oatmeal but it was too late and the resident already had it in their mouth. CNA #1 reported the resident made a crying noise and was visibly in pain. The note documented LPN #1 went in and observed the resident sitting in bed with blankets up to their mouth. The resident was hesitant for the nurse to look in their mouth but after a few moments opened their mouth and the nurse noted two white blisters on the top of the resident's mouth. The note showed LPN #1 reported the incident to the resident's nurse, LPN #2, and the DON. The note showed LPN #1 provided education to the unidentified aide on proper feeding techniques and safety protocol. A progress note, dated [DATE] at 10:24 a.m., showed Resident #10's physician was notified of the incident which caused two white blisters in the back, soft portion of the resident's oral cavity. The note showed the resident's family member was notified concerning the incident during which the resident had a bite of oatmeal that was too hot, causing blisters in the back of their oral cavity. An incident report to the Oklahoma State Department of Health, dated [DATE], showed an incident in which an unidentified aide was feeding Resident #10 hot oatmeal and caused two blisters in the resident's mouth. The report showed CNA #1 saw the other aide starting to put a steaming spoon of oatmeal in the resident's mouth and could not stop them before it was in the resident's mouth. The report showed the nurse assessed the resident and found two white blisters in the resident's mouth. An All Nursing Staff in-service training, dated [DATE], showed the DON gave an in-service over hot foods and liquids. The in-service sign-in sheets included kitchen staff. A care plan for Resident #10, dated [DATE], showed the resident had a potential for nutritional problems related to adult failure to thrive and protein calorie malnutrition. The care plan showed the resident required a mechanical soft diet. On [DATE] at 4:22 p.m., CNA #1 was interviewed regarding the incident with Resident #10. CNA #1 reported they heard the resident holler and when they walked into the room to see what was wrong, they could see steam coming off the oatmeal another aide was feeding the resident. CNA #1 reported they did not know the other aide's name. CNA #1 stated they did not know how the oatmeal stayed so hot from the kitchen to the resident's room and did not know if the oatmeal had been reheated. On [DATE] at 4:30 p.m., CNA #1 reported they could not remember who the aide was that was observed feeding Resident #10. CNA #1 reported the DON immediately gave a detailed in-service following the incident. On [DATE] at 11:06 a.m., the DON provided the employee file for aide #1, and reported this was the aide who was feeding Resident #10 when they got burned. The DON reported the aide no longer worked in the facility. A copy of the aide's Long Term Aide certification showed the certification had expired [DATE]. (continued on next page)

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F 0804 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:13 a.m., the BOM reported aide #1 had worked in the facility about a week and a half. The BOM reported the aide came from a sister facility where they had been in the hospitality aide program, and they had planned to have the aide continue the training at this facility. The BOM stated the aide worked for a short period of time and then did not show up one day. On [DATE] at 1:14 p.m., CNA #2 reported any aide that was not certified was used as a hospitality aide while waiting to go through CNA training. CNA #2 reported aides in training do not provide direct resident care. On [DATE] at 2:15 p.m., CNA #4 reported hospitality aides provide only non-direct care and do not feed residents. On [DATE] at 2:23 p.m., CNA #3 reported they had worked at the facility a little over 2 weeks. The CNA reported they had not been in-serviced on hot liquids/hot foods. CNA #3 was asked if they went through an orientation period and stated, no, they went straight to the floor. On [DATE] at 2:36 p.m., Resident #10's physician reported they saw the resident a few days after the incident when the resident was burned. The incident happened on [DATE] and the physician saw the resident on [DATE]. The physician reported they saw no blisters or redness in the resident's mouth at that time. On [DATE] at 3:06 p.m., the DM reported they were not aware of an incident with Resident #10 in which the resident was burned from hot oatmeal. The DM reported if they send something out of the kitchen they temp it beforehand. On [DATE] at 4:43 p.m., the BOM reported it was their understanding, after talking to OSDH, that nurse aides in training were the same as a hospitality aide in what they can and cannot do. The BOM stated basically they should be shadowing a CNA and not providing direct care to residents. On [DATE] at 9:58 a.m., LPN #1 was interviewed by phone. LPN #1 reported they had worked at the facility as needed and was no longer working at the facility. LPN #1 reported they did not think they were working Resident #10's hall at the time of the incident, but responded when the aide asked for help. LPN #1 reported it took them a few minutes to calm the resident, but was eventually able to coax the resident to open their mouth. LPN #1 reported the blisters were easily seen when the resident opened their mouth. LPN #1 stated they reported the information to LPN #2 since they were the charge nurse for that hall. On [DATE] at 10:38 a.m., LPN #2 was interviewed by phone and reported they were the charge nurse the day of the incident with Resident #10. The LPN reported they returned from lunch and was told the resident's mouth was burned and the physician had been notified. LPN #2 reported LPN #1 told them there were two blisters in the resident's mouth and it might be hard for the resident to eat for awhile, and reported they had left the resident with cool liquids to drink. On [DATE] at 11:23 a.m., the DON reported the incident happened on a Saturday and they came to the facility to in-service all staff that same day. The DON was asked if they interviewed the aide who was feeding the resident and they stated, yes, but was not sure if they had any documentation of the interview.