STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375382	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Village of Owasso	12600 East 73rd Street North Owasso, OK 74055

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on record review and interview, the facility failed to ensure resident assessments for discharge were completed and submitted to CMS for two (#68 and #63) of 11 sampled residents who were reviewed for resident assessments. The administrator identified 79 residents who resided at the facility. Findings: 1. Resident #68 admitted with diagnoses which included acute and chronic respiratory failure, diabetes type II, and congestive heart failure. Review of the face sheet for Resident #68 revealed they had transferred to the hospital on [DATE] and expired at the hospital on [DATE]. On [DATE] at 11:42 a.m., a review of the assessment log for Resident #68 revealed a discharge assessment had not been completed/submitted. On [DATE] at 1:49 p.m., MDS Coordinator #1 stated Resident #68 had been sent to the hospital on [DATE] and expired on [DATE]. They stated the discharge assessment was missing from the log for Resident #68. MDS Coordinator #1 stated the assessment was missed because it was an unplanned discharge and was not written on their calendar. 2. Resident #63 was admitted with diagnoses which included malignant neoplasm of cervix, chronic kidney disease stage III, and type II diabetes. Review of the face sheet for Resident #63 revealed they discharged to the hospital on [DATE]. On [DATE] at 11:42 a.m., a review of the assessment log for Resident #63 revealed a discharge assessment had not been completed/submitted. On [DATE] at 1:49 p.m., MDS Coordinator #1 stated the discharge assessment for Resident #63 was not completed timely. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:03 p.m., MDS Coordinator #1 stated they had forgotten to put the discharge assessment in the system because it was an unplanned, hospital discharge.

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. 41809 Based on record review and interview, the facility failed to ensure coordination and certification of assessments for four (#23, 37, 42 and #73) of 11 sampled residents who were reviewed for assessments. The administrator identified 79 residents who resided at the facility. Findings: Review of the electronic clinical record, revealed Residents #23, 37, 42 and #73, were missing quarterly assessments, due to no signature from the RN. Resident #73 was missing a quarterly which required correction and to be opened by the RN. On 07/23/24 at 11:42 a.m., MDS Coordinator #1 stated the quarterly assessments required a signature from the RN before the assessments could be submitted. They stated Resident #74 had a rejected assessment for the mood miscalculation and required to be unlocked by the RN before the correction could be made. The MDS Coordinator stated they sent emails to the RN for signatures and when assessments required re-opening for correction.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 43023 Based on record review and interview, the facility failed to ensure residents did not receive an antipsychotic medication, unless for a specific diagnosis condition for three (#37, 55, and #43) of five residents reviewed for unnecessary medications. The Administrator reported 79 residents resided in the facility. Findings: 1. Resident #37 admitted to the facility with diagnoses which included dementia, depression, and cognitive communication deficit. A physician's order, dated 02/05/24, documented Risperdal 0.25 mg tablet Hour Of Sleep for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The resident's electronic health record was reviewed and contained no documentation the resident had a diagnoses of psychotic disturbance/mood disorder. 2. Resident #55 admitted to the facility with diagnoses which included dementia, altered mental status, anxiety, and cognitive communication deficit. A physician order, dated 3/27/24, documented Quetiapine 25mg tablet 1/2 tablet every evening for unspecified dementia. The resident's electronic health record was reviewed and contained no documentation the resident had a diagnoses of psychotic disturbance/mood disorder or depression. 41220 3. Resident #43 admitted to the facility with diagnoses which included dementia, anxiety, and cognitive communication deficit. A physician's order, dated 03/27/24, documented Quentiapine 25 mg 0.5 tablets every evening for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The resident's electronic health record was reviewed and contained no documentation the resident had a diagnoses of psychotic disturbance/mood disorder. On 07/24/24 at 8:47 a.m., the DON and Corporate RN stated they would need to speak with the pharmacy consultant to determine if dementia was an appropriate diagnosis for the use of an antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/24/24 at 8:59 a.m., the pharmacy consultant reported dementia was not an appropriate diagnosis for the antipsychotic medications.