STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375384	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Hope Retirement & Care Center	1220 East Electric Blvd McAlester, OK 74501

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on observation, record review, and interview, the facility failed to provide treatment and services to prevent worsening of a pressure ulcer for one (#4) of four sampled residents reviewed for pressure ulcers. The LPN #1 identified two residents with pressure ulcers. Findings: A facility pressure ulcer policy and procedure read in part, the facility will provide care based on each resident's comprehensive assessment to ensure that a resident who enters the facility with pressure ulcers does not develop pressure ulcers unless pressure ulcers are unavoidable. The policy also read, aggressive and appropriate preventative measures and care are provided to address a resident's unique risk factors. Res #4 admitted to the facility on [DATE] with diagnoses which included peripheral vascular disease, osteoporosis, and fracture of part of the neck of right femur. A care plan, dated 07/15/24, documented to assess skin condition and treat as needed. A nursing note, dated 07/15/24, documented a small pressure area noted to buttocks, zinc oxide applied. No redness noted to surrounding skin. There was no further description or mention of this wound until 07/22/24. A bath sheet, dated 07/19/24, documented the presence of a scratch/tear to right leg. There was no mention of pressure wounds at all. A nursing note, dated 07/22/24, documented the CNA that bathed resident noticed some wounds and notified the nurse. It was documented as noted 3 open areas to buttocks. A 1cm x1cm open area to left lower sacrum. A 3 cm by 4 cm open area with slough noted to sacrum in center of buttocks. A 3 cm by 3 cm open area, black in color, noted to right buttocks. The wounds were not staged only described. A nursing note, dated 07/23/24, documented the physician was notified of the wounds to buttocks and sacrum, and new orders were received to cleanse area with NS or wound wash. pat dry. apply medihoney, cover and secure every shift and as needed until resolved. This was the first notification to the physician of the wound. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Actual harm Residents Affected - Few	A physician order, dated 07/24/24, documented to provide a cushion to wheelchair at all times while up. On 07/31/24, at 11:11 a.m., LPN #1 and DON were observed providing wound care to resident #4's buttocks, left of sacrum. The wound was not measured but was approximately the size of a quarter. It was 100% covered in slough. On 07/31/24 at 12:13 p.m., LPN #1 stated they admitted resident #4, and the area to the buttocks was not open at that time. They stated residents are to be turned every 2 hours, but resident #4 wants to sit down in their wheelchair and lay on their back. They stated staff tell each other interventions verbally, but it also will show up in the Treatment record. The Treatment record documented the order for medication to the wounds were initiated on 7/23/24 and the cushion to the wheel chair was initiated on 07/24/24. Repositioning every 2 hours was the only wound care intervention documented prior to 07/22/24. On 07/31/24, at 12:20 p.m., the administrator stated it looks like we haven't done anything. The administrator stated that resident #4 has now seen VOHRA wound care once since the wound was identified, but they were unable to provide those records.