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	11/07/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 33097 Based on observation, record review, and interview, the facility failed to date and cover urinary catheter bags for two (#11 and #35) of two sampled residents reviewed for urinary catheters. The DON identified four residents with urinary catheters. Findings: 1. Res #11 had diagnoses which included overactive bladder, paraplegia, and a stage 4 sacral pressure ulcer. A physician order, dated 05/29/23, documented catheter care per facility guidelines. A discharge return anticipated assessment, dated 10/24/24, documented the resident was modified independent for daily decision making and had a urinary catheter. On 11/05/24 at 11:00 a.m., the resident was lying in bed with a urinary catheter bag hanging from the bedside. The bag was not dated or covered. On 11/07/24 at 2:23 p.m., the DON stated the resident's urinary catheter bag should have been dated and covered. 2. Res #35 had diagnoses which included retention of urine and congenital bladder neck obstruction. A physician order, dated 08/07/24, documented catheter care per facility guidelines. On 11/05/24 at 11:21 a.m., the resident was sitting in a recliner in their room. The resident's urinary catheter bag was hanging from the side of the chair. The catheter bag was not dated or covered. On 11/06/24 at 8:33 a.m., the resident was sitting in a chair in their room. The resident's catheter bag was hanging from the chair. The catheter bag was no dated or covered. On 11/07/24 at 10:20 a.m, the resident was sitting in their room in a recliner. The resident's catheter bag was hanging from the chair. The catheter bag was not dated or covered. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/07/24 at 2:23 p.m., the DON stated the resident's urinary catheter bag should be dated and covered.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45913 Based on record review and interview, the facility failed to ensure DNR orders were in place for three (#4, 7 and #10) of 14 sampled residents whose advance directives were reviewed. The administrator identified 12 residents who were DNR's. Findings: A Do Not Resuscitate Order policy, dated [DATE], read in part, 1. Do not resuscitate orders must be signed by the resident's Attending Physician on the physician's order sheet maintained in the resident's medical record. 1. Res #4 had diagnoses which included type 2 diabetes mellitus and cerebral infarction. A Do Not Resuscitate care plan, dated [DATE], documented Res #4 did not want CPR performed if their heart/respirations should stop. Res #4 signed an Oklahoma Do Not Resuscitate (DNR) Consent Form was signed on [DATE]. Res #4 did not have a physician's order for a DNR. 2. Res #7 had diagnoses which included Parkinson's, dementia, behavioral disturbance, and anxiety. A Do Not Resuscitate care plan, dated [DATE], documented Res #7 did not want CPR performed if their heart/respirations should stop. The POA for Res #7 signed an Oklahoma Do Not Resuscitate (DNR) Consent Form on [DATE]. Res #7 did not have a physician's order for a DNR. 3. Res #10 had diagnoses which included chronic kidney disease stage 3, type 2 diabetes mellitus, and congestive heart failure. A Do Not Resuscitate care plan, dated [DATE], documented Res #10 did not want CPR performed if their heart/respirations should stop. Res #10 signed an Oklahoma Do Not Resuscitate (DNR) Consent Form was signed on [DATE]. Res #10 did not have a physician's order for a DNR. On [DATE] at 10:58 a.m., the MDS coordinator reported the residents did not have an order for a DNR and was not aware an order needed to be written for DNR residents.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 33097 Based on record review and interview, the facility failed to ensure the physician was notified of out of parameter blood sugars for two (#21 and #31) of three sampled residents whose diabetic records were reviewed. The administrator identified 12 residents whose blood sugars were monitored. Findings: 1. Res #21 had diagnoses which included type 2 diabetes with autonomic polyneuropathy. A physician's order, dated 04/26/24, read in part, Obtain and record FSBS (finger stick blood sugar) .ac and hs. Notify physician if FSBS <70 or >400. On 10/02/24 at 4:30 p.m., Res #21's blood sugar was 458. There was no documentation in the narrative note or blood glucose MAR the physician was notified of the out of parameter blood sugar. 2. Res #31 had diagnoses which included type 2 diabetes mellitus. A physician's order, dated 08/12/23, read in part, Obtain and record FSBS .ac and hs .Notify physician if FSBS <60 or >400. There was no documentation in the narrative note or blood glucose MAR the physician was notified of the following out of parameter blood sugars: a. on 09/20/24 at 10:10 p.m., blood sugar was 403, b. on 09/24/24 at 10:15 p.m., blood sugar was 475, c. on 09/27/24 at 8:30 p.m., blood sugar was 404, d. on 09/30/24 at 9:00 p.m., blood sugar was 431, and e. on 10/14/24 at 4:18 p.m., blood sugar was 429. On 11/07/24 at 1:20 p.m., RN #1 reported the physician should be notified of an out of parameter blood sugar. On 11/07/24 at 1:25 p.m., the DON reported physician notification of an out of parameter blood sugar would be documented in the narrative note or the blood glucose MAR. If there was no documentation the physician was not notified and should have been. 45913

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45913 Based on record review and interview, the facility failed to ensure resident assessments were accurate for two (#21 and #28) of 14 sampled residents whose resident assessments were reviewed. The administrator identified 39 residents who resided in the facility. 1. Res #21 had diagnoses which included heart failure, cerebral infarction, and history of pulmonary embolism. A physician's order, dated 09/24/22, documented the resident was taking aspirin (antiplatelet mecication) 81 mg daily. A 5 day resident assessment, dated 09/24/24, documented the resident was taking an anticoagulant. The resident assessment did not document the resident was taking an antiplatelet. On 11/07/24 at 10:55 a.m., the MDS coordinator reported the medication section of the resident assessment is auto-populated and they did not catch the error of an anticoagulant being documented. The MDS coordinator reported antiplatelet should have been documented. 33097 2. Res #28 had diagnoses which included atrial fibrillation and chronic obstructive pulmonary disease. A physician's order, dated 08/21/24, documented the resident was admitted to hospice services for a diagnosis of chronic obstructive pulmonary disease. The admission assessment, dated 08/27/24, did not document the resident was receiving hospice services. On 11/07/24 at 3:29 p.m., the MDS coordinator reviewed the admission assessment for the resident. They stated the assessment did not document the resident was receiving hospice services.

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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. 33097 Based on record review and interview, the facility failed to ensure a resident experiencing pain was monitored for pain for one (#39) of one sampled resident reviewed for pain. The administrator identified 39 residents who resided in the facility. Findings: Res #39 had diagnoses which included muscle spasm, pain, and anxiety disorders. A physician order, dated 09/27/24, documented the resident was to receive Tramadol (a narcotic medication) 50 mg two tablets by mouth every eight hours as needed for pain. The resident did not have a physician order for scheduled pain medication. An admission assessment, dated 10/01/24, documented the resident was cognitively intact and had occasional pain rated six on a pain scale from 0 to 10. The care plan, dated 10/04/24, documented the resident had pain. The care plan documented the resident was to have pain relieved or controlled as evident by facial expression and verbalization of pain relief. A physician order, dated 10/15/24, documented staff was to monitor the resident's pain daily every morning, evening, and night shift. The staff was to document a Y for yes if the resident had pain and a N for no pain. On 11/05/24 at 2:53 p.m., the resident stated they always had pain to their left arm and leg. They stated the pain medication given provided some relief. On 11/07/24 at 1:49 p.m., the DON stated monitoring for pain was not completed as ordered by the physician for the resident.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 45913 Based on observation and interview, the facility failed to post the required staffing information. The administrator identified 39 residents who resided in the facility. Findings: On 11/05/24 at 11:00 a.m., posted staffing was observed to be documented on a white board at the nursing station. The date, census, and staff/title were documented. The facility name and projected and actual staffing hours were not documented. On 11/07/24 at 9:02 a.m., posted staffing was observed to be documented on a white board at the nursing station. The date, census, and staff/tile were documented. The facility name and projected and actual staffing hours were not documented. On 11/07/24 at 9:52 a.m., the DON reported they were unaware of what staffing information was required to be documented on the staffing board.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 33097 Based on record review and interview, the facility failed to ensure a resident who received psychotropic medication had an acceptable diagnosis/indication for the use of an antipsychotic medication for one (#33) of five sampled residents reviewed for unnecessary medications. The DON identified 10 residents who received antipsychotic medications. Findings: Res #33 had diagnoses which included dementia without behavioral or psychotic disturbances, anxiety disorders, and unspecified mood affective disorder. A physician order, dated 10/21/24, documented the resident was to receive Risperidone (an antipsychotic medication) 0.5 mg two times a day. The admission assessment, dated 10/28/24, documented the resident was cognitively intact and was receiving a antipsychotic and a antianxiety medication. The care plan, dated 11/01/24, documented the resident received psychotropic medication. The care plan documented staff were to monitor for behaviors, verbal and non-verbal, for which the medication was being given. On 11/06/24 at 4:01 p.m., the DON reviewed the resident's clinical record. The DON was unsure if the resident had an appropriate diagnosis for the use of the antipsychotic medication. On 11/06/24 at 4:06 p.m., the facility pharmacist reviewed the resident's medication and diagnoses list. The pharmacist stated the resident was receiving an antipsychotic medication and did not have a diagnosis for the use of the medication.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 33097 Based on record review and interview, the facility failed to ensure there was documentation of the coordination of care between hospice and the facility for one (#28) of one sampled resident reviewed for hospice care. The DON identified three residents who received hospice services. Findings: Res #28 had diagnoses which included atrial fibrillation and chronic obstructive pulmonary disease. A physician's order, dated 08/21/24, documented the resident was admitted to hospice services for a diagnosis of chronic obstructive pulmonary disease. The admission assessment, dated 08/27/24, did not document the resident was receiving hospice services. On 11/06/24 at 2:41 p.m., the administrator could not provide hospice documentation regarding the resident's hospice services, including the plan of care.