

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Forest Hills Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4300 West Houston Broken Arrow, OK 74012	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure injuries of unknown origin were reported to the Oklahoma State Department of Health as required for 1 (#80) of 3 sampled residents reviewed for abuse.</p> <p>The DON reported 140 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy titled Abuse Prevention, revised 10/21/23, read in part, Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of an unknown source and misappropriation of a residents property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. If the events that cause the allegation do not involve abuse or result in serious bodily injury, are reported immediately, but not later than 24 hours after the allegation is made, to the administrator of the facility and to other officials (including State Survey Agency, and local law enforcement as required).</p> <p>An admission record, dated 06/20/24, showed Resident #80 had diagnoses which included kidney failure and dementia.</p> <p>A nurse note, dated 03/02/25 at 2:29 p.m., showed Resident #80's family informed the nurse the resident's shoulder was hurting. The note showed an assessment was completed with swelling and warmth being noted, and an x-ray of the left shoulder was ordered.</p> <p>A nurse note, dated 03/02/25 at 9:12 p.m., read in part, Results from shoulder x-ray received and are positive for left shoulder subluxation [partial dislocation].</p> <p>A nurse note, dated 03/03/25 at 8:22 p.m., showed the resident was sent to the emergency room for evaluation of the left shoulder.</p> <p>A significant change assessment, dated 04/09/25, showed Resident #80 had a BIMS summary score of 13 which was indicative of intact cognition. The assessment also showed Resident #80 was totally dependent on staff for care.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/30/25 at 9:30 a.m., LPN #1 stated they were on duty when the resident's family complained their shoulder was hurting. LPN #1 also stated they were not sure what caused the injury.</p> <p>On 05/06/25 at 10:40 a.m., the DON stated that Resident #80's dislocated shoulder was not reported to the Oklahoma State Department of Health as an injury of unknown origin and that they had performed an internal investigation. The DON also stated the injury was unwitnessed and the resident was unable to explain what had happened.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure injuries of unknown origin were thoroughly investigated for 1 (#80) of 3 sampled residents reviewed for abuse.</p> <p>The DON reported 140 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy titled Abuse Prevention, revised 10/21/23, read in part, The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and to provide protection to any alleged victims to prevent harm during the continuance of an investigation.</p> <p>An admission record, dated 06/20/24, showed Resident #80 had diagnoses which included kidney failure and dementia.</p> <p>A nurse note, dated 03/02/25 at 2:29 p.m., showed Resident #80's family informed the nurse that the resident's shoulder was hurting. The note showed an assessment was completed and that swelling and warmth to the left shoulder were noted, and an x-ray of the left shoulder was ordered.</p> <p>A nurse note, dated 03/02/25 at 9:12 p.m., read in part, Results from shoulder x-ray received and are positive for left shoulder subluxation [partial dislocation].</p> <p>A nurse note, dated 03/03/25 at 8:22 p.m., showed the resident was sent to the emergency room for evaluation of the left shoulder.</p> <p>A significant change assessment, dated 04/09/25, showed Resident #80 had a BIMS summary score of 13 which was indicative of intact cognition. The assessment also showed Resident #80 was totally dependent on staff for care.</p> <p>On 04/30/25 at 9:30 a.m., LPN #1 stated they were on duty when the resident's family complained that their shoulder was hurting. LPN #1 also stated they were not sure what caused the injury or if an investigation was completed.</p> <p>On 05/06/25 at 10:40 a.m., the DON stated Resident #80's dislocated shoulder was investigated internally, but they did not document interviews with staff members or the physician, nor did they interview any additional residents regarding their treatment in the facility.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42171</p> <p>Based on observation, record review and interview, the facility failed to ensure comprehensive care plans were developed for 2 (#80 and #108) of 20 sampled residents whose care plans were reviewed.</p> <p>The DON reported 140 residents resided in the facility.</p> <p>Findings:</p> <p>1. On 04/29/25 at 2:37 p.m., Resident #80 was observed in bed. Resident #80's right hand was observed to be contracted.</p> <p>A facility policy titled Comprehensive Person-Centered Care Plan, reviewed 10/23/19, read in part, Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the facility will provide care.</p> <p>An admission record, dated 06/20/24, showed Resident #80 had diagnoses which included kidney failure and dementia.</p> <p>A care plan, initiated 06/20/24, did not show interventions for the resident's contracted right hand.</p> <p>A significant change assessment, dated 04/09/25, showed Resident #80 had a BIMS summary score of 13 which was indicative of intact cognition. The assessment also showed Resident #80 was totally dependent on staff for care and had a range of motion impairment to one side of their upper body.</p> <p>On 05/06/25 at 9:41 a.m., LPN #4 stated they sometimes put hand rolls in Resident #80's hand, but there were no formal interventions in place.</p> <p>On 05/06/25 at 4:45 p.m., the MDS coordinator stated interventions should be in place for Resident #80's contracted right hand and the care plan should include those interventions.</p> <p>2. An admission record, dated 10/21/24, showed Resident #108 had diagnoses which included obstructive and reflux uropathy and retention of urine.</p> <p>A significant change assessment, dated 02/11/25, showed Resident #108 had a BIMS summary score of 12 which indicated the resident was moderately impaired in cognition for daily decision making. The assessment also showed Resident #108 had an indwelling urinary catheter.</p> <p>A care plan, revised 04/06/25, did not include the use of an indwelling urinary catheter.</p> <p>On 05/06/25 at 4:45 p.m., the MDS coordinator stated the use of a urinary catheter should be included on the resident's care plan.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>42171</p> <p>Based on observation, record review, and interview, the facility failed to provide ADL care for 1 (#3) of 3 sampled residents reviewed for ADL care.</p> <p>The DON identified 27 residents were dependent of staff for nail care.</p> <p>Findings:</p> <p>On 04/27/25 at 9:05 a.m., Resident #3 was observed lying in bed. The resident's toenails were observed to be long and unkempt.</p> <p>A facility policy titled Nail Care, reviewed 07/21/22, read in part, The purpose of nail care is to clean the nail bed, trim nails, and prevent infection.</p> <p>A significant change assessment, dated 03/06/25, showed Resident #3 had a BIMS summary score of 14 which was indicative of intact cognition, and they required substantial assistance from staff.</p> <p>A Skin Monitoring CNA Bathing Review form, dated 04/16/25, showed the resident's toenails needed to be trimmed.</p> <p>On 04/27/25 at 9:11 a.m., Resident #3 stated since they went off hospice no one was trimming their toenails. They also stated their toenails were so long they were uncomfortable.</p> <p>On 04/28/25 at 2:15 p.m., CNA #1 stated CNAs were supposed to provide nail care to residents on their hall on the resident's shower day unless the resident was diabetic, then they were supposed to inform the nurse.</p> <p>On 04/28/25 at 2:21 p.m., CNA #2 stated Resident #3's toenails were long and needed to be trimmed, but they were not sure if the resident was diabetic or not.</p> <p>On 04/28/25 at 2:28 p.m., LPN #1 stated charge nurses were responsible for ensuring residents received appropriate nail care.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. range of motion services were provided for 2 (#97 and #75); and</p> <p>b. provide contracture interventions for 1 (#80) of 3 sampled residents who were reviewed for range of motion.</p> <p>The DON identified 12 residents with contractures and 43 residents with limited range of motion.</p> <p>Findings:</p> <p>1. A policy titled Establishment of an Individual Restorative Program, dated 01/02/24, read in part, To provide treatment and services to maintain and improve functional abilities per physician order.</p> <p>A policy titled Range of Motion, dated 01/24/24, read in part, To exercise the resident's joints and muscles as required and/or clinically indicated.</p> <p>A Restorative Nursing Care Plan, dated 03/28/25, showed Resident #75 was to receive restorative services two to three times a week for eight weeks.</p> <p>A PT [Physical Therapy] Evaluation and Plan of Treatment, dated 04/18/25, read in part, Patient educated on initiation of RNP to maintain currently [sic] functional status. RNP to be established on this date.</p> <p>An OT [Occupational Therapy] Evaluation and Plan of Treatment, dated 04/18/25, read in part, Pt is currently at [their] baseline in physical function. Pt to participate in restorative program.</p> <p>The quarterly assessment, dated 04/23/25, showed Resident #75 had a diagnosis of hemiplegia affecting left nondominant side, had a BIMS score of eight which indicated the resident was moderately impaired in cognition for daily decision making, upper extremity impairment on one side, lower extremity impairment on both sides, and had not received any restorative services during the look back period.</p> <p>A Restorative Delivery Documentation form, dated April 2025, showed Resident #75 had received restorative nursing services on 04/24/25 and 04/30/25.</p> <p>On 04/27/25 at 10:35 a.m., Resident #75 stated they were supposed to receive restorative services. They stated they only received restorative services one day in the past week.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/07/25 at 10:32 a.m., the DON stated the resident was evaluated for skilled nursing services, but it had been determined the resident was at their baseline functioning level. They stated the resident was to be on restorative services. The DON stated restorative services had not been being performed as indicated for the residents.</p> <p>2. A Plan of Care Note, dated 07/15/24 at 11:20 a.m., showed during a care plan meeting a family member had verbalized they would like Resident #97 to be evaluated for restorative services.</p> <p>The quarterly assessment, dated 04/23/25, showed Resident #97 had a BIMS score of 08, which indicated the resident was moderately impaired in cognition for daily decision making, had impairment to one side of their upper body and impairment to both sides of the lower body, and no therapies or restorative nursing services had been received during the look back period.</p> <p>On 05/07/25 at 10:30 a.m. the DON stated they did not have documentation Resident #97 had been assessed for the restorative program. They stated they had instructed staff to perform range of motion exercises during ADL care. They stated they did not have any documentation range of motion had been provided for the resident.</p> <p>42171</p> <p>3. On 04/29/25 at 2:37 p.m., Resident #80 was observed in bed. Resident #80's right hand was observed to be contracted.</p> <p>An admission record, dated 06/20/24, showed Resident #80 had diagnoses which included kidney failure and dementia.</p> <p>A significant change assessment, dated 04/09/25, showed Resident #80 had a BIMS summary score of 13 which was indicative of intact cognition. The assessment also showed Resident #80 was totally dependent on staff for care and had a range of motion impairment to one side of their upper body.</p> <p>Review of the electronic health record did not show any interventions for the resident's contracted right hand.</p> <p>On 05/06/25 at 9:41 a.m., LPN #1 stated they sometimes put hand rolls in Resident #80's hand, but there were no formal interventions in place.</p> <p>On 05/06/25 at 4:45 p.m., the MDS coordinator stated interventions should be in place for Resident #80's contracted right hand and the care plan should include those interventions.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were secure for 1 (500 hall medication/treatment cart) of 2 medication/treatment carts observed on the 500 hall.</p> <p>The DON identified 15 medication/treatment carts in the facility.</p> <p>Findings:</p> <p>On 04/29/25 at 11:50 a.m., the 500 hall medication/treatment cart was observed to be unlocked and unattended on the 500 hall across from the restrooms.</p> <p>On 04/29/25 at 11:54 a.m., the administrator locked the 500 hall medication/treatment cart as they walked by and stated they needed to find out who was assigned to the medication/treatment cart.</p> <p>On 04/29/25 at 11:57 a.m., LPN #5 stated they should have locked the cart, but had forgotten.</p> <p>On 05/07/25 at 10:38 a.m., the DON stated medication/treatment carts were to remain locked when left unattended. They stated they monitored medication/treatment carts to ensure they were locked when unattended. They stated it was a constant battle.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42171</p> <p>Based on observation, record review and interview, the facility failed to:</p> <p>a. follow EBP during the provision of care for 1 (#108) of 2 sampled residents reviewed for catheter care; and</p> <p>b. ensure clean laundry was transported appropriately.</p> <p>The DON reported 11 residents had urinary catheters and 110 residents' laundry was cleaned by the facility.</p> <p>Findings:</p> <p>1. On 05/05/25 at 3:45 p.m., LPN #3 was observed providing catheter care to Resident #108. LPN #3 was not observed to wear a gown.</p> <p>A facility policy titled Enhanced Barrier Precautions, reviewed 05/15/24, read in part, The facility may expand the use of PPE [personal protective equipment] & refer to the use of gowns & gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to hands/clothing. The use of gown & gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for facility residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with colonization.</p> <p>An admission record, dated 10/21/24, showed Resident #108 had diagnoses which included obstructive and reflux uropathy and retention of urine.</p> <p>A significant change assessment, dated 02/11/25, showed Resident #108 had a BIMS summary score of 12 which indicated the resident was moderately impaired in cognition for daily decision making. The assessment also showed Resident #108 had an indwelling urinary catheter.</p> <p>On 05/05/25 at 3:55 p.m., LPN #3 stated they should have been wearing a gown while providing care to Resident #108.</p> <p>On 05/06/25 at 10:37 a.m., the DON stated the facility used EBP and a gown should be worn when providing direct care to a resident with an indwelling urinary catheter.</p> <p>35474</p> <p>2. On 05/06/25 at 4:58 p.m., laundry personnel #1 was observed to deliver clean personal laundry to residents on the 600 hall. The laundry cart/rack was observed to be uncovered when it was delivered to six rooms.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/06/25 at 5:07 p.m., laundry personnel #1 stated the cover for the laundry cart/rack was in the washing machine. They stated they should have waited to deliver the clean laundry until they had a cover to protect the clothing, but since they were delivering laundry to only five or six residents they delivered it without covering the clean laundry.</p> <p>On 05/07/25 at 11:25 a.m., the laundry supervisor stated laundry should be covered when it was delivered to the residents' rooms.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>35474</p> <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>Based on record review and interview, the facility failed to ensure residents were offered the pneumococcal immunization for 3 (#28, 83, and #330) of 5 sampled residents reviewed for immunizations.</p> <p>The DON identified 140 residents resided in the facility.</p> <p>Findings:</p> <p>A policy titled Pneumococcal Vaccine, dated 12/05/24, read in part, The opportunity to receive the Pneumococcal Vaccine will be extended to all Residents. The facility will provide pertinent information regarding the Risks/Benefits of receiving the Vaccine.</p> <p>1. An undated face sheet showed Resident #330 had a diagnosis of diabetes.</p> <p>Review of the immunization tab in the electronic clinical record did not show the resident had been offered the pneumococcal immunization.</p> <p>2. A significant change assessment, dated 02/14/25, showed Resident #83 had a diagnosis of a stroke and the pneumococcal immunization was up to date.</p> <p>Review of the immunization tab in the electronic clinical record did not show when the resident had received the pneumococcal immunization or that the facility had offered the immunization.</p> <p>3. A quarterly assessment, dated 04/30/25, showed Resident #28 had a diagnosis of heart failure, had a BIMS score of nine which indicated the resident was moderately impaired in cognition for daily decision making, and the pneumococcal immunization had been offered and declined.</p> <p>Review of the immunization tab in the electronic clinical record did not show when the resident had been provided education/offered the pneumococcal immunization.</p> <p>On 05/07/25 at 1:04 p.m., the DON stated pneumococcal immunization documentation should be under the immunization tab in the electronic clinical record. They stated they did not have information related to the pneumococcal immunization for Resident #330, 83, or Resident #28.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure a resident was offered the COVID-19 vaccination for 1 (#83) of 5 sampled residents reviewed for the COVID-19 vaccination.</p> <p>The DON identified 140 residents resided in the facility.</p> <p>Findings:</p> <p>A policy titled Covid Vaccine, dated 09/04/24, read in part, The Facility will offer the COVID Vaccine to Employees/Residents to assist in mitigating the spreads [sic] of COVID-19.</p> <p>A significant change assessment, dated 02/14/25, showed Resident #83 had a diagnosis of a stroke and the COVID-19 vaccination was not up to date.</p> <p>Review of the immunization tab in the electronic clinical record did not show when the resident had been offered or received the COVID-19 vaccination.</p> <p>On 05/07/25 at 1:04 p.m., the DON stated Resident #83 must have been out of the facility when they had offered the COVID-19 vaccination during a COVID clinic. The DON stated, We must have missed it.</p>		