

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Woodview Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  1630 3rd Avenue Northeast 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>51813</p> <p>Based on observation, record review, and interview, the facility failed to implement a fall prevention per the resident's care plan for one (#13) of three sampled residents reviewed for falls.</p> <p>The administrator reported 44 residents resided in the facility.</p> <p>A Falls - Clinical Protocol policy, dated March 2018, read in part, If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling .The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.</p> <p>Resident #13 had diagnoses which included Alzheimer's disease, congestive heart failure, chronic pain, and a history of falls.</p> <p>An MDS assessment, dated 11/25/24, documented Resident #13 had severely impaired cognition. The assessment documented the resident had no falls since admission.</p> <p>A fall risk assessment for Resident #13, dated 11/26/24, documented the resident had a high risk for falls.</p> <p>An incident report, dated 12/02/24, documented Resident #13 was found on the floor. The report documented an intervention was a fall mat to be placed beside the bed and staff would monitor the intervention.</p> <p>A care plan for Resident #13, dated 12/03/24, documented the resident was at risk for falls due to psychotropic medication use and impaired balance. The care plan documented a fall mat would be placed beside the bed.</p> <p>On 12/11/24 at 3:03 p.m., Resident #13 was observed lying in bed asleep. There was no fall mat observed on the floor.</p> <p>On 12/11/24 at 3:07 p.m., CMA #1 checked Resident #13's room and reported there was no fall mat in the room. The CMA reported they were not aware a fall mat was supposed to be in use.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Woodview Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  1630 3rd Avenue Northeast 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/11/24 at 3:27 p.m., the DON reported there should be a fall mat in place for Resident #13. They reported the updated care plan included the fall mat as an intervention to prevent falls.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Woodview Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  1630 3rd Avenue Northeast 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>51813</p> <p>Based on observation, record review, and interview, the facility failed to remove a medication patch as ordered for one (#16) of 10 sampled residents observed during a medication pass.</p> <p>The administrator reported 44 residents resided in the facility.</p> <p>Findings:</p> <p>An Administering Medications policy, dated April 2019, documented medications were to be administered in accordance to prescriber orders, including any required time frame.</p> <p>Resident #16 had diagnoses which included Alzheimer's dementia, hypertension, diabetes, and pain.</p> <p>An MDS assessment for Resident #16, dated 09/13/24, documented the resident was severely impaired with cognition.</p> <p>A care plan for Resident #16, dated 09/16/24, documented the resident had pain and medications would be administered as ordered.</p> <p>A physician's order for Resident #16, dated 10/12/24, documented Lidoderm (lidocaine) adhesive medicated patch 5%, 1 topical, apply to lower back every day at 9:00 a.m., then remove patch every evening at 9:00 p. m.</p> <p>On 12/10/24 at 10:00 a.m., CMA #2 was observed to remove a patch from Resident #16 and observed to apply a new lidocaine patch. CMA #2 reported the patch they removed should have been removed on 12/09/24 at 9:00 p.m. The CMA reported the lidocaine patch was to be applied in the morning, left in place for 12 hours, then removed in the evening.</p> <p>On 12/11/24 at 9:18 a.m., the DON reported CMA #2 had reported the lidocaine patch was not removed as ordered. The DON provided a copy of a medication error report completed on 12/10/24 and reported the physician order was not followed.</p>		