

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER Sequoyah East Nursing Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 701 South Taylor Road Roland, OK 74954	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure the resident's representative was notified of transfer for one (#6) of 1 resident who was reviewed for notification of change.</p> <p>The administrator reported the census was 45.</p> <p>Findings:</p> <p>Resident #6 had diagnoses which included mild intellectual disabilities and a fractured left femur.</p> <p>A quarterly assessment, dated 02/10/24, documented the resident was moderately impaired for daily decision making and required moderate assistance from staff.</p> <p>A nurse noted dated 03/01/24 at 4:10 p.m., documented the resident had been transferred to another facility for therapy.</p> <p>A review of the resident's record did not document the resident's representative had been notified of the transfer.</p> <p>On 03/05/24 at 11:00 a.m., the administrator stated they did not notify the resident's representative because they thought the facility the resident transferred to had contacted them.</p> <p>On 03/07/24 at 10:00 a.m., the administrator stated that when a resident transfers the resident's representative should be notified, and it should be documented in the resident's chart.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to prevent a certified nurse aide from mentally abusing one (#7) of seven sampled residents reviewed for abuse.</p> <p>A facility resident roster, dated 02/29/24, documented 45 residents resided in the facility.</p> <p>Findings:</p> <p>A facility abuse reporting and investigation policy, dated September 2022, read in part, .Abuse is defined . the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish .</p> <p>Resident #7 had diagnoses which included dementia and psychosis.</p> <p>A quarterly assessment, dated 02/07/24, documented Resident #4's cognition was moderately impaired.</p> <p>A progress note, dated 02/04/24 at 1:01 p.m., documented Resident #7 had made the statement, The Indians are after me and they are going to kill my children. It further documented the staff changed the television channel away from a channel that showed old movies.</p> <p>A progress note, dated 02/04/24 at 5:22 p.m., documented Resident #7 again made statements about Indians eating children as well as the regret the resident had about helping black people. It further documented the staff changed the television channel away from a channel that showed old movies.</p> <p>A progress note, dated 02/05/24 at 12:55 p.m., documented the resident had an intake into a community mental health organization.</p> <p>A progress note dated 02/07/24 at 3:01 p.m., documented Resident #7 had participated in 21 minutes of psychotherapy.</p> <p>On 03/05/24 at 12:12 p.m., CNA #14 stated that on 02/06/24 on the evening shift (2:00 p.m. through 10:00 p. m.) they had witnessed CNA #13 antagonize Resident #7 who was reporting to staff that Indians were going to eat their children. CNA #14 stated CNA #13 had asked the resident if they were going to eat her babies. They stated CNA appeared to psychologically torment the resident. They stated they attempted to deescalate the resident, but CNA #13 would not stop talking to the resident. They stated CNA did eventually leave the unit with another staff member.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 2:20 p.m., CNA #15 stated on 02/06/24 they and CNA #14 had gone into the room of Resident #7 who was making comments about Indians eating babies, drinking blood, and scalping. They stated CNA #13 then entered the room and stated they (CNA #13) and CNA #14 were Indians. CNA #13 stated they bet the resident babies tasted good. They stated, the resident then began to cry. They stated the resident asked CNA #13 what they had done with the rest of the children to which the CNA allegedly replied they had eaten them all. They stated they and CNA #14 had tried to calm the resident, but CNA #13 continued to antagonize the resident. They stated they left the unit and asked someone at the nurses' station to remove CNA #13 because of what they were doing. They stated they returned to the unit and told CNA #13 they were needed elsewhere but they stayed another five to ten minutes antagonizing the resident before finally departing.</p> <p>On 03/06/24 at 8:29 a.m., the administrator stated that on 02/12/24 CNA #14 and CNA #15 had informed them of the incident between Resident #7 and CNA #13 which had occurred on 02/06/24. They stated after an investigation CNA #13's employment was terminated.</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to implement facility policy and procedures to ensure that applicants employment history and references were checked; and ensure that applicants registry checks were completed prior to employment.</p> <p>The administrator reported the census was 45.</p> <p>Findings:</p> <p>A facility policy titled Background Check Policy, read in part, The background checks of new employees will be completed prior to the first day of assigned work. The background check results will be documented in the employee file and kept confidential .Following the application, interview, and decision to hire, an offer of employment will be made pending a background check consisting of at least the following: prior employment verification, reference check, license verification and criminal background check . If all background checks meet the facility standards, the applicant will be offered the position .</p> <p>On 03/04/24 at 10:23 a.m., the business office manager stated that they were responsible for checking applicants employment history and references. They also stated that they did not typically document checking the references or employment history. The business office manager stated they were trained to complete the registry checks after the first day of employment.</p> <p>On 03/05/24 at 9:00 a.m., the business office manager was asked for documentation that reference and employment history checks had been completed for CNA's #1, #9 and #10. No documentation was provided.</p> <p>Nineteen staff employment records were reviewed. One record had no documentation of registry checks. Seven records did not have OSDH background check letters. None of the 19 records had documentation that the facility verified previous employment or contacted references.</p> <p>A review of CNA #1's employment file documented the first day of employment was 02/16/24 and the registry checks were completed on 2/18/24.</p> <p>On 03/07/24 at 10:00 a.m., the administrator stated the BOM was responsible for completing and documenting employment history checks and reference checks, and ensuring the registry checks were completed prior to employment.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>34270</p> <p>Based on record review and interview the facility staff failed to report allegations of abuse to their administrator within the timeframe indicated in state regulations for four (#1, 2, 3, and #7) seven sampled residents reviewed for abuse.</p> <p>A facility resident roster, dated 02/29/24, documented 45 residents resided in the facility.</p> <p>Findings:</p> <p>A facility abuse reporting and investigation policy, dated September 2022, read in part, .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of an unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury .</p> <p>1. Resident #1 had diagnoses which included dementia, anxiety, and heart failure.</p> <p>An annual assessment, dated 12/21/23, documented the resident's cognition was intact.</p> <p>An incident report, incident date 02/08/24, documented an allegation of abuse which involved Resident #1 and CNA #2. It further documented the facility's social services director had been informed of the incident on 02/09/24 at 8:30 a.m.</p> <p>2. Resident #2 had diagnoses which included vascular dementia and cerebrovascular disease.</p> <p>A quarterly assessment, dated 12/16/23, documented Resident #2's cognition was severely impaired.</p> <p>An incident report, incident date 02/17/24, documented an allegation of abuse which involved Resident #2 and CNA #1. It further documented the facilities social services director had informed local law enforcement on 02/17/24 at 9:30 p.m.</p> <p>3. Resident #3 had diagnoses which included neurocognitive disorder with Lewy bodies and chronic obstructive pulmonary disease.</p> <p>A quarterly assessment, dated 12/08/23, documented Resident #3's cognition was severely impaired.</p> <p>An incident report, incident date 02/17/24, documented an allegation of abuse which involved Resident #3 and CNA #1. It further documented the facilities social services director had informed local law enforcement on 02/17/24 at 9:30 p.m.</p> <p>4. Resident #7 had diagnoses which included dementia and psychosis.</p> <p>A quarterly assessment, dated 02/07/24, documented Resident #7's cognition was moderately impaired.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An incident report, incident date 02/12/24, documented an allegation of abuse which involved Resident #7 and CNA #13. It further documented the incident actually occurred on 02/06/24 and was reported to the administrator on 02/12/24.</p> <p>On 03/04/24 at 10:05 a.m., the administrator stated they found out about the allegation of abuse regarding Resident #1 at approximately 9:30 a.m. the day after the alleged incident [02/09/24].</p> <p>On 03/06/24 at 8:29 a.m., the administrator stated that on 02/12/24, CNA #14 and CNA #15 had informed them of the incident between Resident #7 and CNA #13 that had occurred on 02/06/24.</p> <p>At 8:40 a.m., the administrator stated the incident regarding Resident #2 and Resident #3 had occurred on 02/17/24 at 12:30 p.m., and reported to them at 8:00 p.m. that evening.</p> <p>On 03/07/24 at 10:30 a.m., the DON stated the staff had not been following policy regarding the reporting of abuse allegations.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270</p> <p>Based on record review and interview the facility failed to revise resident care plans related to falls for three (#1, 5, and #6) of seven sampled residents reviewed for abuse and neglect.</p> <p>A facility resident roster, dated [DATE], documented 45 residents resided in the facility.</p> <p>Findings:</p> <p>A Goals and Objectives, Care Plan policy, dated [DATE], read in part, .Goals and Objectives are reviewed and/or revised: a. when there has been a significant change in the resident condition; b. when the desired outcome has not been reached; c. when the resident has been readmitted to the facility from a hospital /rehabilitation stay; and d. at least quarterly .</p> <p>1. Resident #1 had diagnoses which included dementia, anxiety, and heart failure.</p> <p>A facility face sheet documented Resident #1 was admitted to the facility on [DATE] and discharged [DATE].</p> <p>A review of Resident #1's progress notes from [DATE] through [DATE] found the resident had eight falls during that period. Three of the falls resulted in injury. On [DATE] the resident suffered a skin tear to their right arm, on [DATE] the resident suffered a skin tear to their right arm, and on [DATE] the resident suffered a fracture of their right orbital floor (a fracture of the bones of the right eye socket).</p> <p>2. Resident #5 had diagnoses which included hypertension and emphysema.</p> <p>A Medicare 5-day assessment, dated [DATE], documents the resident was severely impaired for daily decision making. And required moderate assistance with ADL's.</p> <p>A fall care plan, edited [DATE], documented no new fall interventions had been added to the care plan since [DATE].</p> <p>A review of Resident #5's medical record documented the resident had falls on [DATE], [DATE], [DATE], and [DATE].</p> <p>3. Resident #6 had diagnoses which included mild intellectual disabilities and anxiety.</p> <p>A quarterly assessment, dated [DATE], documented the resident was moderately impaired for daily decision making and required partial assistance from staff.</p> <p>A fall care plan, edited [DATE], documented no new fall interventions had been added to the care plan since [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #6's medical record documented the resident had a fall on [DATE] and a fall resulting in a broken left femur on [DATE].</p> <p>On [DATE] at 10:35 a.m., the MDS coordinator stated Resident #1's care plan had not been updated regarding falls since July of 2022. They stated the resident had falls since that time including falls with injuries, but they had not added any new interventions since 2022. They stated they did not know why the falls section of the care plan had not been updated. They stated new interventions were given to them when nurses fill out forms in the fall packet or when they have care plan meetings. They stated the families, and they usually attend the care plan meetings. They stated they send invitations for the meetings to the department heads each week. They stated the department leaders usually do not attend the meeting, but they believe they are required to attend. They stated the medical director had not participated in the care plan meetings. They stated Resident #1 had an annual assessment in December of 2023 but for some reason they did not update the care plan.</p> <p>At 11:08 a.m., the DON stated after review, Resident #1's care plan had not been updated for falls since 2022. They stated the care plan did not reflect Resident #1's condition prior to their death on [DATE]. They stated they had not attended any care plan meetings. They stated they were unaware they were supposed to attend care plan meetings. They stated all departments and staff utilize the care plans. They stated that they honestly did not know much about the care plan process, and it was just their job to assure the MDS coordinator was doing their job.</p> <p>At 11:20 a.m., the administrator stated their expectations for the care plans were that they would be updated regularly and accurately reflect the residents' conditions and treatments. She stated the department heads attend the care plan meetings. They stated they were unaware if the medical director had attended any care plan meetings. They stated Resident #1 had falls since [DATE] including those with injuries. They stated Resident #1 had a fall with a fracture on [DATE]. They stated it was the DON's responsibility to supervise the MDS coordinator to ensure accuracy of their work.</p> <p>On [DATE] at 8:15 a.m., the MDS coordinator stated that even though Residents' #5 and #6 both had recent falls no new care plan interventions had been added since [DATE] for Resident #5 and [DATE] for Resident #6. They also stated that interventions should have been added and they were not sure why they hadn't been.</p> <p>On [DATE] at 10:20 a.m., the DON stated, the facility care planning is awful and the MDS coordinator was not following the care planning policy and procedures.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 Interview and record review it was determined the facility failed to ensure showers were given as ordered for two (#5 and #6) of three residents reviewed for bathing.</p> <p>The administrator reported the census was 45.</p> <p>Findings:</p> <p>1. Resident #5 had diagnoses which included hypertension and emphysema.</p> <p>A Medicare 5-day assessment, dated 11/15/23, documented the resident was severely impaired for daily decision making and required moderate assistance with ADL's.</p> <p>A point of care history sheet, dated February 2024, documented the resident had received two showers and refused two showers during the month of February 2024.</p> <p>2. Resident #6 had diagnoses which included mild intellectual disabilities and anxiety.</p> <p>A quarterly assessment, dated 02/10/24, documented the resident was moderately impaired for daily decision making and required partial assistance from staff.</p> <p>A point of care history sheet, Dated February 2024, documented Resident #6 had received two showers and refused three showers during the month of February 2024.</p> <p>On 03/05/24 at 8:50 a.m., CNA #8 was asked to review the February shower documentation for Resident's #5 and #6. CNA #8 stated both residents were on the Tuesday, Thursday, and Saturday shower schedule, they also stated Resident #5 had received two showers and refused two showers and that Resident #6 had received two showers and refused three showers in February. CNA #8 further stated that on the nine other scheduled shower days for Resident #5 and the eight other scheduled shower days for Resident #6 either the resident did not get a shower, or the shower was given and not documented.</p> <p>On 03/07/24 at 10:00 a.m., the administrator stated the charge nurse should ensure that showers were administered as ordered, but ultimately the DON and administrator were responsible.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270</p> <p>Based on record review and interview, the facility failed to provide supervision to prevent falls for two (#1 and #5) of seven sampled residents reviewed for abuse.</p> <p>A facility resident roster, dated [DATE], documented 45 residents resided in the facility.</p> <p>Findings:</p> <p>A Falls and Fall Risk, Managing policy, revised date [DATE], read in part, .Based on previous information and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant .If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature of the category of falling, until falling is reduced or stopped, or until the reason for the continuation of falling is identified as unavoidable .</p> <p>1. Resident #1 had diagnoses which included dementia, anxiety, and heart failure.</p> <p>A facility face sheet documented Resident #1 was admitted to the facility on [DATE] and discharged [DATE].</p> <p>A care plan problem for falls, located in Resident #1's care plan, had a start date of [DATE]. It documented the care plan problem had an edit date of [DATE]. The problem listed falls on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The goal start date was documented as [DATE] and the goal target date was [DATE]. The problem for falls had 11 approaches (interventions) documented. The approaches listed were:</p> <ul style="list-style-type: none"> a. OT/PT to evaluate and treat, dated [DATE]; b. Avoid use of restraints, dated [DATE]; c. Encourage resident to use environmental devices such as hand grips, handrails, etc., dated [DATE]; d. Check every hour for 30 days, dated [DATE]; e. CNA to offer and assist with toileting every two hours when awake, dated [DATE]; f. Provide the resident a reach extender and teach/encourage use, dated [DATE]; g. Keep call lights in reach at all times, dated [DATE]; h. Keep personal and frequently used items within reach, dated [DATE]; <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>i. Provide the resident a clutter free environment, dated [DATE]; and</p> <p>j. Provide toileting assistance rounds as part of bedtime preparation, date [DATE].</p> <p>A review of Resident #1's progress notes from [DATE] through [DATE] found the resident had eight falls during that period.</p> <p>A progress note, dated [DATE] at 5:44 a.m., documented Resident #1 had slid from a bed onto the floor. It documented the resident received a skin tear to the right arm because of the fall.</p> <p>A progress note, dated [DATE] at 1:21 p.m., documented Resident #1 fell from their wheelchair and received a skin tear to their right arm.</p> <p>A progress note, dated [DATE] at 4:28 a.m., stated Resident #1 had been sitting in a wheelchair next to the nurse station. LPN #5 documented they had heard a noise and when looking in their direction found the resident had fallen forward from their wheelchair. The resident was bleeding from the forehead and there was bruising and swelling around the right eye. The resident was transferred to a local hospital.</p> <p>A hospital record, dated [DATE] at 4:46 a.m., documented Resident #1 had been sent to the hospital after a fall from a wheelchair. The resident was documented as having a large laceration with significant swelling to the right forehead, eye, and cheek. It further documented a CT scan of the head without contrast found the resident had suffered a right orbital floor fracture (fracture of the eye socket).</p> <p>A progress note, dated [DATE] at 9:19 a.m., documented the resident had returned to the facility. Resident was documented as sitting in a wheelchair by the nurse's station, having sutures on the right forehead, and was tearful and in pain. The note stated the resident's aspirin and blood thinner were ordered held for 14 days. The note documented the resident was placed by the nurse's station for observation purposes.</p> <p>A physician's note, dated [DATE] at 9:39 p.m., documented Resident #1 had died at 9:30 p.m.</p> <p>2. Resident #5 had diagnoses which included hypertension and emphysema.</p> <p>A Medicare 5-day assessment, dated [DATE], documents the resident was severely impaired for daily decision making. And required moderate assistance with ADL's.</p> <p>A fall care plan, edited [DATE], documented no new fall interventions had been added to the care plan since [DATE].</p> <p>A review of Resident #5's medical record documented the resident had falls on [DATE], [DATE], [DATE], and [DATE].</p> <p>On [DATE] at 10:35 a.m., the MDS coordinator stated Resident #1's care plan had not been updated regarding falls since July of 2022. They stated they did not know why the falls section of the care plan had not been updated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2024
NAME OF PROVIDER OR SUPPLIER Sequoyah East Nursing Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 701 South Taylor Road Roland, OK 74954	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>At 11:08 a.m., the DON stated after review, Resident #1's care plan had not been updated for falls since 2022. They stated the care plan did not reflect Resident #1's condition on or prior to their death on [DATE].</p> <p>At 11:20 a.m., the administrator stated their expectations for the care plans were that they would be updated regularly and accurately reflect the residents' conditions and treatments. They stated Resident #1's care plan problem of falls had not been updated since July of 2022.</p> <p>On [DATE] at 8:15 a.m., the MDS coordinator stated that even though Resident #6 had recent falls no new care plan interventions related to falls had been added to the resident's plan of care since [DATE]. They also stated interventions should have been added and they were not sure why they hadn't been.</p> <p>On [DATE] at 10:20 a.m., the DON stated, the facility care planning is awful and the MDS coordinator was not following the care planning policy and procedures.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to prevent a licensed nurse from allowing a staff member to work outside their scope of practice by attempting a blood draw for one (#2) of seven residents reviewed for abuse.</p> <p>A facility resident roster, dated 02/29/24, documented 45 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy and procedure, titled Obtaining Blood Specimens from a Direct Venipuncture, revised date March 2022, read in part, .The purpose of this procedure is to provide guidelines for the safe and aseptic sampling of the resident's blood via direct venipuncture .</p> <p>Resident #2 had diagnoses which included vascular dementia and cerebrovascular disease.</p> <p>On 02/29/24 at 11:06 a.m., the ADON stated they had observed the SSD attempt to collect a blood sample from Resident #2. They stated the SSD did use a phlebotomy set to attempt the blood draw in one arm of the resident and check the other arm for a good site. They stated they told the SSD not to try again as the resident would require hydration. They stated they did not give the SSD directions to attempt the blood draw but did not think to stop them.</p> <p>At 11:14 a.m., LPN #3 stated that on 02/08/24 they had witnessed the SSD performing a blood draw on Resident #2. They stated the ADON was present in the room at the time. They stated when they entered the room where the resident was, they observed a tourniquet on the resident's left arm. They then observed the SSD palpating the resident's arm then inserting the needle into it. They stated the SSD then applied a tourniquet to the resident's right arm and palpate. They stated the ADON decided to not try another attempt to obtain a sample as the resident required hydration. They stated the SSD and ADON collected their equipment and departed the resident's room.</p> <p>At 12:42 p.m., the SSD stated that approximately two or three weeks prior to this date they had attempted to draw a blood sample from the left arm of Resident #2. They stated the contract phlebotomist had been unable to get a sample and LPN #3 had requested assistance from the ADON. They stated they and the ADON went to where the resident was, and they (SSD) did attempt to get a blood sample with a phlebotomy set but was unsuccessful. They stated they looked at the other arm but did not attempt because the ADON believed the resident would need to be given fluids first. The SSD stated they were certified as a phlebotomist in the past but were no longer and had not been hired for that position at the facility.</p> <p>On 03/01/24 at 7:55 a.m., the administrator stated that when the SSD was hired, they had mentioned their experience as a certified phlebotomist. They stated they had asked the SSD at that time if they would perform that task there and the SSD declined.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/07/24 at 10:40 a.m., the DON stated the ADON should have stopped the SSD from attempting to collect a blood sample from Resident #2. They stated the ADON was not following policy regarding venipuncture.</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>34270</p> <p>Based on record reviews and interviews the facility failed to ensure a certified nurse aide did not use their bare hands while providing personal care to residents for two (#2 and #3) of seven sampled residents reviewed for abuse.</p> <p>A resident roster, dated 02/29/24, documented 45 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy titled, Standard Precautions, dated September 2022, read in part, .Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease .</p> <p>1. Resident #2 had diagnoses which included vascular dementia and cerebrovascular disease.</p> <p>A quarterly assessment, dated 12/16/23, documented Resident #2's cognition was severely impaired.</p> <p>2. Resident #3 had diagnoses which included neurocognitive disorder with Lewy bodies and chronic obstructive pulmonary disease.</p> <p>A quarterly assessment, dated 12/08/23, documented Resident #3's cognition was severely impaired.</p> <p>A handwritten statement by CNA #6, dated 02/17/24, documented CNA #1 had been observed putting their bare hand down the brief of Resident #3 to check dryness.</p> <p>A handwritten statement by CNA #7, dated 02/17/24, documented CNA #1 had been observed changing the brief of Resident #2 with their bare hand. They stated CNAs ungloved handmade contacted the resident's bare buttocks.</p> <p>A handwritten statement by CNA #5, dated 02/17/24 at 12:30 p.m., documented CNA #1 had placed their ungloved hand down the pants of Resident #2 and then proceeded to perform perineal care without donning gloves.</p> <p>On 03/01/24 at 8:33 a.m., CNA #5 stated they had observed CNA #1 perform perineal care on Resident #2 without donning gloves.</p> <p>On 03/05/24 at 10:45 a.m., LPN #5 stated that on 02/17/24 during the evening shift [they could not recall the time], CNA's #5 and CNA #6 reported that during the previous shift, CNA #1 had performed personal care on Residents #2 and #3 without donning gloves.</p> <p>On 03/07/24 at 10:30 a.m., the DON stated nursing staff know to wear gloves during resident care. They stated CNA #1 did not follow standards of practice and facility policy and their employment had been terminated.</p>		