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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375395 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/02/2024 |
| NAME OF PROVIDER OR SUPPLIER Eufaula Manor Nursing and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1152 Eunice Burns Road Eufaula, OK 74432 | |

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>45913</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were provided with a comfortable, homelike environment for two (#60 and #75) of six sampled residents who were reviewed for noise level/comfortable, homelike environment.</p> <p>The DON identified 76 residents who resided in the facility.</p> <p>Findings:</p> <p>Res #74 had diagnoses which included anxiety.</p> <p>Res #74's progress notes on 07/17/24, 07/19/24, 07/21/24, 07/22/24, 07/24/24, 07/25/24, 07/26/24, 07/30/24, 07/31/24, and 08/02/24 documented behaviors for Res #74 of yelling and screaming.</p> <p>On 07/30/24 between 9:00 a.m. and 10:45 a.m., observed Res #74 yelling loudly the same phrases repeatedly. The resident was also observed to be yelling profanity very frequently. The yelling was continual for approximately 1 hour and 45 minutes.</p> <p>On 08/02/24 at 11:15 a.m., Res #74 was observed to be yelling loudly the same phrases repeatedly for approximately 5 minutes.</p> <p>On 07/30/24 at 10:30 a.m. Res #60 reported they couldn't eat breakfast this am due to Res #74 yelling. Reports the yelling is non-stop all day and night. Res #60 stated, Res #74's yelling is so upsetting to me. Reports they can hear Res #74 yelling even with door closed. Res #60 reported they had a terrible night's sleep. I only slept a few hours and it wasn't quality sleep. Res #60 reported they are catholic and need peace and quiet to pray and does not feel at peace spiritually due to the constant yelling and cursing. During the interview, the door was shut and Res #74 who is on the opposite side of the hall three doors down could be heard clearly yelling and cursing.</p> <p>On 07/30/24 at 10:40 a.m. Res #75's husband was at bedside. Both reported Res #74's (who is next door) screaming keeps Res #75 up at night. The husband stated, it's very disruptive. Res #75 reported the yelling/screaming was non-stop, day and night and has been going on since their admission (07/23/24). Res #75's husband reported they have mentioned the yelling to the staff and stated, they have been very 'apologetic' but have not done anything about it.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 08/01/24 at 9:36 a.m., LPN #2 reported it's normal for Res #74 to yell/scream constantly LPN #2 stated, Other residents can't sleep because of Res #74's yelling.</p> |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure resident assessments were accurate for one (#74) of six sampled residents whose assessments were reviewed for accuracy.</p> <p>The DON identified 76 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility had no policies regarding resident assessments.</p> <p>Res #74 had diagnoses which included anxiety.</p> <p>Res #74's progress notes on 07/17/24, 07/19/24, 07/21/24, 07/22/24, 07/24/24, 07/25/24, 07/26/24, 07/30/24, 07/31/24, and 08/02/24 documented behaviors for Res #74 of yelling and screaming.</p> <p>Progress noted, dated 07/18/24, documented Res #74 had a fall and sustained a laceration above their left eye which resulted in the resident being transferred to the local hospital emergency department where they received seven sutured to the laceration.</p> <p>An admission resident assessment, dated 07/22/24, did not document any behaviors or a fall with injury for Res #74.</p> <p>On 08/02/24 at 2:00 p.m., the administrator reported they had no policies regarding resident assessments and use the RAI Manual as guidance.</p> <p>On 08/02/24 at 3:45 p.m., the MDS Coordinator reported they should have documented the fall for Res #74 as a fall with injury.</p> <p>On 08/02/24 at 3:53 p.m., the social services director reported they were not aware the resident had any behaviors of yelling and screaming. The social services director reported had they known about the yelling and screaming, they would have documented behaviors for Res #74 on their resident assessment.</p> | | |

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| <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>45913</p> <p>Based on observation, record review, and interview, the facility failed to care plan behaviors for one (#74) of six sampled residents whose care plans were reviewed for accuracy.</p> <p>The DON identified 76 residents who resided in the facility.</p> <p>Findings:</p> <p>Res #74 had diagnoses which included anxiety.</p> <p>Res #74's progress notes on 07/17/24, 07/19/24, 07/21/24, 07/22/24, 07/24/24, 07/25/24, 07/26/24, 07/30/24, 07/31/24, and 08/02/24 documented behaviors for Res #74 of yelling and screaming.</p> <p>Res #74's comprehensive care plan did not have a care plan for behaviors.</p> <p>On 07/31/24 between 9:00 a.m. and 10:45 a.m., observed Res #74 yelling loudly the same phrases repeatedly. The resident was also observed to be yelling profanity very frequently. The yelling was continual for approximately 1 hour and 45 minutes.</p> <p>On 08/02/24 at 11:15 a.m., Res #74 was observed to be yelling loudly the same phrases repeatedly for approximately 5 minutes.</p> <p>On 08/02/24 at 4:20 p.m., the MDS Coordinator reported the behaviors for Res #74 should have been care planned.</p> |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure physician's orders were documented properly for one (#49) of six residents whose physician's orders were reviewed for accuracy.</p> <p>The DON identified four residents who had tube feedings</p> <p>Findings:</p> <p>Res #49 had diagnoses which included cerebral infarction and dysphagia.</p> <p>A physician's order, dated 03/29/24, documented Res #49 is to receive Jevity 1.5, 250ml via peg tube every 6 hours.</p> <p>A physician's order, dated 06/12/24, documented Res #49 is to receive Jevity 1.5, 350ml via peg tube every 6 hours.</p> <p>The July and medication administration record documented both feedings were administered each time the resident was administered a feeding.</p> <p>The August medication administration record documented both feedings were administered each time the resident was administered a feeding.</p> <p>On 08/02/24 at 3:32 p.m., the DON reported they aren't sure why there are two physician's orders for Res #49's feeding.</p> <p>On 08/02/24 at 4:05 p.m., the DON reported they wrote a new physician's order to clarify the feeding and reported the nurses were giving one feeding, and if the resident was still hungry, they gave the other feeding. DON reported when the new order was written in June, the old order from March should have been discontinued.</p> <p>On 08/02/24 at 5:51 p.m., LPN #1 reported they were giving Res #49 both feedings. LPN #1 was reported they thought both feedings were to be given because the resident had lost weight. LPN #1 reported they would give one feeding and ask the resident if they were still hungry and give the additional feeding if they were. LPN #1 reported the physician's orders did not document an order to give both feedings if Res #49 was still hungry. LPN #1 reported they now wish they had gotten clarification of the orders because they are confusing and they didn't know what to do.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>33148</p> <p>Based on observation and interview, the facility failed to ensure the kitchen was maintained in good repair.</p> <p>The administrator identified 73 residents received services from the kitchen. Three residents received nutrition and hydration solely through a feeding tube.</p> <p>Findings:</p> <p>On 08/01/24 at 8:30 a.m., a tour of the kitchen was conducted. The following observations were made.</p> <ul style="list-style-type: none"> a. the wall was not finished and base boards were missing in the ice machine area, b. ceiling lights were burned out and/or not working and not shielded, c. base boards were missing in the dish wash area. There were gaps between the wall and the floor, d. the gasket on the walk in cooler door was split on the bottom of the door, e. the metal threshold on the door opening to the walk in cooler was not secure to the floor, f. the metal floor in the walk in cooler was raised and not level. There was brown residue and standing water on the floor, and g. there was an accumulation of ice on the walk in freezer door. <p>On 08/01/24 at 11:02 a.m., the DM was how staff ensure the kitchen was maintained in good repair. They stated they reported to maintenance. They were shown the above observations.</p> |