STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375400	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Hills Nursing Center	2416 North Ann Arbor Oklahoma City, OK 73127

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 35389 Based on record review and interview, the facility failed to ensure a physician ordered psychiatric evaluation was arranged for one (#2) of three sampled residents reviewed for outside appointments. The ADON identified 56 residents resided in the facility. Findings: The facility's Social Services policy, dated 2024, read in part, .social services designee, will pursue the provision of any identified need for medically-related services of the resident .Services to meet the resident's needs may include .Making referrals and obtaining needed services from outside entities . Resident #2 had diagnoses which included depression. A Physician Order, dated 06/11/24, read in part, Psych evaluate and treat as indicated. There was no documentation this order had been acted upon. Social Services was unavailable for interview. On 07/26/24 at 9:34 a.m., LPN #3 stated when a resident's family requested an appointment for a psychologist of licensed therapist, the nurse would notify the physician and the DON. LPN #3 stated the physician would sign the resident up for services and the nurse would print out the order and give it to social services. On 07/26/24 at 9:33 a.m., the DON stated the facility would receive an order for a referral for a psychologist or licensed therapist from the physician. They stated the order would go to Social Services and they would set up an appointment and arrange for transportation. On 07/26/24 at 10:40 a.m., the DON stated Resident #2 had an order for a psychiatric evaluation and treat as indicated that was dated 06/11/24. They stated the facility had a company that came to the facility for these services once a month. They stated Social Services would have gotten with the company to complete the order. The DON stated they were checking to see if the facility had arranged any appointments for this order. (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/26/24 at 12:10 p.m., the DON stated the facility did not arrange for Resident #2 to receive a psychiatric evaluation and treatment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35389 Based on record review and interview, the facility failed to ensure: a. medication was administered as ordered for one (#2); and b. medication was available for administration for one (#2) of three sampled residents reviewed for pain. The ADON identified 56 residents resided in the facility. Findings: The facility's Medication Administration policy, dated 2024, read in part, .Medications are administered .as ordered by the physician and in accordance with professional standards of practice . Resident #2 had diagnoses which included chronic pain syndrome. A Physician Order, dated 05/11/24, documented lidocaine external patch four percent, apply to back topically one time a day related to chronic pain syndrome. The May 2024 TAR documented blanks for the lidocaine patch administration on the 11th, 13th, 14th, and 15th. A Physician Order, dated 06/14/24, documented gabapentin 100 mg give one capsule by mouth one time a day related to chronic pain syndrome. The June 2024 MAR documented blanks for the gabapentin administration on the 14th, 15th, 16th, 17th and 18th. MAR Notes, dated 07/20/24, documented unable to apply, on order per this nurse for the lidocaine patch. MAR Notes, dated 07/21/24, documented on order for the lidocaine patch. The July 2024 TAR documented other see nurse notes on the 20th and 21st. On 07/25/24 at 7:46 a.m., Resident #2 stated they took medication to treat pain. They reported concerns with the as needed medication to treat pain, but were unable to elaborate on what the concerns were. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/26/24 at 9:34 a.m., LPN # 3 stated the facility had a schedule for administering medications to the residents. They stated they referred to the orders to identify what was scheduled. They stated the morning shift ordered medications and the night shift received them and put them away. They stated everyone was responsible to ensure medications were ordered, and the facility had an emergency kit if they ran out. On 07/26/24 at 9:45 a.m., LPN #3 reviewed resident #2's July 2024 administration record and notes for the lidocaine patch and stated it was on order but not in the facility yet. LPN #3 reviewed the June 2024 administration for gabapentin and stated it was ordered to start on the 16th. They stated the medication probably wasn't here and it might have taken pharmacy five days to deliver. LPN #3 reviewed the May 2024 administration record for the lidocaine patch and stated they did not find anything to explain the blanks. On 07/26/24 at 10:15 a.m., the DON stated staff were to verify the resident rights, review the MAR, and administer medications as ordered. They stated the CMAs reordered medication when it was low. They stated the DON or ADON put in new orders and they would arrive in the evening. They stated the ADON pulled a 24 hour report each day and verified new medications were on hand and discontinued medications were pulled off the carts. On 07/26/24 at 10:25 a.m., the DON stated Resident #2's lidocaine was on order for 07/20 and 07/21/24. The DON stated the gabapentin looked like it wasn't given on the 14th, 15th, 16th, 17th, and 18th of June 2024. The DON stated the lidocaine patch wasn't given on the 11th, 13th, 14th, or 15th of May 2024.