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	09/27/2024

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 34460 Based on record review and interview, the facility failed to ensure the advance directive acknowledgement forms were completed for two (#7 and #23) of three sampled residents reviewed for advance directives. The Administrator identified 58 residents resided in the facility. Findings: Resident #7 admitted to the facility 04/11/23. There was no advance directive form found in their electronic health record or their admission packet designating the decision by the resident or the resident's representative. Resident #23 admitted to the facility 05/06/23. There was no advance directive form found in their electronic health record or their admission packet designating the decision by the resident or the resident's representative. On 09/24/24 at 12:56 p.m., social services stated there was no advanced directive found in the admission packet or electronic health record with the decision of the resident or resident representative about advance directives for resident #7 and resident #23.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on observation, record review and interview, the facility failed to ensure Resident Assessments were accurately coded for one (#17) of 15 residents reviewed for assessments. The Administrator identified 58 residents resided in the facility. Findings: A Conducting an Accurate Resident Assessment policy, undated, read in part, qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record. Resident #17 had diagnoses which included generalized anxiety, psychotic disorder with delusions, and sclerosis of central nervous system. A care plan initiated on 06/28/19, documented that Resident #17 had a behavior problem related to dementia and other psychological causes that included continuously screaming out and repeating the same thing. A quarterly Resident Assessment and Care Screening dated 08/23/24, documented that resident #17 had no behaviors during the previous 7 days. On 08/17/24 at 11:13 a.m., a progress note documents, Was a behavior observed? YES On 08/20/24 at 9:15 a.m., a progress note documents, Was a behavior observed? YES On 08/22/24 at 9:15 a.m., a progress note documents, Was a behavior observed? YES On 09/23/24 at 9:36 a.m., LPN #1 stated resident #17 yells out to get staffs attention. On 09/23/24 at 9:36 a.m., Resident #17 was heard yelling help me. LPN #1 acknowledged them. On 09/25/24 from 9:00 to 9:07, CMA #2 tried to get resident to take medications, then LPN #1 tried to get resident #17 to take medications. Resident #17 refused and stated they were upsetting them. On 09/25/24 at 10:20 a.m., CMA #2 and LPN #1 both attempted to convince resident #17 to take their medications. Resident #17 refused. Resident #17 was heard throughout survey yelling help me multiple times per day, even when staff were observed to have just left their room. On 09/26/24 at 9:25 a.m., corporate nurse #1 stated the MDS dated [DATE] was inaccurate in regard to behaviors. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/27/24 at 9:40 a.m., the administrator and corporate nurse #2 were interviewed and corporate nurse #2 stated the policy was to code the MDS accurately.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34460 Based on record review and interview, the facility failed to ensure an accurate comprehensive care plan was developed and implemented for three (#7, #23, and #53) of 24 sampled residents who were reviewed for accurate comprehensive care plans. The Administrator identified 58 residents resided in the facility. Findings: Resident #7 admitted to the facility 04/11/23. They had a diagnosis of vascular dementia with behavioral disturbances, but there was no care plan to address their needs. Resident #23 admitted to the facility 05/06/23. They had an illeostomy, but there was no care plan to address their needs. Resident #53 admitted to the facility 05/10/24. The resident was dependent on staff to provide incontinent care, but the care plan documented, .daily care .toileting .I need staff assistance to use the bathroom . including help transferring on/off toilet . On 09/27/24 at 1:45 p.m., CNA #6 stated they do not toilet (resident #53) on the commode, they can not put on or take off their shoes or pants, and has not changed since they were hired. On 09/27/24 at 1:55 p.m., RN #2 stated care plans should be reviewed and updated.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on record review and interview, the facility failed to ensure a physician's order for monthly catheter changes was followed and failed to ensure a resident with a indwelling urinary catheter received services to help prevent urinary tract infections for one (#35) of two sampled residents reviewed for catheters. The deficient practice resulted in a bladder stone. The MDS Resident Matrix, dated 09/23/24, identified four residents with catheters. Findings: A Clinical Supplies in Case of Emergency policy, reviewed 09/17/24, read in part, It is the policy of this facility to establish procedures to ensure that needed clinical supplies are available to maintain continuity of care in the case of emergency. It also read, Par levels of various supplies will be set, base on use, and procedures for reordering will be followed accordingly to ensure availability of supplies on an ongoing basis. Res #35 had diagnoses which included acute kidney failure and retention of urine. The admission assessment, dated 04/29/24, documented the Brief Interview for Mental Status score of 15 indicating this resident was cognitively intact. A physician order, dated 04/22/24, documented to change indwelling catheter on the 15th of every month on the 10-6 shift starting on the 15th and ending on the 18th every month. The care plan did not mention their refusal to allow nurses to change catheter, or their request for urologist to provide this care. A progress note, dated 05/16/24 at 9:58 a.m., documented the catheter size was not currently in the building. A progress note, dated 05/17/24 at 6:14 a.m., documented the catheter size was on order. A progress note, dated 05/18/24 at 2:25 a.m., documented the catheter size not available that it was on order. There was no documentation that the physician or DON was notified that the catheter had not been replaced. After three days the order was removed from the medication administration notifying the staff that it needed to be done until it appeared again on the following month administration record for the 15th through the 18th. A progress note, dated 06/14/24 at 9:40 p.m., documented the catheter was draining cloudy yellow urine with foul odor and cream sediment observed in the drainage tube. It was documented the physician was notified and Macrobid (antibiotic medication) 100mg twice daily initiated. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 06/15/24 at 10:18 p.m., documented the catheter continues to drain cloudy yellow urine with foul odor and cream color sediment in tube. The catheter was not changed. A progress note, dated 06/16/24 at 9:38 p.m., documented the catheter was draining cloudy yellow urine with foul odor. It was documented the resident was on an antibiotic for UTI. A progress note, dated 06/17/24 at 6:05 a.m., documented the resident refused to have their catheter changed and was witnessed by two nurses. It was documented the resident continued on antibiotics and would continue to monitor. There was no notification of the refusal to the physician or DON. A progress note, dated 06/18/24 at 7:29 a.m., documented resident refused to allow any nurse to change their catheter, as they insisted on the urologist to change catheter. It was documented the physician was notified and gave an order to send to the ER for catheter change. It was documented the resident refused to go to ER. There was no documentation the physician or DON was made aware of their refusal to go to ER or that their catheter had remained unchanged since prior to the 04/22/24 admitted . A progress note, dated 07/16/24 at 6:09 a.m., documented the resident refused catheter change. It was documented they verbalized they would wait unit Wednesday to talk to their new primary care physician to refer them to a urologist instead. It was documented the ADON was notified. A progress note, dated 07/26/24 at 11:12 a.m., documented that resident's catheter was leaking. It was documented two nurses went to room to reinforce the resident's catheter. A progress note, dated 08/02/24 at 6:33 a.m., documented the resident reported not having any urine flow via catheter at 4:45 a.m. It was documented a nurse assessed and found 60cc urine in bag with no leak and abdomen distended. It was documented the resident complained of lower abdominal pain and felt like they were peeing. It was documented the physician was notified and an order was received to change the catheter. It was documented the resident refused stating they wanted a urologist to put in the catheter and wanted to go to ER. It was documented the DON was notified and the resident was transferred to hospital. A hospital update, faxed to the facility on [DATE], documented the resident had a new diagnosis of a bladder stone received on 08/02/24. A progress note, dated 08/08/24 at 4:48 p.m., documented the resident returned from the hospital on 08/08/24 at 3:40 p.m. It was documented a new order for finasteride (5-alpha reductase inhibitor) 5mg was sent with resident. A progress note, dated 08/18/24 at 1:44 a.m., documented the resident refused catheter change stating it was changed in the hospital. A progress note, dated 08/24/24 at 9:18 a.m., documented the resident told the nurse their catheter was leaking and had been disconnected at the hub and they had been reconnecting it. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 08/24/24 at 9:37 a.m., documented the DON and ADON were notified. It was documented the ADON instructed the nurse to send the resident to the hospital to have the catheter changed out. It was documented the resident refused stating they had an appointment with the urologist coming up. A progress note, dated 08/24/24 at 2:56 p.m., documented nurse was allowed by resident to change out the drainage containment part to see if that would help with the leaking. A progress note, dated 09/16/24 at 4:51 a.m., documented the resident refused to have their catheter changed. On 09/26/24 at 2:42 p.m., the ADON was asked the reason the resident was allowed to go so long without having their catheter changed. They stated, Hindsight is 20/20, coulda, shoulda, woulda. I don't know. On 09/27/24 at 9:43 a.m., the administrator and corporate nurse #2 stated the protocol was to notify the DON or administrator if supplies were not in the facility so the administrator could place an order. Corporate Nurse #2 stated the resident should have been educated on the consequences of not changing catheter or allowing staff to provide care. They stated going forward they will just make sure Resident #35 had a urologist appointment monthly to allow the urologist to change their catheter.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49701 Based on interview and record review, the facility failed to provide dietary interventions as ordered by the physician for one (#5) of one resident whose clinical records were reviewed for nutrition. The Administrator identified 58 residents resided in the facility. Findings: A Medication Orders policy, dated 01/08/24, documented Handwritten Order Signed by the Physician- The charge nurse on duty at the time the order is received should note the order and enter it on the physician order sheet or electronic order format . Resident #5 had diagnoses which included severe intellectual disabilities, cerebral palsy, and dysphagia. The Weight Summary documented a weight of 176.8 lbs. on 04/01/24, followed by a weight of 164.0 lbs. on 05/01/24, indicating a 5% decrease in one month. On 05/27/24, the dietician recommended health shakes twice a day to aid in weight loss prevention. On 06/03/24, the physician agreed and ordered weekly weights times four. On 07/01/24, Resident #5's weight was documented as 159 lbs. On 07/23/24, the dietician recommended updating diet orders. On 07/24/24, the physician ordered please get twice daily health shakes on resident #5's orders. On 08/01/24, Resident #5's weight was documented as 156.2 lbs. On 08/01/24, an order for house health shakes three times a day for supplement was placed in the electronic health record. There was no documentation to indicate that weights were done weekly in June as ordered. Health shakes were not provided to the resident as ordered until 08/07/24, two months after initially ordered by physician. On 09/25/24 at 11:58 a.m., the ADON stated once we receive the order the nurse on the floor is responsible to put the physician order in to the computer. On 09/25/24 at 12:12 p.m., the dietician returned call and stated that the physician ordered the health shake on 06/03/24, but it was not started until 08/01/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/27/24 at 9:41 a.m., the administrator and corporate nurse #2 were interviewed and corporate nurse #2 stated that orders should be transcribed to the medication administration record in a timely manner.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46653 Based on record review and interview, the facility failed to ensure a resident who received an antipsychotic medication had an appropriate diagnosis for the use of medication for one (#36) of five sampled residents for psychotropic medication. The Administrator identified 58 residents resided in the facility. Findings: The DON stated 58 residents resided in the facility. The Medication Orders Policy dated, 01/08/24, read in part, This facility shall use uniform guidelines for the ordering of medication. J. Diagnosis or indication of use. Resident #36 had a diagnosis of which included Congestive Heart Failure. On 09/26/24 at 8:32a.m., Resident #36 had a September physician order which documented, Buspirone HCL of 15 MG, start date of 06/29/24 at 6:00 a.m., twice daily, with no diagnosis or reason for administering medication. On 09/26/24 at 8:35a.m., the updated diagnosis record, care plan, gradual dose reduction and nursing level of care assessment plan, had no documentation of anxiety diagnosis found for Resident #36. On 09/26/24 at 8:39a.m., the ADON reported the updated diagnosis sheet, care plan, gradual dose reduction and nursing level of care assessment plan, had no documentation of a diagnosis of anxiety. On 09/26/24 at 8:40a.m., the Regional Director of Clinical Systems reported Resident #36 should have had a diagnosis for the administration anti-anxiety medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49701 Based on observation and interview, the facility failed to ensure the medication room was secured when not in use. The Administrator identified 58 residents resided in the facility. Findings: A Medication Storage policy, dated 01/08/24, read in part, All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. On 09/23/24 at 10:45 a.m., the medication room door was observed propped wide open with the trash can holding the door open. There were no staff inside or in sight. The medication room was located right across from the dining room where multiple mobile residents were located. One resident was observed within four feet of the wide-open door. They were in a wheelchair they could propel themselves. On 09/23/24 at 10:48 a.m., LPN #1 stated the policy is to keep the door closed and locked. They stated the other staff just loaded their cart and must have forgot to close the door. On 09/27/24 at 9:38 a.m., the administrator and corporate nurse #2 were interviewed and corporate nurse #2 stated the policy was to keep medications locked and secured.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49701 Based on observation, record review, and interview, the facility failed to ensure accurate menus were posted and followed for three of three meal services observed. Findings: The Administrator identified 58 residents resided in the facility. The facility's policy Menus and Adequate Nutrition dated 08/01/24, read in part Menus will be posted in the kitchen and in areas accessible by residents at least one week in advance. Menus will be followed as posted. Notification of any deviation from the menu shall be made as soon as practicable. On 09/23/24 at 7:35 a.m., observation of breakfast to be served was oatmeal, scrambled eggs, sausage patties, bacon and toast. The menu guide report documented ham egg cheese skillet was to be served for this meal. On 09/23/24 at 8:10 a.m., cook #1 stated the food was already being cooked when they arrived. They stated they normally follow the menu. Only the daily menu was posted. The alternatives were not posted and the weekly menu was not posted. On 09/24/24 at 12:23 p.m., residents were observed eating roasted turkey breast, mashed potatoes and gravy, mixed vegetables, and buttered corn muffins. The alternatives were not posted and the weekly menu was not posted. The menu guide report documented roasted turkey breast, wild rice greens of choice, and buttered corn muffin were to be served for this meal. The dietary manager stated they changed the rice to mashed potatoes because the residents just had rice for lunch yesterday. On 09/25/24 at 8:10 a.m., residents were observed eating oatmeal, scrambled eggs, sausage, bacon, and biscuit with gravy. The menu guide report documented blueberry pancakes were to be served for this meal. On 09/25/24 at 2:18 p.m., cook #1 stated they did not get the supplies to make blueberry pancakes, so they made the decision on what to serve instead. The alternatives were not posted and the weekly menu was not posted. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/25/24 at 3:12 p.m. the dietary manager was on the phone with the corporate executive. The dietary manager stated their supply company only forgot the blueberries, but they did have pancake mix. The dietary manager stated their supply company was often out of the things that were on the menu making it difficult to follow the menu. The corporate executive stated we are not supposed to make substitutions all the time, only for extenuating circumstances or for resident preferences. The corporate executive stated they would work on getting the menu updated to reflect resident preferences and items the supply company would be able to supply. They stated an accurate menu was supposed to be posted for residents to access, but they did not want to post alternatives in case they didn't always have them available. On 09/26/24 at 1:25 p.m., CNA #1 stated staff does not ask what residents want for breakfast they get what the kitchen provides. [NAME] #1 stated residents get whatever they previously stated they wanted and then if they don't want that, the aides will let the kitchen know to make the residents something else. On 09/27/24 at 9:30 a.m., the administrator stated residents should be able to know what is on the menu at least a week ahead of time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49701 Based on observation, record review, and interview, the facility failed to ensure food was maintained at an appropriate temperature for two of two kitchen observations and maintain a sanitary tray line for one of two kitchen observations. The administrator identified 58 residents resided in the facility. Findings: A Record of Food Temperatures policy, reviewed 01/08/24, read in part, Hot foods will be held at 135 degrees Fahrenheit or greater. A Maintaining a Sanitary Tray Line policy, reviewed 01/08/24, read in part, Change gloves when activities are changed, or when the type of food being handles is changed, or when leaving the workstation. It also read, Periodically monitor food temperatures throughout the meal service to ensure proper hot (at or above 135 degrees) or cold holding temperatures (at or below 41 degrees) are maintained. On 09/23/24 at 7:35 a.m., the food to be served was observed sitting on the grill of the stove. The temperature of the pureed sausage was noted to be at 113.2 degrees Fahrenheit. [NAME] #1 stated the facility had not had a steam table in years. On 09/23/24 at 7:42 a.m., cook #1 is observed wearing gloves to prepare plates. [NAME] #1 is observed spreading out the menu cards onto the prep table to be read, then proceeding to dish out food including touching toast with gloved hands that were just touching menu cards and prep table. [NAME] was noted to only change gloves once during entire service. On 09/23/24 at 8:10 a.m., [NAME] #1 stated the policy was to try not to touch foods with same gloves. They stated the prep table should have been cleaned today, but they did not clean it. On 09/24/24 at 8:15 a.m., the test tray was handed to surveyor directly from the serving line that was on the grill, with temperatures recorded to be eggs 110 degrees, sausage patty 98 degrees, hash brown 94 degrees. On 09/27/24 at 9:35 a.m., the administrator stated staff are supposed to temperature check food before providing to the residents to prevent food borne illness. The administrator stated staff are supposed to wash hands and change gloves between touching different surface areas.

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	09/27/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49701 Based on observation and interview, the facility failed to ensure glucometers were disinfected appropriately before and after use on residents. The administrator identified 58 residents resided in the facility. Findings: A Glucometer Disinfection policy, undated, read in part, The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. On 09/25/24 at 10:24 a.m., LPN #1 was observed pulling a glucometer from the cart and using it on a resident to obtain blood sugar level. LPN #1 sanitized their hands and wore gloves but did not disinfect the glucometer before or after use. On 09/25/24 at 10:28 a.m., LPN #1 stated, The policy was to clean the glucometer before and after using. They stated they did not clean the glucometer. On 09/27/24 at 9:38 a.m., the administrator and corporate nurse #2 stated, The policy was to cleanse the glucometer properly before and after use.