STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375405	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrah Nursing Center	2400 Whites Meadow Drive Harrah, OK 73045

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41318 Based on record review and interview, the facility failed to notify a resident's representative of changes with medications for one (#38) of one sampled resident reviewed for notification of change. The administrator identified 72 residents resided in the facility. Findings: Resident #38 had diagnoses which included anxiety disorder and osteoarthritis. A Third Party Facility Communication Form, dated 01/20/25, documented Resident #38's morphine (a narcotic) and Ativan (a benzodiazepine) was discontinued. There was no documentation the resident's representative was notified of the changes. On 01/27/25 at 2:56 p.m., Resident #38's family member stated the facility staff never contacted them with changes. On 01/30/25 at 8:33 a.m., LPN #1 stated they were to notify the resident's representative when there were medication changes. They stated if they received a third part communication form, they were to input the orders and notify the resident's representative. On 01/30/25 at 8:36 a.m., LPN #1 was asked to review Resident #38's third part communication form and was asked if the resident's representative had been notified of the changes. They stated they did not locate where the resident's representative had been notified.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41318 Based on observation, record review, and interview, the facility failed to ensure residents were assisted with incontinent care for one (#19) of one sampled resident reviewed for ADL care. The administrator identified 72 residents resided in the facility. Findings: An ADL policy, dated March 2018, documented residents who were unable to carry out ADLs independently would receive services to maintain good personal hygiene. Resident #19 had diagnoses which included muscle weakness and need for assistance with personal care. A Care Plan, dated 10/31/24, documented to check Resident #19 every two hours and provide incontinent care as needed. An Admission assessment, dated 11/20/24, documented Resident #19 had moderate cognitive impairment. It documented they had impairments to both lower extremities, were frequently incontinent of urine, and was dependent on staff for toileting. On 01/28/25 at 8:14 a.m., Resident #19 was observed laying in their bed. They stated a staff member came in at 1:30 a.m., and stated they would be back to change them, but never came back. A strong urine odor was smelled in the resident's room. On 01/28/25 from 8:17 a.m. to 8:41 a.m., CNA #1 was observed to provide incontinent care to Resident #19. Resident #19's brief was observed saturated with urine. The resident's shirt, bed pad, and fitted sheet were observed wet. The pillow case and mattress under Resident #19 were observed wet. While CNA #1 was cleaning Resident #19, Resident #19 stated, I don't think I have ever been this wet. On 01/28/25 at 8:56 a.m., CNA #1 stated Resident #19 had never been that wet when they had changed them. CNA #1 stated Resident #19 should have been changed about 5:00 a.m. this morning, but Resident #19 stated they had not been changed all night. CNA #1 stated Resident #19 was incontinent, but could tell the staff when they needed to be changed. On 01/30/25 at 9:04 a.m., the DON stated staff were to check and change residents every two hours and as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41318 Based on record review and interview, the facility failed to ensure the fall policy was implemented for one (#37) of three sampled residents reviewed for accidents. The administrator identified 72 residents resided in the facility. Findings: A Fall policy, dated March 2018, documented the physician would identify medical conditions affecting the fall risk. It documented the staff and the physician would identify possible causes of falls within 24 hours. It documented the staff and the physician would identify pertinent interventions to try and prevent further falls. It documented the staff and the physician would monitor and document the individual's response to interventions. Resident #37 had diagnoses which included dementia, anxiety, and concussion. An Annual assessment, dated 05/29/24, documented Resident #37's cognition was severely impaired. It documented they were independent with bed mobility and ambulation. It documented the resident had two falls since the prior assessment. A Fall Risk assessment, dated 10/19/24, documented Resident #37 was at high risk for falls. A facility Incident Report, dated 10/30/24, documented the resident tripped over the base of a mechanical lift. It documented the intervention was for the equipment to be removed from the hallway. A Fall Risk assessment, dated 11/06/24, documented Resident #37 was at high risk for falls. A facility Incident Report, dated 11/06/24, documented the resident was observed laying on the floor in the hallway next to a mechanical lift. It documented to maintain a clear and clutter free pathway. A Fall Risk assessment, dated 11/16/24, documented Resident #37 was at high risk for falls. A facility Incident Report, dated 11/16/24, documented the resident was laying on the floor with a skin tear to their right forearm. An intervention was not documented. A Fall Risk assessment, dated 12/07/24, documented Resident #37 was at high risk for falls. A facility Incident Report, dated 12/07/24, documented the resident was laying on the floor with a laceration to the right side of their head. An intervention was not documented. On 01/28/25 at 1:46 p.m., Resident #37 was observed with an area to the right side of the head. The area was quarter sized, slightly raised, and had dry blood. The top of the resident's right hand had green and yellow bruising. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 3:06 p.m., the DON stated when a resident had a fall, the staff tried to figure out what happened. The DON stated they would implement interventions after a fall. The Incident Reports, dated 10/30/24 and 11/06/24, were reviewed with the DON. They stated they had repeated similar interventions. The DON was asked if the staff were to remove the equipment from the hallway on 10/30/24, and the resident was observed laying next to the lift on 11/06/24, was the intervention effective. They stated, No. The Incident Report, dated 11/16/24, was reviewed with the DON. They were asked what the intervention was for the fall. They stated there was not one documented. The Incident Report, dated 12/07/24, was reviewed with the DON. They stated the resident's medications were reviewed. The DON was asked where the intervention regarding the medication review was located. They stated they did not see it. They stated they just looked at the medication, but did not request any reduction. On 01/28/25 at 3:32 p.m., the DON was asked if they were familiar with the fall policy. They stated they were. The DON was asked if the physician identified any medical condition affecting Resident #37's fall risk. They stated the physician had not. The DON was asked if the staff and practitioner identified the possible cause of the fall within 24 hours of Resident #37's falls. They stated, No. The DON was asked if the staff and physician identified pertinent interventions to try and prevent further falls for Resident #37. They stated, No. The DON was asked if the staff and physician documented monitoring of the response to interventions related to Resident #37. They stated, No. They were asked if the fall policy had been followed. They stated, No.