

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2024
NAME OF PROVIDER OR SUPPLIER  Baptist Village of Enid		STREET ADDRESS, CITY, STATE, ZIP CODE  5801 North Oakwood Road Enid, OK 73703	

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 - Some</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>41872</p> <p>Based on record review and interview the facility failed:</p> <p>a. to notify the physician for one (#5) of three sampled residents reviewed for physician notification, and</p> <p>b. notify the resident representative for one (#2) of three residents reviewed for a change in condition.</p> <p>The administrator identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>1. Resident #5 had diagnoses which included renal insufficiency, and diabetes mellitus.</p> <p>Resident #5 had a physician order for Eliquis 5 mg tablet two times per day.</p> <p>A nurse's Change in Condition note, dated 04/21/24 at 5:19 a.m., read in part Res was noted with milky thick urine with foul oder [sic]. Encouraged res to drink more water .</p> <p>There was no documentation the physician had been notified.</p> <p>A nursing progress note, dated 05/05/24 at 11:13 p.m., read in part staff reported to this nurse res had bright red blood in brief and toilet x2 this shift res explained past experience r/t bladder and blood transfusion res has no s/s of weakness noted states also f/u in am r/t condition call light et fluids within reach</p> <p>A Change in Condition nurse note, dated 05/06/24 at 6:47 a.m., read in part Res is noted with blood in her brief and in toilet when [they] urinates. Denies pain or discomfort [at] this time.</p> <p>A nursing Daily Note, dated 5/6/24 at 12:48 p.m., read in part blood in urine no blood noted in urine today, res states this happens sometimes, eliquis initially held this AM, until nurse able to assess urine. no blood noted.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A nurse's Daily Note, dated 05/07/24 at 12:49 p.m., read in part staff reported res urine is dark, cloudy and foul odor. UA collected and sent to lab with pending results.</p> <p>There was not documentation the physician had been notified of the blood in the brief on 05/05/24, 05/06/24 and 05/07/24.</p> <p>On 07/17/24 at 8:31 a.m., the DON was asked if the cloudy thick urine and blood in the urine should have been reported to the physician. They stated, Yes.</p> <p>2. Resident #2 had diagnoses which included Alzheimer's, and dysphagia.</p> <p>A Physician order, dated 07/29/23, documented mechanical soft with ground meat and nectar thick liquids.</p> <p>A quarterly assessment, dated 06/09/24, documented the resident had a memory problem and was moderately impaired regarding decisions for tasks of daily life.</p> <p>A Radiology Interpretation, dated 06/24/24, documented a chest xray was completed and the impression was congestive heart failure.</p> <p>A East Hall 24 hour communication log, dated 06/26/24, read in part, 11-7 shift . [Residents name] educate staff check lungs Hospice will call .7-3 shift .wont Keep [oxygen] NC on RA sat 90%-92% .3-11 shift . [oxygen] cannula refusal nasty cough nose bleed .</p> <p>A nursing hospice communication note, dated 07/01/24, read in part Received call back from hospice director of nursing on concern about resident being given thin liquids</p> <p>There was no documentation Resident #2's family had been notified of the change in condition.</p> <p>On 07/15/24 at 1:58 p.m., Resident #2's family member was asked if they were notified when there was a change in the residents health. They stated, No, they usually find out some other way.</p> <p>On 07/16/24 at 9:58 a.m., the DON was asked to review a progress note dated 06/24/24 that documented the resident was coughing and their pulse ox had dropped. The resident had been started on Mucinex and a chest xray had been ordered. They were asked if the family had been notified. They stated No.</p> <p>On 07/16/24 at 10:51 a.m., the DON was asked if the family was notified when the resident may have been given thin liquids. They stated, they did not find out about the incident until 07/01/24 then spoke with Hospice. There was no documentation the family had been notified.</p>		

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<p>F 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>41872</p> <p>Based on observation, record review, and interview the facility failed to ensure residents and resident representatives were able to file a grievance form anonymously, and post information regarding the name of the grievance official.</p> <p>The Administrator identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>A Grievance Procedure, revised 03/2018, read in part Whenever the Guest has a need or request that is not being met, the Guest or his/her Representative should .Report it to the person in charge .Additional notices of health care center grievance process will be displayed in prominent locations throughout the health center . Grievance may be given to any friends' team member who will forward the grievance to the Grievance Office or they may file the grievances anonymously in the designated box located .</p> <p>Ombudsman contact name, resident rights, and OSDH complaint poster was observed in a box with a glass cover on the wall near the front entrance.</p> <p>There was no signage to indicate the person to contact to file a grievance or a box to place grievance forms.</p> <p>On 07/15/24 at 2:28 p.m., Resident #3's family member was asked if they knew how to file a grievance. They stated they did not know.</p> <p>On 07/15/24 at 2:49 p.m., the DON was asked was there a sign posted on how a grievance could be filed. They reviewed the signage posted near the front entrance and stated there was not one on how to file a grievance. They stated the information is in the admission packet. They were asked how would the resident know who to ask if time has passed. They stated they were unsure.</p> <p>On 07/15/24 at 3:22 p.m., Resident #4's family member was asked if they knew how to file a grievance. They stated, they were unsure but thought it would be with the social services director.</p> <p>On 07/16/24 at 11:13 a.m., CNA #1 was asked if a resident wanted to file a grievance how did that process work. They stated they would tell the resident to go to the nurse. They were asked if they knew how the process worked. They stated no, they would just send them to the nurse.</p> <p>On 07/17/24 at 6:30 a.m., RN #2 was asked if a resident wanted to file a grievance how did that process work. They stated they were unsure and would take it to the DON or ADON. They were asked who was the grievance official. They were not sure.</p> <p>On 07/17/24 at 6:53 a.m., CNA #2 was asked if a resident wanted to file a grievance how did that process work. They stated they would tell their direct supervisor. They were asked who was the grievance official. They were not sure.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 07/17/24 at 3:04 p.m., the grievance procedure was reviewed with the Administrator. They were asked if there was a letter to identify who the grievance officer was. They stated the social services director is in every care plan meeting. They were asked if there was a box available for residents or representatives to file a grievance anonymously. They stated, No.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41872</p> <p>Based on record review and interview the facility failed to report an allegation of misappropriation of property to the OSDH for one (#5) of three sampled residents reviewed for misappropriation of property.</p> <p>The Administrator identified 65 residents who resided in the facility.</p> <p>Findings:</p> <p>A Grievance Procedure, revised 03/2018, read in part .If there is an allegation of .or misappropriation of Guest property, an incident report outlining corrective and preventative measures will be sent to the Oklahoma State Department of Health and the Department of Human Services .The investigation will consist at least the following .Interviews with any witnesses to the incident or concern .a search of the resident room . An interview with team members having contact with the resident during the relevant periods or shifts of the alleged incident .interviews with the resident's roommate, family members, and visitors .A root cause analysis of all circumstanced surrounding the incident .</p> <p>A Abuse, Neglect, mistreatment and misappropriation of resident property, policy, revised 06/2023 read in part . It is the policy of this health center that reports of abuse .(misappropriation of property) are promptly and thoroughly investigated .the policy also read, The health center will ensure that all alleged violations involving .misappropriation of resident property, are reported immediately .but not later that 2 hours after the allegation is made .</p> <p>An email, dated 02/26/24, read in part I spoke with [resident] .west this morning [they] said that [they] is missing clothing from the time [they] was in isolation 3 gowns and a couple other items . The email was sent to the social services director on 03/04/24.</p> <p>A Concern/Suggestion form, dated 03/04/24, read in part [Resident #5] stopped me this morning to talk about missing clothing .[They] was missing 2 pair of black slacks, 1 denim capris 1 long sleeve striped [sic] turtel [sic] neck, 1 aqua green sweat shirt 2 night gowns. pantsize lz pette [sic]. I asked [laundry] about these items [they] said they were never brought to laundry .</p> <p>A Grievance/Concern Form, dated 03/04/24, (author was Administrator and Social services)read in part Resident stopped me this morning to [NAME] about missing clothing. [They] said [they] was missing two pairs of black slacks, a pair of denim capris, one long sleeve striped turtleneck, a aqua green sweatshirt (name on shirt) [and] two nightgowns . signed by the Administrator.</p> <p>There was no documentation a report had been filed with the OSDH for misappropriation of property. There was no documentation, a search of the room was completed, or staff and other residents were interviewed regarding missing property.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/16/24 at 2:40 p.m., the Administrator was asked if they had concluded what happened to the resident's personal items that were missing. They stated they thought the items were put into a biohazard bag, the resident room was searched and laundry was searched the items were not found. They were asked if they had documented the investigation into the allegation and filed a state report. They stated they did not.</p>

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>41872</p> <p>Based on record review and interview the facility failed to assess, and monitor for one (#5) of seven sampled residents reviewed for change in condition.</p> <p>The administrator identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #5 had diagnoses which included renal insufficiency, and diabetes mellitus.</p> <p>A nurse's Change in Condition note, dated 04/21/24 at 5:19 a.m., read in part Res was noted with milky thick urine with foul oder [sic]. Encouraged res to drink more water .</p> <p>There was no documentation the resident had been monitored for worsening of symptoms.</p> <p>On 07/17/24 at 8:31 a.m., the DON was asked if the Resident should have been monitored for worsening of symptoms. They stated, Yes.</p>