| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375410 | A. Building<br>B. Wing | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Gran Gran's Place | 1110 South Cornwell Drive<br>Yukon, OK 73099 |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>Based on record review and interview, the facility failed to have a trained and designated infection preventionist to oversee the infection control program. The administrator identified 32 residents resided in the facility. Findings:An undated facility INFECTION CONTROL PROGRAM policy, read in part, The goals of the Infection Control Program are to .Insure [sic] compliance with state and federal regulations relating to infection control.An undated, untitled, employee listed did not document a designated infection preventionist.On 04/22/26 at 11:21 a.m., the administrator stated the DON was responsible for infection control surveillance and antibiotic stewardship in the facility. They stated the DON did not complete training required for the infection preventionist role. The administrator stated they did not have a trained and designated infection preventionist since the previous DON left in December 2025.On 04/22/26 at 11:23 a.m., the administrator stated they have not made any attempts to acquire a trained infection preventionist.On 04/22/26 at 11:40 a.m., the DON stated they did not have a formal training for the infection preventionist role. |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, record review, and interview, the facility failed to ensure a care plan was developed for:a. interventions for anticoagulant use for 2 (#1 and #2) of 5 sampled residents reviewed for unnecessary medication; and b. catheter care for 1 (#6) of 2 sampled residents reviewed for catheter care. The administrator identified 32 residents resided in the facility and MDS coordinator #1 identified 15 residents received anticoagulant medication. The DON identified two residents had indwelling catheters. Findings:<br><br>1. On 04/19/26 at 12:56 p.m., Resident #6 was observed to have an indwelling catheter.<br><br>An undated facility Care Plan Policy, read in part, A care plan policy establishes the standard and expectations for creating and maintaining a care plan that reflects the individual needs, preferences, and goals of a resident.Care plan should be comprehensive.Care plans should be regularly reviewed, especially when a client's health or social circumstances change, to ensure ongoing relevance and effectiveness.<br><br>A quarterly assessment for Resident #6, dated 02/05/26, showed the resident's cognition was intact with a BIMS of 15.<br><br>A physician's order for Resident #6, dated 03/12/26, showed to place an indwelling 18 French/cubic centimeter to gravity catheter.<br><br>A care plan for Resident #6, revised 03/12/26, showed indwelling catheter re-inserted with intake and output every shift. The care plan did not contain interventions for catheter care.<br><br>On 04/19/26 at 12:57 p.m., Resident #6 stated the indwelling catheter was placed because they could not empty their bladder.<br><br>On 04/21/26 at 1:33 p.m., LPN #1 stated catheter care was to clean the indwelling catheter tubing and do peri-care each shift and change the indwelling catheter once a month.<br><br>On 04/21/26 at 1:40 p.m., RN #1 stated catheter care included the use of enhanced barrier precautions, cleaning of the catheter tubing during peri-care, and routine catheter change.<br><br>On 04/22/26 at 10:36 a.m., MDS coordinator #1 stated Resident #6's care plan did not have catheter care interventions because there was no physician's order for catheter care.<br><br>2. A care plan for Resident #2, dated 09/12/25, did not include anticoagulant interventions.<br><br>A physician's order for Resident #2, dated 08/18/25, showed Eliquis (anticoagulant blood thinner medication) 2.5 mg one tablet by mouth every 12 hours for anticoagulant.<br><br>A quarterly assessment for Resident #2, dated 02/26/26 showed they received an anticoagulant (blood thinner) medication.<br><br>On 04/21/26 at 2:20 p.m., LPN #1 stated for anticoagulant usage they would look to see if a resident was bruising out of nowhere, a cut that would not stop bleeding, and look at laboratory. They stated<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #2 was on Eliquis and that the anticoagulant monitoring would be under lab reports.<br><br>On 04/21/26 at 2:28 p.m., MDS coordinator #1 stated the anticoagulant side effect monitoring should have been on the care plan and they were aware that it was not.<br><br>3. A physician's order for Resident #1, dated 09/16/24, for Xarelto (anticoagulant medication) 15 mg one tablet by mouth one time a day related to atrial fibrillation.<br><br>A quarterly assessment for Resident #1, dated 03/20/26, showed the resident had diagnoses which included coronary artery disease, atrial fibrillation, and heart failure. The assessment showed the resident was on an anticoagulant.<br><br>A care plan for Resident #1, dated 04/01/26, did not include interventions for the use of an anticoagulant.<br><br>On 04/23/26 at 11:46 a.m., MDS coordinator #1 stated Resident #1's care plan did not have interventions for the use of an anticoagulant. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident had skin assessments performed to prevent pressure ulcers for 2 (#4 and #26) of 2 sampled residents reviewed for wounds. The administrator identified 32 residents resided in the facility. Findings: An undated policy titled Skin Integrity Check, read in part, Complete Skin integrity check (head to toe) weekly on all residents.Record the results of the assessment on the treatment documentation form. 1. A care plan for Resident #4, dated 09/12/25, showed they were a pressure ulcer risk related to urinary incontinence. The care plan showed to monitor skin during all activities of daily living. The care plan did not show to perform skin assessments. A quarterly assessment for Resident #4, dated 02/09/26, showed a reentry date of 05/09/24. The assessment showed they were dependent on mobility, had a stage four pressure ulcer that was not present on admission, and was at risk for pressure ulcers. Monthly physician's orders for Resident #4, dated 04/2026, did not show to perform skin assessments. 2. admission orders for Resident #26, dated 04/06/26, did not show to perform skin assessments. An interim care plan for Resident #26, dated 04/08/26, showed skin treatment orders, but did not show any skin assessment or monitoring. An admission assessment for Resident #26, dated 04/16/26, showed the resident admitted to the facility on [DATE]. The assessment showed the resident had an unstageable wound present on admission and were at risk for pressure ulcers. The assessment showed Resident #26 was dependent for mobility. There was no documentation of full body skin assessments located in Resident #26's medical record. On 04/22/26 at 1:13 p.m., the DON stated the skin assessments were done every time they did the wound treatment. The DON stated residents received a skin assessment upon admission or readmission and when wound care was done. The DON stated the residents that did not have wounds would not have a skin assessment by the nurse if not an admit, instead the CNA notified the nurse if anything of concern was found. They stated they did not have a skin assessment sheet that had been implemented. The DON stated there was documentation of skin assessments in the nurses note with each dressing change. On 04/22/26 at 1:15 p.m., the DON stated performing skin assessments was not in the scope of practice for the CNA. On 04/22/26 at 1:27 p.m., LPN #2 stated they had been doing the skin assessments with wound care but did not document them anywhere. They stated that other than with wound care, a skin assessment was not completed. On 04/22/26 at 1:27 p.m., CNA #1 stated they performed skin assessments when they laid a resident down or changed them, and if they noticed a concern they notified the nurse. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on observation, record review, and interview, the facility failed to obtain a physician's order for catheter care for 1 (#6) of 2 sampled residents reviewed for catheter care. The DON identified two residents who had indwelling catheters resided in the facility. Findings:On 04/19/26 at 12:56 p.m., Resident #6 was observed to have an indwelling catheter.On 04/21/26 at 1:13 p.m., LPN #1 was observed to perform catheter care for Resident #6. Resident #6 had a weak gait and held on to the television stand for support during ambulation from the bed to the recliner upon completion of care.A quarterly assessment for Resident #6, dated 02/05/26, showed the resident needed supervision or touching assistance with toileting hygiene from staff. The assessment showed the resident's cognition was intact with a BIMS of 15.A physician's order for Resident #6, dated 03/12/26, to place an indwelling catheter 18 French/cubic centimeter to gravity.There was no physician's order for catheter care.A care plan Resident #6, revised 03/12/26, showed indwelling catheter re-inserted with intake and output every shift.On 04/21/26 at 8:10 a.m., LPN #1 stated the day shift did not have orders for catheter care for Resident #6.On 04/21/26 at 1:22 p.m., Resident #6 was asked how often staff clean their catheter like LPN #1 just did. They stated they do not unless they were changing their indwelling catheter. Resident #6 stated they cleaned themselves.On 04/21/26 at 1:33 p.m., LPN #1 stated catheter care was to clean the indwelling catheter tubing and do peri-care each shift and change the catheter once a month.On 04/21/26 at 1:34 p.m., LPN #1 stated nurses were responsible for catheter care, but certified nurse aides could perform peri-care.On 04/21/26 at 1:35 p.m., LPN #1 stated Resident #6 did not have an order for catheter care. They stated there should be an order.On 04/21/26 at 1:40 p.m., RN #1 stated catheter care included the use of enhanced barrier precautions, cleaning of the catheter tubing during peri-care, and routine catheter change.On 04/21/26 at 1:51 p.m., RN #1 stated there should be a physician's order for catheter care to ensure documentation of completed care.On 04/22/26 at 9:37 a.m., the DON stated there was no documentation catheter care was completed for the resident since insertion. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on record review and interview, the facility failed to ensure anticoagulant medication was not administered without adequate monitoring for 2 (#1 and #2) of 5 sampled residents reviewed for unnecessary medication.MDS Coordinator #1 identified 15 residents received anticoagulant (blood thinner) medication resided in the facility. Findings:<br><br>1. A physician's order for Resident #1, dated 09/16/24, for Xarelto (anticoagulant medication) 15 mg one tablet by mouth one time a day related to atrial fibrillation.<br><br>There was no order for monitoring side effects of the anticoagulant medication.<br><br>An annual assessment Resident #1, dated 03/20/26, showed the resident had diagnoses which included coronary artery disease, atrial fibrillation, and heart failure. The assessment showed the resident received an anticoagulant medication.<br><br>A care plan Resident #1, dated 04/01/26, did not include interventions for the use of an anticoagulant.<br><br>Medication and treatment administration records for Resident #1 from 04/01/26 through 04/22/26 did not show anticoagulant monitoring for Xarelto. The record showed the medication was administered as ordered.<br><br>On 04/23/26 at 11:43 a.m., LPN #2 stated they had monitored side effects for anticoagulant use but did not document monitoring was completed.<br><br>2. A physician order for Resident #2, dated 08/18/25, showed Eliquis (anticoagulant medication) 2.5 mg every 12 hours.<br><br>A quarterly assessment for Resident #2, dated 02/26/26, showed the resident received an anticoagulant medication.<br><br>A care plan for Resident #2, dated 03/13/26, did not show anticoagulant therapy or monitoring.<br><br>Medication and treatment administration records for Resident #2 were reviewed 02/2026 through 04/2026. The records showed the medication was administered 02/2026 through 04/2026. There was no documentation to show any anticoagulant monitoring for Eliquis.<br><br>On 04/21/26 at 2:30 p.m., LPN #1 stated anticoagulant monitoring was to see if there was bruising out of nowhere or a cut that would not heal and lab. They stated the anticoagulant monitoring was located under the lab section and they had not heard of monitoring anticoagulant medication.<br><br>On 04/21/26 at 2:25 p.m., LPN #1 stated they only documented either in the nurse's notes or in an incident report if the bleeding took a while to stop or labs were ordered. They stated there was not any other documentation on paper for anticoagulant monitoring.<br><br>On 04/21/26 at 2:29 p.m., the DON stated anticoagulant therapy monitoring was on the medication and treatment administration record and were checked off twice a day for nose bleeds, dark stools, blood in the urine, bruising and gums bleeding.<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 04/21/26 at 2:32 p.m., RN #1 stated they only did documentation of monitoring for nose bleeds, dark stools, blood in the urine, bruising and gums bleeding when a resident received two or more blood thinners. They stated they used their nursing judgment for monitoring when not on two or more medications. They stated the instruction was given by their consulting pharmacist.<br><br>On 04/22/26 at 8:49 a.m., RN #1 stated they went by the pharmacy recommendations for the medication. They stated signs and symptoms of bleeding included black tarry stools, nose bleeds, and that it would get reported to the nursing staff, and those residents were on routine labs.<br><br>On 04/22/26 at 8:55 a.m., RN #1 stated staff was educated on what to monitor for but, that it was not documented anywhere.<br><br>On 04/22/26 at 9:50 a.m., pharmacist #1 stated they would probably expect to see documentation of monitoring for signs and symptoms of bleeding for the use of anticoagulant medication. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review, and interview, the facility failed to ensure gloves were used appropriately during wound care for 2 (#4 and #11) of 4 sampled residents reviewed for wounds.The DON identified five residents with wounds resided in the facility. Findings:1. On 04/21/26 at 10:39 a.m., LPN #1 was observed to don a gown and gloves to perform wound care for Resident #4.On 04/21/26 at 10:42 a.m., LPN #1 removed Resident #4's old coccyx wound dressing, cleansed the wound, and applied a new dressing to the resident's wound.LPN #1 did not change their gloves after removing the old dressing, cleaning the wound, and applying the new wound dressing for Resident #4. An undated facility Infection Control policy, read in part, Caregivers must wash their hands before contact with supply of clean dressing or dressing supplies, prior to the dressing or treatment.Once the hands of the caregiver are soiled with wound secretions, they should not come in contact with the remaining clean dressings and other supplies until the gloves are removed and hands washed.A quarterly assessment for Resident #4, dated 02/09/26, showed the resident had one unhealed pressure ulcer.A physician's order Resident #4, dated 04/16/26, showed to cleanse coccyx wound with an antiseptic solution, pat dry, apply calcium alginate (a wound dressing), cover with silicone dressing every day and as needed.2. On 04/21/26 at 11:34 a.m., LPN #1 was observed to don on a gown and gloves. They cleaned Resident #11's left pinky toe and applied new dressing.On 04/21/26 at 11:37 a.m., LPN #1 with the same gloves, cleaned Resident #11's left heel, patted dry, applied betadine (an antiseptic solution) to the wound, and left open to air.On 04/21/26 at 11:38 a.m., LPN #1 with the same gloves, cleaned Resident #11's right leg and applied clean dressing.LPN #1 did not change their gloves between cleaning Resident #11's wound and applying the new dressing. LPN #1 did not change their gloves after treating each wound. A quarterly assessment for Resident #11, dated 02/09/26, showed the resident had diagnoses which included peripheral vascular disease and coronary artery disease. The assessment showed the resident had an unhealed pressure ulcer.A physician's order for Resident #11, dated 04/09/26, showed to cleanse skin tear to lateral right lower extremity with normal saline, patted dry, apply triple antibiotic ointment, collagen, dry dressing, and secure with tape every day.A physician's order Resident #11, dated 04/16/26, showed:a. for the left pinky toe, continue with steri-strips, cover with xeroform (a medicated wound dressing), gauze, island dressing every day, andb. to cleanse left heel wound with normal saline, pat dry, apply betadine and leave open to air.On 04/21/26 at 1:36 p.m., LPN #1 stated the process for glove use during wound care was to change the gloves between each wound. They stated they probably forgot to change their gloves.On 04/21/26 at 1:37 p.m., LPN #1 stated they did not change their gloves between cleaning the wounds and applying new dressing unless their gloves became bloody.On 04/21/26 at 2:05 p.m., the DON stated the process for glove use during wound care was to change gloves after removing old dressing, use alcohol-based hand rub or wash hands, wear new gloves, finish wound care, and change gloves prior to applying new dressing. On 04/21/26 at 2:08 p.m., the DON stated gloves should be changed between multiple wounds on the same resident. |