

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  Haskell Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  405 North Choctaw Haskell, OK 74436	

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to implement their abuse policy for one (#10) of twelve sampled residents reviewed for abuse and one (CNA#1) of five sampled employees whose background checks were reviewed.</p> <p>The administrator identified 35 residents who resided in the facility.</p> <p>Findings:</p> <p>A policy titled ABUSE POLICY read in part, .THIS FACILITY HAS PROCEDURES TO IDENTIFY EVENTS, SUCH AS SUSPICIOUS BRUISING OF RESIDENT, OCCURRENCES, PATTERNS AND TRENDS THAT MAY CONSTITUTE ABUSE .THIS FACILITY HAS PROCEDURES TO INVESTIGATE DIFFERENT TYPES OF INCIDENTS AND IDENTIFY THE STAFF MEMBER/MEMBERS RESPONSIBLE FOR THE INITIAL REPORTING .PROTECT RESIDENTS FROM HARM DURING AN INVESTIGATION .REPORT ALL ALLEGED VIOLATIONS AND ALL SUBSTANTIATED INCIDENTS TO THE STATE AGENCY AND TO ALL OTHER AGENCIES AS REQUIRED .</p> <p>An undated Abuse Policy, read in part, This facility has procedures to screen potential employees for a history of abuse, neglect or mistreating residents. The screening will include .checking with the the appropriate licensing boards and registries.</p> <p>A Background Screening Investigations policy, dated, November 2015, read in part, Our facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on direct access employees .The personnel/human resources director .will conduct background checks .and criminal conviction checks on all potential employee .within two days of an offer of employment or contract agreement .</p> <p>1. Res #10 had diagnoses which included quadriplegia, depressive episodes, mood disorder due to known physiological condition, anxiety disorder, and pain.</p> <p>A care plan, dated 05/24/24, documented the resident had an ADL self care deficit related to a diagnosis of quadriplegia. The care plan documented the resident was at risk of altered psychosocial well being related to no family support and history of ineffective coping mechanisms.</p> <p>The quarterly assessment, dated 08/18/24, documented the resident was not impaired cognitively and was dependent with activities of daily living.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/23/24 at 1:22 p.m., CNA #3 stated nursing staff was told by the DON about a week ago Res #10 and CNA #2 were a couple.</p> <p>On 09/23/24 at 1:34 p.m., LPN #2 stated last week a staff member stated Res #10 and CNA #2 Were trying to get together. The LPN stated they were told by staff the DON was aware of the situation, so they did not take any further action.</p> <p>On 09/25/24 at 8:57 a.m., Res #10 was interviewed regarding their relationship with CNA #2. The resident stated they were good friends and nothing more. The resident stated CNA #2 would sometimes come in early or stay later after their shift to visit them.</p> <p>On 09/25/24 at 9:34 a.m., the administrator stated they were unaware of the relationship between Res #10 and CNA #2 until yesterday when the DON reported it to them. The administrator stated they thought it was a concern if the resident was cognitive and consenting. The administrator stated the previous administrator, when made aware of the relationship, did not investigate or report the incident. The administrator stated an incident report would be completed and the staff member suspended pending the investigation.</p> <p>On 09/25/24 at 10:03 a.m., CNA #2 was interviewed by telephone regarding their relationship with Res #10. The CNA stated two or three weeks ago a meeting was requested with administration regarding their relationship. The CNA stated a meeting was held with the previous administrator, the DON, and the assistant administrator/office manager regarding their relationship. The CNA stated the previous administrator, the DON, and the assistant administrator gave them their blessing regarding their relationship if it had developed into something more than just friends. The CNA stated physical contact with Res #10 were hugs at the time.</p> <p>2. CNA #1 was hired on 10/09/15. There was no background check/clearance letter on file for their most recent date of hire.</p> <p>On 09/26/24 at 9:54 a.m., a representative from OK Screen stated the employee had been separated in the system by another employer on 10/12/15. The representative reported the facility did not put in a new application for CNA #1 upon hire. The representative stated CNA #1 had not been monitored since 2015.</p> <p>On 09/26/24 at 1032 a.m., the administrator stated there should have been a background check completed for CNA #1. The administrator stated they completed annual checks for all employees to ensure they have background checks/clearance letters, and the background check for CNA #1 must have been overlooked.</p> <p>45913</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to report an allegation of abuse for one (#10) of two sampled residents reviewed for abuse.</p> <p>The administrator identified seven allegations of abuse within the last six months.</p> <p>Findings:</p> <p>A policy titled ABUSE POLICY read in part, .REPORT ALL ALLEGED VIOLATIONS AND ALL SUBSTANTIATED INCIDENTS TO THE STATE AGENCY AND TO ALL OTHER AGENCIES AS REQUIRED AND TAKE ALL NECESSARY CORRECTIVE ACTIONS DEPENDING ON THE RESULTS OF THE INVESTIGATION .</p> <p>Res #10 had diagnoses which included quadriplegia, depressive episodes, mood disorder due to known physiological condition, anxiety disorder, and pain.</p> <p>A care plan, dated 05/24/24, documented the resident had an ADL self care deficit related to a diagnosis of quadriplegia. The care plan documented the resident was at risk of altered psychosocial well being related to no family support and history of ineffective coping mechanisms.</p> <p>The quarterly assessment, dated 08/18/24, documented the resident was not impaired cognitively and was dependent with activities of daily living.</p> <p>On 09/23/24 at 1:22 p.m., CNA #3 stated nursing staff was told by the DON about a week ago Res #10 and CNA #2 were a couple.</p> <p>On 09/23/24 at 1:34 p.m., LPN #2 stated last week a staff member stated Res #10 and CNA #2 Were trying to get together. The LPN stated they were told by staff the DON was aware of the situation, so they did not take any further action.</p> <p>On 09/25/24 at 8:57 a.m., Res #10 was interviewed regarding their relationship with CNA #2. The resident stated they were good friends and nothing more. The resident stated CNA #2 would sometimes come in early or stay later after their shift to visit them.</p> <p>On 09/25/24 at 9:34 a.m., the administrator stated they were unaware of the relationship between Res #10 and CNA #2 until yesterday when the DON reported it to them. The administrator stated they thought it was a concern if the resident was cognitive and consenting. The administrator stated the previous administrator, when made aware of the relationship, did not investigate or report the incident. The administrator stated an incident report would be completed and the staff member suspended pending the investigation.</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 - Some</p>	<p>On 09/25/24 at 10:03 a.m., CNA #2 was interviewed by telephone regarding their relationship with Res #10. The CNA stated two or three weeks ago a meeting was requested with administration regarding their relationship. The CNA stated a meeting was held with the previous administrator, the DON, and the assistant administrator/office manager regarding their relationship. The CNA stated the previous administrator, the DON, and the assistant administrator gave them their blessing regarding their relationship if it had developed into something more than just friends. The CNA stated physical contact with Res #10 were hugs at the time.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for one (#10) of two sampled residents reviewed for abuse.</p> <p>The administrator identified seven allegations of abuse within the last six months.</p> <p>Findings:</p> <p>A policy titled ABUSE POLICY read in part, .THIS FACILITY HAS PROCEDURES TO INVESTIGATE DIFFERENT TYPES OF INCIDENTS AND IDENTIFY THE STAFF MEMBER/MEMBERS RESPONSIBLE FOR THE INITIAL REPORTING, LEADING TO THE INVESTIGATION OF ALLEGED VIOLATIONS AND REPORTING OF RESULTS TO THE PROPER AUTHORITIES .</p> <p>Res #10 had diagnoses which included quadriplegia, depressive episodes, mood disorder due to known physiological condition, anxiety disorder, and pain.</p> <p>A care plan, dated 05/24/24, documented the resident had an ADL self care deficit related to a diagnosis of quadriplegia. The care plan documented the resident was at risk of altered psychosocial well being related to no family support and history of ineffective coping mechanisms.</p> <p>A quarterly assessment, dated 08/18/24, documented the resident was not impaired cognitively and was dependent with activities of daily living.</p> <p>On 09/23/24 at 1:22 p.m., CNA #3 stated nursing staff was told by the DON about a week ago Res #10 and CNA #2 were a couple.</p> <p>On 09/23/24 at 1:34 p.m., LPN #2 stated last week a staff member stated Res #10 and CNA #2 Were trying to get together. The LPN stated they were told by staff the DON was aware of the situation, so they did not take any further action.</p> <p>On 09/25/24 at 8:57 a.m., Res #10 was interviewed regarding their relationship with CNA #2. The resident stated they were good friends and nothing more. The resident stated CNA #2 would sometimes come in early or stay later after their shift to visit them.</p> <p>On 09/25/24 at 9:34 a.m., the administrator stated they were unaware of the relationship between Res #10 and CNA #2 until yesterday when the DON reported it to them. The administrator stated they thought it was a concern if the resident was cognitive and consenting. The administrator stated the previous administrator, when made aware of the relationship, did not investigate or report the incident. The administrator stated an incident report would be completed and the staff member suspended pending the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/25/24 at 10:03 a.m., CNA #2 was interviewed by telephone regarding their relationship with Res #10. The CNA stated two or three weeks ago a meeting was requested with administration regarding their relationship. The CNA stated a meeting was held with the previous administrator, the DON, and the assistant administrator/office manager regarding their relationship. The CNA stated the previous administrator, the DON, and the assistant administrator gave them their blessing regarding their relationship if it had developed into something more than just friends. The CNA stated physical contact with Res #10 were hugs at the time.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure a resident assessment was accurate for one (#7) of six sampled residents whose resident assessments were reviewed.</p> <p>The administrator identified 35 residents who resided in the facility.</p> <p>Findings:</p> <p>Res #7 had diagnoses which included major depressive disorder, anxiety, bipolar disorder, and suicidal ideations.</p> <p>Res #7 had a level II PASARR which was completed on 09/22/21.</p> <p>An annual resident assessment, dated 08/29/24, documented Res #7 did not have a level II PASARR.</p> <p>On 09/27/24 at 3:22 p.m., the MDS coordinator stated they miscoded the resident assessment for Res #7. They stated knew the resident had a level II PASARR, but just failed to code it on the resident assessment.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure a resident was competent to self administer medication and report medication errors to the physician for one (#7) of six sampled residents whose medications were reviewed.</p> <p>The administrator identified 35 residents who resided in the facility.</p> <p>Findings:</p> <p>Res #7 had diagnoses which included major depressive disorder, anxiety, bipolar disorder, and suicidal ideations.</p> <p>Res #7's Level II PASARR, dated 09/22/21, documented Res #7 required professional nursing supervision with medication and required medication management.</p> <p>A physician's order, dated 07/05/23, documented an order for folic acid (a supplement) 1 mg daily.</p> <p>A physician's order, dated 07/05/23, documented an order for tamsulosin (a medication for enlarged prostate) 0.4 mg at bedtime.</p> <p>A physician's order, dated 07/05/23, documented an order for Sodium Bicarbonate (a medication for heartburn) 650 mg three times a day.</p> <p>A physician's order, dated 07/05/23, documented an order for calcitriol (a medication for low calcium) 0.25 mcg every other day.</p> <p>A physician's order, dated 07/14/23, documented an order for magnesium (a supplement) 400 mg twice a day.</p> <p>A physician's order, dated 08/31/23, documented an order for atorvastatin (a medication to decrease cholesterol) 40 mg at bedtime.</p> <p>A physician's order, dated 09/01/23, documented an order for fish oil (a supplement) 1000 mg daily.</p> <p>A physician's order, dated 04/19/24, documented an order for buspirone (a medication for anxiety) 5 mg twice a day.</p> <p>A progress note, dated 07/09/24 at 9:59 a.m., documented Res #7 left the facility with their medication to stay with a family member in the hospital.</p> <p>A Release of Responsibility &amp; Medication for Leave of Absence or Discharge and Return form, dated 07/09/24, documented Res #7 left the facility with the following amount of medication:</p> <p>a. folic acid 1 mg - 8 pills,</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Tamsulosin 0.4 mg - 27 pills,</p> <p>c. Sodium Bicarbonate 650 mg - 53 pills,</p> <p>d. calcitriol 0.25 mcg - 12 pills,</p> <p>e. magnesium 400 mg - 43 pills,</p> <p>f. atorvastatin 40 mg - 34 pills,</p> <p>g. fish oil 1000 mg - 27 pills, and</p> <p>h. buspirone 5 mg - 20 pills.</p> <p>A progress note, dated 07/12/24 at 1:56 p.m., documented Res #7 returned to the facility with their medication.</p> <p>A Release of Responsibility &amp; Medication for Leave of Absence or Discharge and Return form, with a return date of 07/12/24, documented Res #7 returned to the facility with the following amount of medication:</p> <p>a. folic acid 1 mg - 6 pills,</p> <p>b. Tamsulosin 0.4 mg - 25 pills,</p> <p>c. Sodium Bicarbonate 650 mg - 47 pills,</p> <p>d. calcitriol 0.25 mcg - 10 pills,</p> <p>e. magnesium 400 mg - 38 pills,</p> <p>f. atorvastatin 40 mg - 28 pills, and</p> <p>g. fish oil 1000 mg - 25 pills</p> <p>h. Buspirone 5mg - 12 pills.</p> <p>The amount of medication returned was reconciled against Res #7's July 2024 MAR with the following discrepancies/errors noted:</p> <p>a. folic acid 1 mg - two doses were missing when there should have been three doses missing,</p> <p>b. Tamsulonsin 0.4 mg - two doses were missing when there should have been three doses missing,</p> <p>c. Sodium Bicarbonate 650 mg - six doses were missing when there should have been nine doses missing,</p> <p>d. calcitriol 0.25 mcg - two doses were missing when there should have only been one dose missing,</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. magnesium 400 mg - five doses were missing when there should have been six doses missing,</p> <p>f. atorvastatin 40 mg - six doses were missing when there should have only been three doses,</p> <p>g. fish oil 1000 mg - two doses were missing when there should have been three doses missing, and</p> <p>h. buspirone 5 mg - eight doses were missing when there should have only been six doses missing.</p> <p>There was no self administration of medication assessment for Res #7. There was no documentation the medication discrepancies/errors were reported to Res #7's physician.</p> <p>On 09/26/24 at 4:15 p.m., the resident stated when they were at hospital with their family member, they took their medication without assistance and stated, I think I did it correctly. I hope I took them right.</p> <p>On 09/26/24 at 4:30 p.m., an interview was conducted with the DON, the corporate nurse and the administrator. The DON stated there was no self administration of medication assessment for Res #7. The corporate nurse stated they thought completing a self administration of medication assessment was only for residents who kept medication at bedside. The corporate nurse stated Res #7 was cognitively intact so they assumed the resident could give themselves their own medication. The DON stated they did not reconcile the returned medication count sheet against the MAR to ensure the resident took their medication properly. The DON stated the medication discrepancy/errors should have been reported to the physician and were not.</p> <p>On 09/27/24 at 9:30 a.m., CNA #4 stated Res #7 took their medication while at the hospital, but they were not sure if the resident took the medication as ordered.</p>		