STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Care Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 33097 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. The administrator identified seven allegations of abuse within the last six months. Findings: 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 . Res #10 had diagnoses which included quadriplegia, depressive episodes, mood disorder due to known physiological condition, anxiety disorder, and pain. 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. The quarterly assessment, dated 08/18/24, documented the resident was not impaired cognitively and was dependent with activities of daily living. 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. 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. 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. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Care Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Care Center	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)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 45913 Based on record review and interview, the facility failed to ensure discharge and entry resident assessments were completed for one (#7) of six sampled residents whose resident assessments were reviewed. The administrator identified 35 residents who resided in the facility. Findings: Res #7 had diagnoses which included cerebral infarction. A progress note, dated 06/24/24 at 2:56 p.m., documented Res #7 left the facility via the facility van to visit their family member at the hospital and stay with another family member. A progress note, dated 06/25/24 at 4:02 p.m., documented Res #7 returned to the facility via the facility van. A progress note, dated 07/09/24 at 9:59 a.m., documented Res #7 left the facility to stay with a family member who was hospitalized . A progress note, dated 07/12/24 at 1:56 p.m., documented Res #7 returned to the facility. There was no discharge return anticipated or re-entry resident assessments completed. On 09/27/24 at 3:27 p.m., the MDS coordinator stated they were not aware discharge and entry tracking resident assessments had to be done when someone was on therapeutic leave. They stated they thought it was only for hospitalization s.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Care Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45913 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. The administrator identified 35 residents who resided in the facility. Findings: Res #7 had diagnoses which included major depressive disorder, anxiety, bipolar disorder, and suicidal ideations. Res #7 had a level II PASARR which was completed on 09/22/21. An annual resident assessment, dated 08/29/24, documented Res #7 did not have a level II PASARR. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Care Center	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)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33097 Based on observation, record review, and interview, the facility failed to: a. ensure a level II PASARR was care planned for one (#7); and b. make a referral to the OHCA after a new serious mental illness diagnosis for one (#9) of two sampled residents whose PASARRs were reviewed. The administrator identified 35 residents who resided in the facility. Findings: 1. Res #7 had diagnoses which included major depressive disorder, anxiety, bipolar disorder, and suicidal ideations. Res #7 had a level II PASARR completed on 09/22/21 and it documented the resident needed a psychiatric consult and counseling services. The care plan for Res #7 did not contain documentation regarding a psychiatric consult or counseling services. On 09/27/24 at 3:22 p.m., the MDS coordinator stated they failed to add interventions as recommended on the PASARR for psych visits/counseling. They stated they usually care planned things like that ,but just failed to do it. 2. Res #9 was admitted to the facility on [DATE]. On 06/29/20 the resident received a diagnosis of schizoaffective disorder. A PASARR level I, dated 04/07/20, documented a level II referral to the OHCA was not required. A form titled PASRR COMMUNICATION FORM, dated 05/24/22, documented notification regarding a diagnosis of schizoaffective disorder was given to the resident. The form did not document who was contacted or if the referral was completed for a level II PASARR. On 09/26/24 at 10:40 a.m., the administrator reviewed the resident's clinical record and stated there was no documentation the OHCA had been contacted regarding the new diagnosis of schizoaffective disorder. 45913

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Care Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45913 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. The administrator identified 35 residents who resided in the facility. Findings: Res #7 had diagnoses which included major depressive disorder, anxiety, bipolar disorder, and suicidal ideations. Res #7's Level II PASARR, dated 09/22/21, documented Res #7 required professional nursing supervision with medication and required medication management. A physician's order, dated 07/05/23, documented an order for folic acid (a supplement) 1 mg daily. A physician's order, dated 07/05/23, documented an order for tamsulosin (a medication for enlarged prostate) 0.4 mg at bedtime. A physician's order, dated 07/05/23, documented an order for Sodium Bicarbonate (a medication for heartburn) 650 mg three times a day. A physician's order, dated 07/05/23, documented an order for calcitriol (a medication for low calcium) 0.25 mcg every other day. A physician's order, dated 07/14/23, documented an order for magnesium (a supplement) 400 mg twice a day. A physician's order, dated 08/31/23, documented an order for atorvastatin (a medication to decrease cholesterol) 40 mg at bedtime. A physician's order, dated 09/01/23, documented an order for fish oil (a supplement) 1000 mg daily. A physician's order, dated 04/19/24, documented an order for buspirone (a medication for anxiety) 5 mg twice a day. 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. A Release of Responsibility & 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: a. folic acid 1 mg - 8 pills, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Care Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. magnesium 400 mg - five doses were missing when there should have been six doses missing, f. atorvastatin 40 mg - six doses were missing when there should have only been three doses, g. fish oil 1000 mg - two doses were missing when there should have been three doses missing, and h. buspirone 5 mg - eight doses were missing when there should have only been six doses missing. 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. 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. 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. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Care Center	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45913 Based on observation, record review, and interview, the facility failed to ensure oxygen tubing and humidifier bottles were changed and labeled monthly for one (#5) of two sampled residents whose oxygen tubing/humidifier bottles were observed. The administrator identified 35 residents who resided in the facility Findings: Res #5 had diagnoses which included COPD, chronic respiratory failure, dyspnea, abnormalities of breathing, and congestive heart failure. A physician's order, dated 07/20/23, documented Res #5's oxygen tubing and humidifier bottle were to be changed and labeled monthly on the 20th of each month. A care plan focus, dated 08/30/23, documented the resident's oxygen tubing and humidifier bottle were to be changed and labeled monthly. A TAR for September 2024, documented Res #5's oxygen tubing and humidifier bottle was changed on 09/20/24. On 09/22/24 at 11:10 a.m., the oxygen tubing and humidifier bottle labels were dated 08/21/24. On 09/23/24 at 2:38 p.m., the oxygen tubing and humidifier bottle labels were dated 08/21/24. On 09/25/24 at 9:41 a.m., the oxygen tubing and humidifier bottle labels were dated 08/21/24. On 09/27/25 at 3:30 p.m., the corporate nurse stated the oxygen tubing and humidifier bottle should have been labeled with a date of 09/20/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375414	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Care Center	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)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 45913 Based on observation and interview, the facility failed to ensure posted staffing information contained projected and actual staffing hours worked. The administrator identified 35 residents who resided in the facility. Findings: On 09/22/24 at 11:05 a.m., a white board at the nursing station was observed to contain the facility name, date, census, staff and their position, but did not contain projected and actual staffing hours worked. On 09/25/24 at 3:54 p.m., a white board at the nursing station was observed to contain the facility name, date, census, staff and their position, but did not contain projected and actual staffing hours worked. On 09/27/24 at 3:52 p.m., the corporate nurse stated they were not aware of the requirements to post projected and actual hours worked.