STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375415	A. Building B. Wing	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Manor	226 E Monroe Street Jay, OK 74346

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 42171 Based on observation and interview, the facility failed to ensure the dignity of a resident was protected for one (#1) of three residents sampled for dignity. The administrator reported the census was 38. Findings: An undated policy titled Resident Rights Policy read in part, .Each resident has a right to a dignified existence, self-determination and exercise of his/her rights .The right to reside in and receive services of the facility with reasonable accommodation of individual needs, maintain quality of life, enhance dignity . Resident #1 had diagnoses which included cirrhosis of the liver and frequent falls. On 01/17/24 at 8:30 a.m., the resident was observed laying on the floor in his room, naked on a fall mat. The door to his room was open and Resident #1 was clearly visible from the hallway. Staff and other residents were observed walking up and down the hallway. On 01/17/24 at 12:32 p.m., Resident #1 was observed laying on the floor in his room, naked on a fall mat. The door to his room was open and Resident #1 was clearly visible from the hallway. Staff and other residents were observed walking up and down the hallway. On 01/17/24 at 2:22 p.m., the resident was observed laying on the floor in his room, naked on a fall mat. The door to his room was open and Resident #1 was clearly visible from the hallway. Staff and other residents were observed walking up and down the hallway. On 1/18/24 at 1:30 p.m., CNA #6 stated the resident should not have been exposed like that. On 1/18/24 at 1:35 p.m., CNA #3 stated the resident was noncompliant, but they should do better protecting the resident's dignity. On 1/23/24 at 4:15 p.m., the DON stated steps should have been taken to protect the resident's dignity.

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 Based on record review and interview, the facility failed to ensure a resident with diabetes mellitus received necessary treatment and services that were consistent with the standards of practice for one (#1) of three residents reviewed for diabetic care. The administrator reported the census was 38. Findings: Resident #1 had diagnoses which included diabetes mellitus and cysts of the pancreas. A baseline care plan, dated 11/25/23, did not document the resident was diabetic. A physician order, dated 11/26/23, documented the resident was to be given glimepiride (a diabetic medication) 4 mg by mouth once a day. An admission MDS, dated [DATE], did not document the resident was diabetic. A review of the resident's medical record did not document the residents blood sugar was being monitored upon admission. A review of the resident's medical record did not document the resident's A1c was being monitored upon admission. An unwitnessed fall report, dated 12/13/23, documented the resident was found on the floor in his room. The fall report document read in part .resident was lying on floor acting like he was trying to get up by grabbing his left leg and then he would start dropping his head back and hitting the back of his head on the floor. This nurse tried several times to get his attention and get him to focus, which he could not. Checked head to toe even when he was throwing his arms and legs. Resident does have knot on the back of his head .resident did not respond to neuro checks .by the time the ambulance arrived resident was in bed snoring like breathing but still not waking and responding to commands and physical or verbal stimuli . A physician order, dated 12/13/23, documented the resident was to start getting FSBS four times a day. A hospital discharge summary, dated 12/15/23, documented upon Resident #1's admission to the emergency room their serum glucose level was less than five. On 01/17/24 at 10:00 a.m., the DON stated the facility knew the resident was diabetic upon admission on 11/25/23 and they didn't know why they weren't monitoring Resident #1's blood sugar. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 01/18/24 at 6:24 p.m., the DON stated that the nurses should be following the physician orders and also monitoring the residents for signs and symptoms of hypoglycemia and hyperglycemia. They tell me that it is not unusual for a resident on oral diabetic medicine to not have routine FSBS ordered but it was unusual for a diabetic resident not to have an A1c ordered on admit and quarterly. On 01/23/24 at 4:15 p.m., the DON stated the baseline care plan and admission MDS probably did not document Resident #1 was diabetic because the documents were rushed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 Based on observation, record review and interview, the facility failed to implement interventions to prevent falls/ minimize injuries for one resident (#1) of three sampled residents reviewed for falls. Resident #1 had 15 falls over 50 days. The last fall resulted in Resident #1 sustaining a facial laceration, hematoma, and their second subdural hematoma related to falls. The administrator reported the facility census was 38. Findings: An undated Fall Prevention Policy read in part, .The care plan will state the goals, interventions and approaches for every resident who is identified as being at risk for falls .The falls prevention approaches will be evaluated by the QA committee to determine the effectiveness of the approaches. With the recommendations of the committee, changes will be implemented to reduce fall risk in the facility. Resident #1 had diagnoses which included history of falls and depression. A Morse Fall Scale, dated 11/25/23, documented a score of 80 which indicates a high risk for falling. An admission MDS, dated [DATE], documented the resident had a history of falls prior to admission. A fall note, dated 11/29/23 at 7:33 p.m., documented the resident was found on the floor near the bed. The note also documented that the resident was reminded to use his call light and that an assessment was conducted, and the resident was without injuries. A fall note, dated 11/30/23 at 9:33 a.m., documented the resident was found on the floor and the resident reported weakness in his legs. No interventions we documented. A fall note, dated 11/30/23 at 2:44 p.m., documented Resident #1 one was found in the floor, it further documented they were trying to go to the bathroom and that Resident #1 was reminded to use the call light. A fall note, dated 12/03/23 at 10:30 p.m., documented the resident was found on floor in bathroom and found to have a large hematoma to top of head, neuro checks were started. The note further documented the resident was educated to wear non-slip socks and use the call light. A fall note, dated 12/07/23 at 11:00 p.m., documented the resident was found on the floor, an assessment was conducted, and the resident was instructed to use the call light for assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A fall note, dated 12/11/23 at 12:46 p.m., documented the resident was found on the floor by the bed. The note also documented redness to left side and mid back was noted and the resident was reminded to use the call light for assistance. An unwitnessed fall report, dated 12/13/23, documented the resident was found on the floor in his room. The fall report document read in part .resident was lying on floor acting like he was trying to get up by grabbing his left leg and then he would start dropping his head back and hitting the back of his head on the floor. This nurse tried several times to get his attention and get him to focus, which he could not. Checked head to toe even when he was throwing his arms and legs. Resident does have knot on the back of his head .resident did not respond to neuro checks .by the time the ambulance arrived resident was in bed snoring like breathing but still not waking and responding to commands and physical or verbal stimuli . No new interventions were documented. A physician order, dated 01/06/24, documented Resident #1's bed was to be in the lowest position. A fall note, dated 01/06/24 at 10:47 a.m., documented the resident was found on the floor and the resident was encouraged to use call light. The note also documented staff were to visit often, no documentation of frequent visits was provided. A fall note, dated 01/07/24 at 9:27 p.m., documented the resident was found on the floor in the bathroom with a large knot noted to back of the resident's head. The note also documented that the resident was reminded to use the call light. A fall note, dated 01/09/24 at 9:24 p.m., documented the resident was found on the floor and was in extreme pain. The note further documents the resident was sent to the emergency room for treatment. No interventions were documented. A nurse note, dated 01/09/24 at 9:35 p.m., documented the resident's family had called and stated the resident had been sent to the hospital with a brain bleed. A nurse note, dated 01/12/24 at 5:50 p.m., documented the resident was readmitted to the facility with a diagnosis of a subdural hematoma. The note further documented the resident was intermittently confused and reminded to use the call light. A fall note, dated 01/14/24 at 00:00 a.m., documented the resident was lying in front of the bathroom door, with scattered bruising to both arms and legs and a new abrasion on the left side. The note further documents that Resident #1 refused to go the ER and that the resident was reminded to use the call light. A fall note, dated 01/15/24 at 9:40 a.m., documented the resident had fallen and was lying on the floor. The note also documented the resident was reminded to use the call light and wear nonslip footwear. A fall note, dated 01/15/24 at 3:30 p.m., documented the resident was found on the floor with no injury. The note further documented the resident would receive frequent visits from staff. Documentation of frequent visits was requested but not received. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A fall note, dated 01/15/24 at 11:15 p.m., documented the resident fell with no injuries. No interventions were documented. A care plan updated 01/17/24, documented to refer to the at-risk plan for interventions. On 01/17/24 at 10:00 a.m., the DON stated the resident was too noncompliant for an at-risk plan. On 01/17/24 at 10:30 a.m., The MDS coordinator stated that Resident #1 does not have an at-risk plan and the facility no longer uses them. They also stated they should stop putting them in the care plan. On 01/17/24 at 1:21 p.m., the DON stated none of the interventions they have put in place for Resident #1 were effective. They also stated that the resident is declining rapidly and does not understand how to use a call light. A fall note, dated 01/18/24 at 5:57 a.m., documented the resident was found on the floor with a hematoma and a cut above the right eyebrow. The note further documented EMS was notified to transfer resident to the ER. A nurse note, dated 01/18/24 at 10:33 a.m., documented the resident was being sent from the ER to another hospital due to a second brain bleed.