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	09/23/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42171 Based on record review and interview, the facility failed to assess, monitor, and intervene for a resident who had increased pain from a fall resulting in a fracture of one (#2) of three sampled residents reviewed for falls. The DON identified the facility census was 38. Findings: An undated facility document titled Fall Prevention Policy, read in part, .If a resident experiences a fall, the charge nurse will complete an Incident Report and document the fall in the resident's record, as well as the 24-hour report. Daily entries regarding the status of the resident's condition will occur each shift for 72 hours following the incident . Resident #2 had diagnoses which included emphysema and muscle weakness. An admission assessment, dated 07/10/24, documented the resident was independent for daily decision making and required moderate assistance from staff with ADLs. It was documented the resident had not experienced pain during the look back period. A physician's order, dated 07/12/24, documented Resident #2 was to receive morphine sulfate concentrate solution (narcotic medication) 20 MG/ML. Give 0.25 ml by mouth every 4 hours as needed for pain. On 08/27/24, the TAR documented Resident #2 received one dose of the as needed morphine for a pain level of 2 out of 10. On 08/28/24, the TAR documented Resident #2 received two doses of the as needed morphine for a pain level rated 7 out of 10. On 08/29/24, the TAR documented Resident #2 received one dose of the as needed morphine for a pain level rated 7 out of 10. On 08/30/24, the TAR did not document the resident received a dose of the as needed morphine. (continued on next page)

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	On 08/31/24, the TAR documented Resident #2 received one dose of the as needed morphine for a pain level rated 8 out of 10. On 09/01/24, the TAR documented Resident #2 received three doses of the as needed morphine for pain levels of 6, 10, and 8 out of ten. On 09/02/24, the TAR documented Resident #2 received one dose of the as needed morphine for pain rated at 7 out of 10. A nurse's note, dated 09/02/24 at 12:54 p.m., documented the resident was sent to the ER for shortness of breath, confusion, and right-side pain. A late entry nurse's note, dated 09/02/24 at 4:28 p.m., documented the DON spoke with the ER physician and the physician stated the resident was complaining of pain related to a fall. The DON informed the physician they were unaware of the resident falling and they would investigate. A late entry nurse's note, dated 09/03/24 at 3:42 p.m., documented the resident had reported a fall to CNA #5 on 08/28/24 at 5:30 a.m. It was further documented CNA #5 reported the fall to RN #1 and that Resident #2 was currently at the hospital awaiting surgery for a hip fracture. An admission assessment, dated 09/18/24, documented Resident #2 had limited daily activities occasionally during the look back period due to pain. It was documented they rated their worst pain in the look back period at an 8 on a scale of 1-10. On 09/19/24 at 7:54 a.m., agency nurse #2 stated if a staff member reported a resident had fallen, they should be assessed, and the physician and family should be notified. On 09/19/24 at 8:02 a.m., LPN #1 stated if a resident had a fall the physician should be notified and the resident should be assessed. On 09/19/24 at 8:44 a.m., LPN #2 stated the physician should be notified and the resident should be assessed immediately. On 09/19/24 at 9:27 a.m., the DON stated if a resident had a fall the expectation was the physician be notified immediately and the resident assessed. On 09/23/24 at 10:10 a.m., the DON stated Resident #2 was sent to the hospital on 09/02/24 for shortness of breath and pain. They stated they called the hospital later to check on the resident and the ER physician stated the resident reported that they had fallen. The DON stated they were unaware of a fall and began an investigation. They stated they determined Resident #2 had reported the fall to a CNA on 08/28/24 around 5:30 a.m. They stated the CNA reported they advised the nurse that Resident #2 had fallen. They stated there was no documentation the nurse assessed the resident, notified the physician/DON, or completed an incident report. The DON stated the hospital determined the resident had a broken hip. They stated from 08/28/24 until Resident #2 went to the hospital on 09/02/24, the resident was asking for pain medications more often than they usually did. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 09/23/24 at 10:58 a.m., LPN #3 stated they had worked the day shift on 08/28/24 and RN #1 did not report to them Resident #2 had fallen. They stated RN #1 did report the resident had complained of hip pain and may have needed an order for an analgesic cream. LPN #3 stated Resident #2 did not complain of pain during their shift. On 09/23/24 at 11:27 a.m., CNA #5 stated on 08/28/24 around 5:30 a.m., Resident #2 reported to them they had fallen hard and broke their hip. CNA #5 stated they informed RN #1 and RN #1 went down to check on Resident #2.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 42171 Based on record review and interview, the facility failed to perform an assessment and notify the physician of a dislodged PEG tube for one (#5) of three sampled residents reviewed for feeding tubes. The DON identified three residents in the facility with feeding tubes. Findings: Resident #5 had diagnoses which included dysphagia and dementia. A care plan intervention, initiated 01/09/24, documented to monitor document and report any signs or symptoms of the tube becoming dislodged, infection, or malfunction of the feeding tube. A nurse's note, dated 01/12/24 at 7:55 p.m., documented Resident #5 pulled the PEG tube out approximately 2 inches and the nurse was unable to replace the PEG tube. It was documented they passed the information to the night nurse to report it to the day nurse. There was no documentation Resident #5 five was assessed or the physician notified. A nurse's note, dated 01/13/24 at 7:29 a.m., documented the nurse assessed Resident #5 and sent them to the hospital for evaluation and treatment. On 09/19/24 at 7:54 a.m., agency nurse #2 stated if a resident dislodged their PEG tube they should be assessed, and the physician should be notified. On 09/19/24 at 8:02 a.m., LPN #1 stated if a resident pulled out their PEG tube the physician should be notified, and the resident should be assessed. On 09/19/24 at 8:44 a.m., LPN #2 stated the physician should be notified and the resident should be assessed immediately. They stated it was not appropriate to just pass it on to the next shift to take care of. On 09/19/24 at 9:27 a.m., the DON stated if a PEG tube was pulled out the expectation was the physician would be notified immediately, and the resident assessed.

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 On [DATE] an Immediate Jeopardy (IJ) was determined to exist related to the facilities failure to provide appropriate tracheostomy care to include replacing a dislodged tracheostomy cannula. On [DATE] at approximately 5:30 a.m., agency nurse #1 entered Resident #1's room and discovered Resident #1's inner cannula had become dislodged and they were bleeding from the tracheostomy site. Agency nurse #1 failed to attempt to reinsert the inner cannula, provide oxygen, address the bleeding, and remain with the resident. On [DATE] at 12:13 p.m., the OSDH was notified and verified the existence of the IJ situation. On [DATE] at 12:23 p.m., the facility administrator was notified of the IJ situation. On [DATE] at 4:06 p.m., an acceptable plan of removal was submitted to the OSDH. The plan of removal documented: 1. Resident (name removed) expired, report sent to Oklahoma State Department of Health and Adult Protective Services. 2. Residents (names removed) tracheostomies were assessed by DON, (name removed) tracheostomy in place and vital signs within comfort zones. 3. DON in-serviced our core staff nurses regarding tracheostomy care and emergency situations on [DATE]. DON oriented agency nurse to facility as well as tracheostomy policy and emergency transportation [DATE]. Core nurses were in-serviced on [DATE] over tracheostomy policy and emergency transportation. 4. All agency nurses will be oriented on facility, tracheostomy policy and emergency situations before beginning shift [DATE]. Tracheostomy observation task placed in PCC per shift to ensure tracheostomy is in place, if not policy will be followed. All items on POR will be completed as of 1600. On [DATE], staff were interviewed regarding recent training/updates related to tracheostomy care and emergency procedure. On [DATE] at 11:17 a.m., the IJ was removed when all components of the plan of removal had been verified. The deficiency remained as an isolated event at a level of potential for harm. Based on record review and interview, the facility failed to provide appropriate tracheostomy care to include replacing a dislodged tracheostomy cannula for one (#1) of three sampled residents reviewed for tracheostomy care. The DON identified two residents in the facility with tracheostomies. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings: An undated facility policy titled Tracheostomy Care, read in part, .Accidental Decannulation .In the event of accidental decannulation, call for help .Attempt to quickly re-insert a new sterile tracheostomy of same size . If this is not possible, insert end of a sterile suction catheter into stoma to help maintain opening .If unable to reinsert, use a bag-valve mask (BVM) resuscitation device (or pocket mask) to ventilate the elder by mouth while covering the tracheostomy stoma with a gloved finger . Resident #1 had diagnoses which included malignant neoplasm of supraglottis and tracheostomy status. A care plan intervention, initiated [DATE], documented Tube out procedures: keep extra trach tube and obturator at bedside. If tube is coughed out, open stoma with hemostat. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. Obtain medical help immediately . A physician's order, dated [DATE] at 3:00 p.m., documented if the trach came out and could not be replaced due to the tumor, give 0.5 ml of morphine concentrate (narcotic medication) immediately and call the hospice provider for an emergency morphine order. A nurse's note, dated [DATE] at 6:53 a.m., documented, This nurse was notified by CNA that resident was asking for this nurse. This nurse entered the resident's room a few minutes later and the resident was laying in [his/her] bed with [his/her] trach pulled out in [his/her] left hand and [his/her] right hand in [his/her] throat while bleeding profusely from throat. This nurse asked if resident could re-insert trach and resident shook [his/her] head no, this nurse stated I'm calling the ambulance, and resident shook [his/her] head yes. This nurse immediately called 911 and asked CNA to see if resident was still bleeding profusely from throat and was told yes from CNA. This nurse hung up with 911 and was told by a CNA that resident was no longer breathing. This nurse immediately checked on resident and resident was taking a breath every ,d+[DATE] seconds and this nurse could not feel a pulse. This nurse immediately called 911 to report the new findings. EMS arrived and resident was no longer breathing and had no pulse. This nurse provided a signed DNR to EMS and resident passed away at 5:48 am. This nurse notified [hospice name withheld] and nurse arrived. This nurse attempted to contact [family member] via phone but [his/her] phone would not connect a call. This nurse attempted to contact [family member] via phone and this nurse left a voicemail. Hospice nurse is here and the body will be discharged to [name withheld] Funeral Home. DON notified by this nurse. On [DATE] at 1:13 p.m., the DON stated agency nurse #1 failed to attempt to reinsert the inner cannula, provide oxygen, address the bleeding, and remain with the resident. On [DATE] at 7:54 a.m., agency nurse #2 stated they had not had training to deal with an emergency decannulation either from their staffing agency or the facility. They stated in the event of an emergency they would get help from the another nurse. They stated there was no orientation for agency staff at the facility. They stated they came to work, received report, and started providing care. On [DATE] at 8:50 a.m., the administrator stated they did not have any documentation of skills check offs for trach care. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:25 a.m., the DON stated there was no formal orientation procedure for agency nurses.