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	08/14/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to ensure a care plan was revised after a resident with a history of elopement attempts was observed by staff opening the facility's locked lobby door for one (#25) of twelve residents reviewed for care plan accuracy. A facility Midnight Census Report, dated 08/10/24, documented 39 residents resided at the facility. Findings: An undated facility policy [NAME] Manor Care Plan Policy, read in part, A comprehensive care plan must be developed within 7 days after the completion the comprehensive assessment and is periodically reviewed and revised by a team of qualified persons after each assessment. Resident #25 had diagnoses which included dementia. A care plan focus located in Resident #25's care plan, dated 05/20/24, read in part, I am an elopement/wanderer (SPECIFY) risk r/t History of attempts to leave facility unattended. The goal connected to the elopement focus was for the resident to remain safe through the next review date and was dated 05/20/24 with a revision date of 08/08/24. There were two interventions attached to the focus. One intervention to assess the resident for falls and a second intervention to attempt to identify the reason the resident attempted to elope. Each intervention was dated 05/20/24. A progress note, dated 06/29/24, documented the resident had been observed by staff attempting to depart the facility through the locked front door. On 08/12/24 at 10:10 a.m., MDS Coordinator #1 stated they did not see how the elopement intervention to assess the resident for falls had any usefulness regarding elopement. They stated the care plan focus for elopement had not been revised following the resident opening the locked door on 06/29/24. On 08/12/24 at 1:19 p.m., CNA #3 stated they had been sitting outside the facility on the date Resident #25 opened the front lobby door. They stated they had heard the alarm for the front lobby door go off and the door open. They stated they could see Resident #25 open the door and then a staff member inside the facility pull their wheelchair back into the lobby. They stated the resident did not exit the building and staff were nearby the resident and responded to the alarm. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 10:02 a.m., the DON stated the facility had done interventions following the attempted elopement but had not documented them. They stated they need to do a better job of care planning.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42171 Based on record review and interview, the facility failed to: a) Ensure side effect monitoring was in place for one (#20) of five residents reviewed for unnecessary medications. b) Ensure PRN psychotropic medication orders are limited to 14 days for one (#26) of five residents reviewed for unnecessary medications. c) Ensure a gradual dose reduction recommendation was addressed by the physician for one (#9) of five residents reviewed for unnecessary medications. The DON identified 29 residents in the facility receiving psychotropic medications. Findings: 1. Resident #20 had diagnoses which included major depressive disorder and insomnia. A care plan intervention, implemented 04/08/22, documented Res #20 was to be given psychotropic medications as ordered and monitored for side effects every shift. A care plan intervention, implemented 11/28/23, documented Res #20 was to be given antidepressant medications as ordered and monitored for side effects every shift. An annual assessment, dated 05/25/24, documented the resident routinely received antipsychotic medication and an antidepressant medication. A review of Res #20's medical records did not document they were being monitored every shift for side effects. On 08/13/24 at 11:32 am, LPN #1 stated side effect monitoring should be documented in the TAR. On 08/13/24 at 12:27 pm, the DON stated they would update Res #20's medical record to include the appropriate side effect monitoring every shift. On 08/14/24 at 8:00 am, LPN #2 stated side effect monitoring for antidepressants and psychotropics should be documented in the TAR. 2. Resident #26 had diagnoses which included anxiety disorder and depression. A quarterly assessment, dated 06/27/24, indicated Res #26 received an antianxiety medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 05/17/23, documented the resident was to receive diazepam (an antianxiety medication) 5mg by mouth PRN every 24 hours. The order did not have a stop date. On 08/13/24 at 11:32 am, the DON stated they were unsure why the order was PRN or why it was ordered for more than 14 days. 34270 3. Resident #9 had diagnoses which included major depressive disorder. An active medication order, dated 11/08/24, documented Resident #9 was to be administered Latuda [an antipsychotic medication] 60 mg once each day at bedtime. A document from the facility's contracted pharmacy, titled Consultant Pharmacist's Medication Regimen Review Active Recommendations Lacking a Final Response, dated 01/29/24, documented Resident #9 had been taking Latuda 60 mg at bedtime since May of 2023. It further documented a pharmacist recommended the resident's physician evaluate the current dose and consider a dose reduction to 40 mg at bedtime. The document further stated there had been no response from the physician. On 08/13/24 at 2:39 p.m., the administrator stated they had called the pharmacy and reviewed their documentation at the facility in regards to the pharmacist's dose reduction recommendation of 01/29/24. They stated they had found no documentation the physician had responded. On 08/14/24 at 10:00 a.m., the DON stated the physician had not followed policy regarding responding to pharmacy recommendations. They stated if a resident did not get a proper dose it could effect them negatively.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34270 Based on observation and interview, the facility failed to ensure an unlocked container of ice was not utilized by residents and visitors. A facility Midnight Census Report, dated 08/10/24, documented 39 residents resided at the facility. Findings: An undated facility Ice Machine / Ice Chest Safety policy, read in part, All employees will use sanitary methods to obtain ice for themselves and for elders and visitors from any ice machine or ice chest. the policy further read in part, Only employees may obtain ice if the use of an ice scoop is needed. On 08/11/24 at 9:51 a.m. a ice chest was observed in the hallway across from the nurses station. The container was full of ice, had an ice scoop located next to it, and there was no lock on the container. On 08/13/24 at 7:33 a.m. a ice chest was observed in the hallway across from the nurses station. The container was full of ice, had an ice scoop located next to it, and there was no lock on the container. On 08/13/24 at 7:35 a.m., CNA #1 stated the ice in the chest was for anyone who needed it. They stated the residents can get their own ice it they want it. On 08/13/24 at 7:42 a.m. CNA #4 stated the ice chest was for staff to give to residents but there was nothing stopping residents or visitors from getting the ice themselves. On 08/13/24 at 7:45 a.m., CNA #3 stated the ice chest was for residents. They stated they had seen family members and resident get ice out of the container. On 08/13/24 at 7:48 a.m., a resident was observed getting ice from the ice chest and putting it into a cup. They stated they always get ice from the container. The resident used the ice scoop but their hand did touch the ice repeatedly. On 08/13/24 at 10:14 a.m., the dietary manager stated they place the ice in the container for the staff to pass out to resident. They stated the residents should not be getting their own ice from the container. On 08/13/24 at 10:14 a.m., the DON stated it was an infection control issue for residents and visitors to get ice from the cooler. On 08/14/24 at 9:41 a.m., the DON stated the staff allowing resident and visitors to get ice from the ice chest were not following infection control standards or facility policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42171 Based on observation, interview and record review, the facility failed to: a) Have a system of surveillance and monitoring designed to identify and prevent Legionnaire's disease. b) Implement a policy and procedure related to enhanced barrier precautions. C) Ensure that infection control practices were followed during wound care for two (#32 and #15) of two residents reviewed for wound care. The administrator reported the census was 39. Findings: 1. On 08/13/24 at 11:40 am, the maintenance supervisor stated they were not aware of any monitoring of the water system related to Legionnaire's disease. On 08/14/24 at 9:56 am, the infection preventionist stated they did not have a program in place to prevent Legionnaire's disease. On 08/14/24 at 10:07 am, the DON stated they needed to implement a water management program at the facility. 2. Resident #32 had diagnoses which included pressure ulcer of the sacral region and diabetes mellitus. On 08/13/24 at 1:20 pm, CNA #1 was observed providing catheter care for Res #32, CNA #1 was not wearing a gown. On 08/13/24 at 2:40 pm, the DON was observed providing wound care for Res #32, the DON was not wearing a gown. On 08/13/24 at 2:40 pm, the DON was observed providing wound care for Res #32. During the procedure, the DON was observed to remove soiled gloves and don clean gloves seven times. On all seven occasions, the DON failed to perform hand hygiene before donning the clean gloves. On 08/14/24 at 7:30 am, RN #1 stated the facility did not use enhanced barrier precautions, and hygiene should be performed before putting on gloves and after removing gloves. On 08/14/24 at 8:00 am, LPN #2 stated they were not familiar with enhanced barrier precautions. On 08/14/24 at 10:07 am, the DON stated they were not using enhanced barrier precautions. On 08/14/24 at 8:00 am, CNA #2 stated hand hygiene should be performed when changing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24 at 10:07 am the DON stated hand hygiene should be performed when changing gloves. 34270 3. Resident #15 had diagnoses which included a stage four pressure ulcer of the sacral region [area of the lower back at the bottom of the spine]. A facility Skin Observation Tool, dated 07/27/24, documented Resident #15 had a stage four pressure ulcer located at the sacral region of their back. On 08/11/24 at 1:09 p.m., Resident #15 stated they did not think the staff changed the bandages on their pressure ulcers as ordered. On 08/12/24 at 2:58 p.m., LPN #1 was observed as they provided wound care to Resident #15. LPN #2 assisted LPN #1 by providing support to the resident during the care. During the wound care Resident #15 required a break and was resting on their back. After the break LPN #1 was observed to grasp the bed pad, that was under the resident's back and buttock, with their gloved hands to assist the resident back onto their side. After the resident was positioned LPN #1 obtained the packing materiel to be used in the sacral pressure wound without first cleaning their hands and changing their gloves. LPN #1 then proceed to pack the material into the wound. On 08/13/24 at 11:37 a.m., LPN #1 stated they had not been 100% confident about the wound care on 08/12/. They stated they believed they should have changed gloves more often. She stated she should have change gloves after touching the bed pad. On 08/14/24 at 10:05 a.m., the DON stated LPN #1 should have change their gloves between making contact with the bed pad and then handling the packing material. They stated LPN #1 had not been following standards of care and facility policy.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42171 Based on record review and interview, the facility failed to ensure influenza vaccinations were offered for two (#32 and #34) of five residents reviewed for immunizations. The administrator reported the census was 39. Findings: An undated Influenza and Pneumonia Immunization Policy read in part, .All residents, staff and volunteers will be offered the influenza vaccine annually .For resident immunizations, documentation of the administration of the vaccine, including education, type of vaccine, lot number and injection site will be documented in the residents' clinical record . 1. Resident #32 had diagnoses which included diabetes mellitus and hypertension. A review of Res #32's immunization record did not document the resident had received or been offered a flu vaccination. 2. Resident #34 had diagnosis which included cerebral palsy and hypertension. A review of Res #34's immunization record did not document the resident had received or been offered a flu vaccination. On 08/14/24 at 9:56 am, the infection preventionist stated no documentation regarding Res #32 or Res #34's vaccination status had been located.