STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375417	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westhaven Nursing Home	1215 South Western Stillwater, OK 74074

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46387 Based on observation, record review, and interview, the facility failed to notify the physician of a new pressure ulcer for one (#4) of one sampled resident reviewed for pressure ulcers. The CMS 802 resident matrix documented two residents had pressure ulcers. Findings: Res #4 had diagnoses which included Alzheimer's disease and dementia. A progress note, dated 07/27/24 at 5:33 a.m., documented Res #4 had an open area measuring 0.5 cm by 0. 5 cm with red tinged drainage. The note documented the wound was cleaned, patted dry, and calazime (barrier cream) was applied. The note did not document the physician was notified. On 08/27/24 at 10:23 a.m., wound care for Res #4 was observed. On 08/27/24 at 11:51 a.m., the DON stated the physician should be notified of new wounds the day they are discovered. They stated they could not see any documentation the physician was notified.

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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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 43023 Based on record review and interview, the facility failed to complete a discharge summary of the residents' stay for three (#60, 67, and #69) of three sampled residents reviewed for discharge. The DON reported 66 residents resided in the facility. Findings: 1. Res #60 was discharged from the facility on 08/22/24. A review of the resident's record did not contain a discharge summary. 2. Res #67 was discharged from the facility on 05/29/24. A review of the resident's record did not contain a discharge summary. 3. Res #69 was discharged from the facility on 05/31/24. A review of the resident's record did not contain a discharge summary. On 08/28/24 at 10:56 a.m., the DON reported the discharge summary's were not completed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35749 Based on observation, record review, and interview, the facility failed to ensure medications were not left at bedside for one (#49) of six sampled resident reviewed for medications. The DON identified 66 residents resided in the facility. Findings: An Administering Medications policy, dated December 2012, read in part, .Medications shall be administered in a safe .manner . An Inservice Education report, dated 11/06/23, read in part, .Medications are not to be placed in residents' room for them to take later. You are to take medication with you, put name and date and placed in medication cart until resident is ready to take medication . On 08/25/24 at 8:33 a.m., Res #49 was observed sitting in their room eating breakfast. Two medication cups were observed on the resident's bedside table. One medication cup contained two white tablets, and the other contained 12-15 tablets/capsules. On 08/25/24 at 8:40 a.m., RN #1 was asked what the policy was for administering medications. They stated staff would check the physician's orders, punch the medications out, initial the MAR, and administer the medications. RN #1 stated they would stay with the resident until they swallowed the medications. On 08/25/24 at 8:43 a.m., RN #1 was shown the two medication cups sitting on Res #49's bedside table. RN #1 told Res #49 they needed to take their medications. Resident #49 informed RN #1 they would take them after they ate breakfast. RN #1 told Res #49 they were going to take the medications and would bring them back after breakfast. Res #49 stated, Why. RN #1 left the two medication cups on the bedside table and left the resident's room.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35749 Based on record review and interview, the facility failed to ensure a MRR pharmacy request to physician had been sent to the physician to be acted upon for one (#6) of five sampled residents reviewed for unnecessary medications. The DON identified 55 residents received psychotropic medications. Findings: A Drug Regimen Review policy, dated 2024, read in part, .The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are reported to the . Director of Nursing .the Primary Physician .physician provides a written response of the report to the facility within one month after the report is sent . Res #6 had diagnoses which included diabetic neuropathy. A physician's order, dated 04/14/21, documented to administer Gabapentin 600 mg TID. A Medication Regimen Review, dated 06/11/24, read in part, Current orders include Gabapentin 600 mg tid. Based on the resident's renal function the maximum recommended dosage is 700 mg bid .Do you feel a dose reduction would be beneficial at this time . There was no documentation in the resident's clinical record the recommendation had been acted upon. On 08/28/24 at 9:12 a.m., the DON was asked to locate the physician response to the MRR pharmacy recommendation letter to the physician. On 08/28/24 at 10:56 a.m., the DON stated they were unable to locate the MRR.

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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. 46387 Based on record review and interview, the facility failed to ensure: a. an as needed psychotropic medication had a 14 day stop date for one (#14), and, b. a MRR psychotropic reduction request was acted upon for one (#37) of five sampled residents reviewed for unnecessary medications. The DON identified 66 residents resided in the facility and 55 residents received psychotropic medications. Findings: 1. Res #14 had diagnoses which included anxiety. A physician order, dated 03/25/24, documented to administer lorazepam 1mg/1ml topically every four hours as needed. The order documented the physician was to re-evaluate on 04/08/24. The order was discontinued on 05/21/24. A physician order, dated 07/15/24, documented to administer lorazepam 1mg/1ml topically every four hours as needed. The order documented the physician was to re-evaluate on 07/29/24. The order was discontinued on 08/05/24. A physician order, dated 08/05/24, documented to administer lorazepam 1mg/1ml topically every four hours as needed. The order documented the physician was to re-evaluate on 08/19/24. The order was discontinued on 08/26/24. On 08/26/24 at 1:46 p.m., Corp. nurse #1 stated when the orders were entered they should have been entered with a set stop date instead of the notation in the body of the order. 35749 2. Res #37 had diagnoses which included anxiety and depression. Physician's orders, dated 09/29/23, documented to administer: a. Lorazepam Tablet 0.5 mg every 6 hours related to anxiety, and b. bupropion extended release 150 mg daily for depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Medication Regimen Review, dated 01/05/24, read in part, .The following medications are due for consideration of gradual dose reduction per state and federal guidelines: bupropion xl 150 mg qd, lorazepam 0.5mg q6h. Do you feel this resident is stable enough to tolerate a trial dosage reduction of either of the above medications at this time . On 08/27/24 at 10:19 a.m., the DON was asked to locate a physician response to the 01/05/24 MRR request to physician. On 08/27/24 at 10:28 a.m., the DON stated they could not locate the MRR request.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43023 Based on observation, record review, and interview, the facility failed to ensure the removal of expired medications and supplies were removed from the medication storage room. The DON reported 66 residents resided in the facility. Findings: On 08/28/24 at 9:20 a.m., a tour of the medication room was completed with the DON. The following medications and supplies were observed to be expired or passed the use by date. 2- boxes of Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg with a use by date of 04/10/24, 1- box of Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg with a use by date of 07/19/24, 2- boxes of Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg with a use by date of 11/23/24, 1- box of Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg with a use by date of 11/25/24, 6- collection and transport swab packets with an expiration date of 02/01/24, 1- bottle Lantus insulin opened and not dated, 1- bottle Milk of Magnesia with a use by date of 05/14/24, 2- bottles Milk of Magnesia with a use by date of 03/22/24, 1- bottle Milk of Magnesia with a use by date of 08/03/24, 1- bottle Milk of Magnesia with a use by date of 05/30/24, 1- bottle Milk of Magnesia with a use by date of 06/05/24, 1- Box Narcan nasal spray with a use by date of 11/02/13, 1- Box Narcan nasal spray with a use by date of 12/07/23, 1- Box Narcan nasal spray with a use by date of 11/02/23. On 08/28/24 at 9:35 a.m., the DON reported the insulin should have been dated when opened and the other medication and supplies should have been removed before the use by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35749 Based on observation, record review, and interview, the facility failed to ensure EBP were implemented during incontinent care and indwelling catheter care for one (#120) of five sampled resident reviewed for infection control. The DON identified nine residents with foley catheters and 23 with EBP's in place. Findings: An undated, Enhanced Barrier Precautions policy, read in part, .EBP .are an infection control intervention designed to reduce transmission of multidrug-resistant organisms .Enhanced Barrier Precautions involve gown and glove during high-contact resident care activities .High-contact resident activities include . Changing briefs .urinary catheter . An Enhanced Barrier Precautions sign, posted on the outside of Resident #120's door, documented staff must wear gloves and a gown during transfers and urinary catheter activity. On 08/25/24 at 9:23 a.m., Res #120 was observed sitting in a wheel chair with a lift sling under them. A urinary drain bag was hooked under the wheel chair. CNA #4 and CMA #1 brought a lift into the room, cleaned their hands, and donned gloves. They attached the sling to the lift and transferred the resident to their bed. CMA #1 provided peri care and indwelling catheter care to Res #120. Resident #120 was turned to their left side and CNA #1 provided incontinent care to the resident's bottom. CMA #1 and CNA #4 did not wear gowns during the incontinent care or indwelling catheter care. On 08/25/24 at 11:06 a.m., CMA #1 was asked what the policy was for EBP. They stated staff would use EBP for residents with COVID, respiratory issues, wound care, skin conditions, scabies, breathing treatments, and for c-diff. CMA #1 was asked if EBP should be implemented during incontinent care and urinary catheter care. They stated they thought it should be.