

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/25/2024
NAME OF PROVIDER OR SUPPLIER  Seminole Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1200 Wrangler Blvd Seminole, OK 74868	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>46582</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan related to pressure ulcers for one (#3) of three residents reviewed for pressure ulcers.</p> <p>The DON identified three residents with pressure ulcers.</p> <p>Findings:</p> <p>Resident #3 had diagnoses which included cerebral infarction, hemiplegia, hemiparesis, and chronic heart failure.</p> <p>A pressure ulcer risk assessment, dated 11/11/23, documented the resident was at moderate risk for development of a pressure ulcer.</p> <p>An admission assessment, dated 11/18/23, documented the resident was moderately cognitively impaired and required substantial to maximum assistance with walking and most activities of daily living. The assessment documented the resident did not have a pressure ulcer/injury upon admission.</p> <p>A nurse note, dated 11/22/23, documented a fluid filled purple discoloration to the left heel and purple/red discoloration to the right heel. The note documented the physician was notified and treatment orders were received.</p> <p>A physician order, dated 11/22/23, documented heel protectors in place at all times and float bilateral heels while in bed.</p> <p>A comprehensive care plan, initiated 11/24/23, did not document Res #3 was at risk for pressure ulcers. The care plan did not document the active pressure ulcers, treatment, monitoring, or preventive measures.</p> <p>A wound physician summary, dated 12/05/23, documented new unstageable deep tissue injuries to the right and left heels.</p> <p>On 01/24/24 at 11:40 a.m., MDS coordinator #1 stated they did not care plan Res #3's pressure ulcers, treatments, monitoring, or preventive measures.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/25/24 at 8:54 a.m., the DON stated Res #3 received pressure ulcer preventive measures and treatments but the pressure ulcer treatments, monitoring, and preventive measures were not documented in the comprehensive care plan.</p>

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46582</p> <p>Based on record review and interview, the facility failed to ensure a discharge summary was completed for one (#3) of one sampled resident reviewed for discharge.</p> <p>The DON identified 21 residents who had discharged home in the last three months.</p> <p>Findings:</p> <p>Res #3 was admitted [DATE] with diagnoses which included chronic heart failure, cerebral infarction, and dementia.</p> <p>A discharge assessment, dated 12/22/23, documented an unplanned discharge with return not anticipated.</p> <p>A nurse note, dated 12/22/23 at 2:58 p.m., read in part, .Resident discharge to home with home health, all medications and belongings sent home with wife, PCP notified of discharge .</p> <p>There was no documentation a discharge summary had been completed.</p> <p>On 01/24/24 at 11:50 a.m., the social services director stated they completed most of the discharge summaries for discharged residents. They stated they had not completed the discharge summary for Res #3.</p> <p>On 01/25/24 at 8:45 a.m., the DON stated the discharge summary for Res #3 had not been completed within thirty days but should have been.</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46582</p> <p>Based on observation, record review, and interview, the facility failed to provide meals in a timely manner.</p> <p>The DON identified 90 residents who received meals from the kitchen.</p> <p>Findings:</p> <p>A Meals and Snacks policy, dated 03/31/21, documented meals shall be scheduled to ensure a maximum of 14 hours from dinner to breakfast on the following day.</p> <p>A schedule of meal times, updated 01/15/24, documented the following meal service times: 8:00 a.m. breakfast, 12:00 p.m. lunch, and 5:00 p.m. dinner.</p> <p>On 01/23/24 at 8:58 a.m., Res # 5 was observed sitting in their room eating breakfast. Res #5 stated meals are often served late which have resulted in food being colder than they preferred.</p> <p>On 01/23/24 at 9:06 a.m., Res #4 was observed lying in bed eating breakfast. Res #4 stated they ate some meals in their room and went to the dining room for other meals. They stated most meals are served at least an hour or longer past the scheduled meal times. Res #4 stated the meals were often cold by the time they received their meal tray.</p> <p>On 01/23/24 from 12:00 p.m. through 1:15 p.m., the lunch meal service was observed.</p> <p>At 12:05 p.m., nine residents were observed in the main dining room waiting for their noon meal. No food had been observed being served from the kitchen. The residents remained without meals until 12:25 p.m. when the first meal tray was served.</p> <p>At 1:15 p.m., the last meal tray was observed having been delivered to the resident in room [ROOM NUMBER] on the north hall of the facility.</p> <p>At 1:45 p.m., the administrator stated noon meal service should begin at 12:00 p.m. and all residents should have their meal within an hour. They stated the noon meal was delivered slightly late for the residents who preferred to eat meals in their rooms.</p> <p>On 01/24/24 from 8:00 a.m. through 9:12 a.m., the breakfast meal service was observed.</p> <p>At 9:12 a.m., the last meal tray was observed having been delivered to the resident in room [ROOM NUMBER] on the north hall of the facility.</p> <p>At 10:30 a.m., the dietary manager stated the breakfast meal was not served to all residents within an hour of the scheduled meal time. They stated dietary services had enough staff to prepare the food but would benefit from additional staff to improve the timeliness of meals being served.</p>