STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seminole Care and Rehabilitation Center	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 33148 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed, a care plan was completed, and a physician order was obtained for the use of a physical restraint for one (#13) of one sampled resident reviewed for physical restraints. The DON identified there were no residents with restraints Findings: A Physical Restraint policy, dated 07/26/23, documented prior to using a restraint an evaluation of the resident should be completed. It was documented a physician order for a restraint was to include the medical symptom for which the restraint was being used and the circumstance in which the restraint was applied. It was documented a comprehensive care plan should address the goal for the use of the restraint. Res #13 had diagnoses which included muscle weakness, cognitive communication, lack of coordination, difficulty in walking, and a history of falling. An inventory sheet of personal items, dated 03/26/24, documented the resident had an electric wheelchair. A safety device tool, dated 06/26/24, documented the resident had no safety device present or in use. A quarterly assessment , dated 07/03/24, documented the resident's cognition was severly impaired. It documented the resident used a wheelchair for mobility and was dependent on staff for transfers. It was documented the resident had no restraints. On 09/15/24 at 12:58 p.m., the resident was observed in their electric wheelchair with a seat belt attached and in place. CNA #1 was asked to have the resident demonstrate they were able to release their seat belt. They resident stated they knew how to do it, but stated their fingers were too fat to release the belt. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/16/24 at 9:55 a.m., the resident was observed in their electric wheelchair with a seat belt attached and in place. RN #1 was asked to have the resident demonstrate they were able to release their seat belt. The resident was observed attempting to release the belt, but was not strong enough to release it. On 09/16/24 at 10:03 a.m., RN #1 stated they did not see a physician's order for the use of the seat belt or where it had been care planned. They stated they did not know if an assessment had been completed. On 09/16/24 at 11:44 am., the administrator stated they knew the resident had a seat belt attached to their electric wheelchair. They stated they did not see where it had been care planned. They were asked to provide documentation the resident had been assessed for the use of the seat belt. On 09/17/24 at 9:13 a.m., the administrator stated there was no assessment completed for the use of the resident's seat belt.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 33148 Based on record review and interview, the facility failed to code MDS assessments accurately for two (#30 and #57) of two sampled residents reviewed for MDS accuracy. The assistant administrator identified 93 residents resided in the facility. Findings: 1. Res #30 had diagnoses which included suicidal ideations, major depressive disorder, and unspecified psychosis not due to a substance or known physiological condition. A physician order, dated 12/24/21, documented zolpidem tartrate (hypnotic medication) 10 mg tablet by mouth at bedtime for sleep. Physician orders, dated 03/23/24, documented Seroquel (antipsychotic medication) 200 mg tablet one time a day; and Seroquel 200 mg tablet at bedtime. An annual assessment, dated 09/11/24, documented the resident did not receive an antipsychotic or hypnotic medication while a resident. On 09/17/24 at 12:46 a.m., MDS Coordinator #2 was asked if the resident's annual assessment was coded for the use of an antipsychotic or hypnotic medication. They stated they missed it. 2. Res #57 had diagnoses which included muscle wasting and atrophy, GERD, HTN, aphasia, anxiety, dementia, depression, and protein calorie malnutrition. A quarterly assessment, dated 07/31/24, documented the resident received an anticoagulant while a resident. There was no documentation the resident received an anticoagulant. On 09/17/24 at 12:43 p.m., MDS Coordinator #1 was made aware the resident's quarterly assessment documented the resident had received an anticoagulant. They were asked if there was documentation the resident received an anticoagulant. They stated they did not see the resident received an anticoagulant. They stated the assessment was coded incorrectly.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 46582 Based on observation, record review, and interview, the facility failed to perform an entrapment risk assessment and to ensure informed consent was obtained prior to the use of bed rails for one (#49) of one resident sampled for bed rails. The administrator identified 33 residents whose beds were equipped with a bed rail of any type. Findings: A Side Rail Policy - Quarter/Assist Rail policy, dated October 2016, read in parts, .The facility will assess and input proper interventions to protect resident from injury .On admission, quarterly and with significant change of condition; the resident will have a side rail assessment completed .Licensed nurse will review the risks with resident and/or responsible party . Res #49 had diagnoses which included congestive heart failure, respiratory failure, and history of falls. A physician order, dated 08/11/22, documented the resident may have U-Rails to both sides of bed for mobility when entering and exiting for 90 days and then review. An annual assessment, dated 05/15/24, documented the resident was moderately impaired in cognition, required supervision to partial assistance with bed mobility, and had no falls. There was no documentation of an entrapment risk assessment or informed consent for bed rails found in the medical record. There was no documentation of the use of bed rails found in the care plan. On 09/15/24 at 11:49 a.m., Res #49 was observed sitting on the side of the bed. Bilateral bed rails were observed on the upper half of the bed in the up position. Res #49 stated they used the rails for positioning. On 09/17/24 at 8:08 a.m., the DON stated there was no documentation of a current entrapment risk assessment or informed consent prior to use of the bed rails for Res #49. On 09/17/24 at 8:15 a.m., the administrator stated the entrapment risk assessment should have been completed quarterly but it had not been completed in a while. They stated the use of bed rails should have been documented in the care plan.

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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. 33148 Based on record review and interview, the facility failed to ensure side effect monitoring was conducted for the use of a psychotropic medication for one (#37) of five sampled residents reviewed for medications. The DON identified 44 residents received psychoactive medications. Findings: Res #37 had diagnoses which included depression. Physicians orders, dated 06/13/24, documented bupropion hydrobromide (antidepressant medication) 150 mg tablet by mouth one time a day; and Lexapro (antidepressant medication) 10 mg tablet one time a day. A care plan, revised 06/24/24, documented the resident used antidepressant medication. It documented to monitor and documented side effects every shift. There was no documentation side effects were monitored. On 09/17/24 at 11:36 a.m., the administrator, ADON, and DON were asked to locate documentation side effects were monitored for the resident. On 09/17/24 at 11:57 a.m., the DON stated side effects were not monitored. They stated the order to monitor had been discontinued.

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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 from two of three medication storage rooms observed. The assistant administrator in training reported 93 residents resided in the facility. Findings: On 09/18/24 at 9:40 a.m., the medication storage room on the skilled hall was observed with CMA #1. The following medications/supplies were observed to be expired. 6- boxes lubricant eye drops with an expiration date of 4/24, 1- V.A.C. Granufoam dressing package opened with and expiration date of 11/30/24. On 09/18/24 at 9:45 a.m., CMA #1 reported the expired medications and supplies should have been removed. On 09/18/24 at 9:54 a.m., the medication room for halls 1 and 2 were observed with CMA #2. The following medications were observd to be expired. 1- Box Ipratropium Bromide & Albuterol Sulfate 0.5mg/3mg per 3ml with a use by date of 3/10/24, 1- Box Ipratropium Bromide & Albuterol Sulfate 0.5mg/3mg per 3ml with a use by date of 5/9/24, 1- Box Ipratropium Bromide & Albuterol Sulfate 0.5mg/3mg per 3ml with a use by date of 9/11/24, 1- Box Ipratropium Bromide & Albuterol Sulfate 0.5mg/3mg per 3ml with a use by date of 7/26/4, 1- Box Ipratropium Bromide & Albuterol Sulfate 0.5mg/3mg per 3ml with a use by date of 6/1/24. On 09/18/24 at 9:59 a.m., CMA #2 reported the medications should have been removed.