

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/07/2024
NAME OF PROVIDER OR SUPPLIER  Okemah Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  112 North Woody Guthrie Okemah, OK 74859	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>41872</p> <p>Based on record review and interview, the facility failed to have a process in place to identify resident's code status for one (#33) of ten residents reviewed for code status.</p> <p>The Administrator identified 43 residents resided in the facility.</p> <p>Findings:</p> <p>An Advanced Directives policy, revised April 2008, read in part, .Changes or revocations of a directive must be submitted in writing to the Administrator .The Care plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment .and care plan .</p> <p>Resident #33 had diagnoses which included type two diabetes mellitus, anemia and malaise.</p> <p>An undated form titled Full Code was observed on the inside of a cabinet door at the nurse's station. The form documented Resident #33 was a full code.</p> <p>Resident #33 had a signed DNR, dated 05/13/22, in their hard chart.</p> <p>On 06/04/24 at 12:03 p.m., LPN #2 was asked what was the list of full code and DNR. They stated To let everyone know the DNR code status, if someone is down they will come up here and check it. They were asked how often the list is updated. They stated they though it was every month or every other month. They were asked who is responsible to update the list. They stated LPN #1.</p> <p>On 06/04/24 at 12:09 p.m., the DON was asked if the resident is a full code or DNR. They stated Resident #33 had a signed a DNR on 05/13/22. They were asked to review the form kept at the nurse's desk and asked how it identified Resident #33. They stated as a full code. They were asked if that was correct. They stated it was not correct.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/05/24 at 1:37 p.m., Corp. Nurse Consult. #1 was asked if the list full code that had been kept at the nurse's desk was accurate. They stated they did not think it was. They were asked how often the list should be updated. They stated with a change in the care plan or anytime it changes. Corp. Nurse Consult. #1 was asked if Resident #33 had signed and dated their DNR on 05/13/22, why wasn't the list updated and accurate. They stated the list had been updated last year. They were asked if their process in place correctly identified the resident's code status. They stated No, it was not.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>41872</p> <p>Based on observation, record review, and interview, the facility failed to ensure privacy curtains were used for two (#9 and #21) of three sampled residents reviewed for privacy.</p> <p>The Administrator identified 43 residents resided in the facility.</p> <p>Findings:</p> <p>An undated Privacy Curtains policy, read in part . It is the policy of this facility that each resident will have a privacy curtain in room to maintain him/her privacy from someone entering the room .</p> <p>Resident #9 had diagnoses which included cerebral palsy and severe intellectual disabilities.</p> <p>A quarterly assessment, dated 05/16/24, documented Resident #9 was dependent on staff for all ADL's.</p> <p>On 06/03/24 at 10:04 a.m., Resident #9 was observed from the hallway. They were lying uncovered with a t-shirt on, and their legs folded up. There was no sheet on the resident's lower body.</p> <p>On 06/03/24 at 2:53 p.m., Resident #9 was observed in bed from the hallway. The privacy curtain was not pulled and the resident was not covered from the waist down.</p> <p>On 06/03/24 at 03:10 p.m., CNA #1 was asked to observe Resident #9. They stated the resident's curtain should be pulled, but the curtain only goes halfway in the room.</p> <p>On 06/03/24 at 3:31 p.m., the Administrator was asked to observe the Resident lying in their bed from the hallway. Resident #9 was observed lying in their bed bilateral legs folded up towards their abdomen, with a blanket bunched up on the side of their right hip. They were asked if the curtain provided privacy for the resident. They stated, No. There was no curtain observed to be hanging to provide privacy for the resident. The curtain did not extend to the right side of the room. They were asked if the resident was exposed. They stated yes.</p> <p>2. Resident #21 had diagnoses which included, pressure ulcer of right buttock Stage 4, dementia, and depressive disorder.</p> <p>On 06/05/24 at 10:57 a.m., upon entry to the room, the resident was lying in the bed with their shorts pulled down with their buttocks exposed to the hallway. The privacy curtain was not pulled. Two staff CNA were observed in the room CNA #2 was on the side of the bed assisting with positioning of resident. They were not wearing PPE. The other staff member left the room and donned PPE. They returned and provided incontinent care. Wound care was performed by the LPN wearing PPE . After completion of wound care CNA #2 was observed to assist with changing the Resident #21's shorts.</p> <p>The privacy curtain was not pulled at any time during provision of pericare or wound care.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/05/24 11:21 a.m., LPN #2 was asked if Resident #21 had a room mate. They stated Resident #21 did have a roommate. They were asked why the privacy curtain had not been pulled during the provision of pericare and wound care. They stated, Because the room mate was not in the room.</p> <p>On 06/05/24 at 1:42 Corp. Nurse Consult. #1 was asked when the privacy curtain should be used. They stated during treatment or care for the resident. They were asked if the curtain should be used during wound care on the buttocks or peri care. They stated, Definitely.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>41872</p> <p>Based on observation, record review, and interview, the facility failed to maintain a clean homelike environment for:</p> <ul style="list-style-type: none"> <li>a. residents who ate their meals in the dining room and who watched TV in the television room, and</li> <li>b. prevent lingering urine odors for two (#9 and #33) of all residents who resided in the facility.</li> </ul> <p>The Administrator identified 43 residents resided in the facility.</p> <p>Findings:</p> <p>An undated Housekeeping policy, read in part .It is the policy of this facility that housekeeping services will be provided every day. Housekeeping will be responsible to clean the residents area Housekeeping will also be responsible for cleaning the .halls .dining room .</p> <p>A. Dining Room</p> <p>On 06/03/24 at 11:54 a.m., Resident #3 was observed entering the television room and sitting near the coke machine. A puddle of water was observed on the floor near the resident and coke machine.</p> <p>On 06/03/24 at 12:05 p.m., the windows in the dining room were observed to have noted to have dust/dirt and dead flies lying on the window ledges. There was a dead fly in the southwest window, two dead flies and dirt and dust in the north west window and seven dead flies in the northwest window. The windows in the TV room were observed to have multiple dead flies and dirt in the southeast window and multiple dead bugs, flies and mouse droppings in the northeast window. The area of waster remained on the floor near the coke machine.</p> <p>On 06/03/24 at 12:33 p.m., CNA #3 was asked to observe the water on the floor. CNA #1 asked dietary manager what the water was, they were unsure. CNA #3 instructed Resident #3 to not walk through the water, but did not attempt to clean the area or notify housekeeping.</p> <p>On 06/03/24 at 12:45 p.m., water was still on the floor in the TV room. A resident was observed sitting nearby on a couch.</p> <p>On 06/03/24 at 12:52 p.m., a Resident #3 sitting in a wheel chair came into the TV room near the water spill.</p> <p>On 06/03/24 at 12:56 p.m., CNA #3 left the TV room and went into the dining room. They were not observed to attempt to clean the area or notify housekeeping.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/03/24 at 1:07 p.m., the DON was asked to observe the dining room. They stated there were dead flies and debris in the west windows and north windows. They were asked who was responsible to clean the windows. They stated kitchen or housekeeping. The DON observed the windows in the TV room and stated it looked like numerous flies and mouse pills. The DON was notified of the water on the floor in the TV room. The DON asked the dietary manager if they were aware of the water on the floor. They stated yes, but was unsure what it was from. The DON was asked what the staff should have done about the water. They stated the staff should have gotten someone (housekeeping) right away or got some towels and cleaned it themselves. The DON asked Maintenance 31 if they had been notified of the water near the coke machine. They stated, No.</p> <p>B. Lingering Odors</p> <p>On 06/03/24 at 2:53 p.m., there was a strong odor of urine in the hallway and in Resident #9's room.</p> <p>On 06/03/24 11:23 a.m., Resident #33's room was noted to have a strong smell of urine.</p> <p>On 06/04/24 at 2:13 p.m., Corp Nurse Consult. #1 was asked what was the odor in Resident #9's room. They stated they smelled bleach.</p> <p>On 06/04/24 at 2:16 p.m., Corp Nurse Consult. #1 was to observe Resident #33's room. They were asked what was the odor in Resident #33's room. They stated the room smelled like pee and there was a wet brief in the trash.</p> <p>On 06/05/24 at 8:10 am a strong odor of urine was noted in Resident #33's room during medication observation.</p> <p>On 06/05/24 at 8:23 a.m., CMA #1 was asked what the odor was in Resident #33's room. They stated, it smelled like urine to them.</p>		

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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>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45583</p> <p>Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for activities for one (#38) of one sampled residents reviewed for activities.</p> <p>The Administrator identified 43 residents resided in the facility.</p> <p>Findings:</p> <p>A Goals and Objectives, Care Plans policy, dated 8/2006, read in part, Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. The policy also read, Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and area able to report whether or not the desired outcomes are being achieved. Goals and objectives are reviewed and/or revised . at least quarterly.</p> <p>A Care Plans-Comprehensive policy, dated 10/2009, read in part, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs is developed for each resident. The policy also read, The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.</p> <p>A Care Planning-Interdisciplinary Team policy, dated 12/2008, read in part, .The care plan is based on the resident's comprehensive assessment and is developed by a Care Panning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel: .The activity Director/Coordinator .</p> <p>Resident #38 admitted with diagnoses which included unspecified psychosis, paranoid personality disorder, dementia, and insomnia.</p> <p>Resident #38's annual assessment dated [DATE] documented their favorite activity was somewhat important and group activities was somewhat important and choosing their bedtime was very important.</p> <p>On 06/03/24 at 2:38 p.m. an activities calendar was observed in a resident room and it had no times or location on it.</p> <p>On 06/03/24 at 2:51 p.m., two residents were observed sitting in front of the front entrance sitting area watching t.v.</p> <p>On 06/04/24 at 9:02 a.m., Resident #38 stated there was nothing to do but sit there all day, sleep, go to the bathroom, watch Tv, sit around and watch everybody. They stated they have bingo once a month. They had told everyone about the activities and they will listen but not do anything. The resident stated they couldn't complain too much. They stated they play on their phone for entertainment. Resident #38 stated they will every once in a while will go out and ride in the van and did so last Friday. It is only done twice a year.</p> <p>(continued on next page)</p>		

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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 06/04/24 at 9:33 a.m., a June 2024 activities calendar was observed on the door of room [ROOM NUMBER] with no times of the activities on it.</p> <p>On 06/05/24 at 10:16 a.m., there were no observations of activities occurring.</p> <p>On 06/05/24 at 10:49 a.m., Resident #38 stated they don't do what was on the calendar. They stated the movies and bowling were interesting but did not know what time or when they were.</p> <p>There was no time or location listed next to the activities on the June 2024 calendar provided to the residents.</p> <p>On 06/05/24 at 10:58 a.m., CNA #4 stated the activities they knew of where movies the day before and that activities were done maybe once a week. They stated the resident sometimes would go to bingo.</p> <p>On 06/05/24 at 11:02 a.m., the activity director stated the new admission and yearly screening was to find out what hobbies were prior, activities they like to do, and if they like music or t.v. and would provide if available. They stated Resident #38 declined activities and watched t.v. westerns or sports and bingo sometimes depending on their mood. They stated the resident participated about 2-3 times a month if there was bingo. The activity director also stated they ensure activities of choice were available by asking during resident council what kind of activities they would like to see and try a new one each month.</p> <p>On 06/05/24 at 11:04 a.m., the activity director stated they forgot to put the time on the June 2024 calendar and that there was a 10:00 a.m. and 2:00 p.m. activity.</p> <p>On 06/05/24 at 11:08 a.m., the MDS coordinator stated they stated Resident #38 did not have an activities care plan and they did not do them for everyone. They stated they had not care planned activities individually. They stated they would only care plan activities for level 2 PASRR, bed ridden, or when in covid isolation. They further stated that staff would know resident activity preferences from the activities coordinator that plans and gathers the residents.</p> <p>On 06/06/24 9:22 a.m., Resident #38 was observed sitting in their wheelchair in the hall outside of their room looking at their cell phone with earbuds in their ears.</p> <p>On 06/06/24 at 11:20 a.m., the Corporate Nurse Consultant #1 stated they would expect each resident to have an activity care plan.</p> <p>On 06/04/24 at 2:39 p.m. the Administrator stated, after looking at the June 2024 activities calendar, that they did not know what time the activities were done by looking at the calendar and they just knew when they were and would have to ask. The administrator also stated the Podiatrist was not an activity as it was listed for Wednesday the 12th. They stated that the movies were also able to be shown on the resident individual t.v. as well as on the public t.v. The administrator stated there had not been any residents to complain about activities.</p> <p>There was no activities care plan located in the medical record.</p> <p>A monthly summary 2024 documented the resident did not participate in activities.</p> <p>(continued on next page)</p>		

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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>An Activity participation note dated 2/29/24 at 1:39 p.m., documented the resident participated in some activities, resident council, sitting outside when the weather permits, and enjoys visiting with staff and residents.</p> <p>An Activity participation note dated 3/29/24 at 2:00 p.m., documented the resident enjoyed watching t.v. in the family room, sitting outside when the weather permits, and visiting with staff and residents.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>41872</p> <p>Based on observation, record review, and interview, the facility failed to ensure Braden skin assessments, and weekly skin assessments were completed for two (#21 and #13) of two sampled residents reviewed for wound care.</p> <p>The Administrator identified 43 residents resided in the facility. The Resident Matrix documented three residents had pressure ulcers that were not present on admission.</p> <p>Findings:</p> <p>An undated, Skin Assessments policy, read in part .It is the policy of this facility that skin assessment will be completed on every resident every week .</p> <p>An undated, Braden Skin Evaluation policy, read in part .A Braden scale skin evaluation will be completed no less than quarterly. This will be most likely completed with the MDS that comes due whether a quarterly, annual, significant change or admission .</p> <p>1. Resident #21 had diagnoses which included, pressure ulcer of right buttock Stage 4, dementia, and depressive disorder.</p> <p>A Braden Scale for Predicting Pressure Ulcer Risk dated 12/29/2023, documented the resident was at high risk for pressure ulcers.</p> <p>The clinical health record did not contain documentation weekly skin assessments had been completed since 04/19/24.</p> <p>On 06/06/24 at 11:52 am LPN #1 was asked if they did skin weekly skin assessments, They stated they did the assessments but had been off, and if there was no documentation they did not get completed.</p> <p>On 06/06/24 at 1:38 p.m., LPN #1 was asked if any skin assessments had been completed for Resident #21 after 04/19/24. They stated they did not complete weekly skin assessments if the Resident #21 had outside wound care visits, unless another issue was identified.</p> <p>On 06/06/24 at 1:42 p.m., the DON was asked who is responsible to complete weekly skin assessments. They stated LPN #1. They were asked where the assessments should be documented. They stated the skin assessments should be in the computer.</p> <p>On 06/06/24 1:44 p.m., LPN #1 was asked how often Braden assessments are completed. They stated quarterly. They were asked when the last assessment had been completed on Resident #21. They stated in December 2023.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/06/24 at 1:47 p.m., Corp. Nurse Consultant #1 was asked who was responsible for completing weekly assessments. They stated LPN #1. They were asked where the assessments should be documented. They stated the assessments should be documented in the computer unless outside wound care see's the resident.</p> <p>2. Resident #13 had diagnoses which included Alzheimer's disease and cognitive impairment.</p> <p>A Braden Scale For Predicting Pressure Sore Risk, dated 12/29/23, documented to completed on admission for four weeks then quarterly. The assessment documented Resident #21 was at risk.</p> <p>An annual assessment, dated 03/01/24, documented the resident needed partial to moderate assistance with toileting, upper body dressing.</p> <p>On 06/05/24 at 12:01 p.m., LPN #2 was asked if Resident #13 currently had a wound. They stated no, the wound had healed.</p> <p>.</p> <p>On 06/06/24 at 2:05 p.m., LPN #1 provided paper copies for Braden assessments for Resident #21 and Resident #13.</p> <p>Resident #21's paper assessment Braden Scale For Predicting Pressure Sore Risk, dated 12/1, 3/1, and 6/3, did not have a year, was unsigned by who completed the assessments, and 6/3 contained blanks on assessment.</p> <p>Resident #13's paper assessment Braden Scale For Predicting Pressure Sore Risk, dated 12/30, 3/1, and 6/1 did not have a year, was unsigned by who completed the assessments, and 6/1 contained blanks on assessment.</p> <p>On 06/06/24 at 2:05 p.m., Corp Nurse Consultant #1 reviewed Resident #21 and #13's Braden assessments and stated These were done last year and they are not completed.</p> <p>On 06/06/24 at 2:07 p.m., Corp. Nurse Consultant #1 was asked if outside wound care assessed other areas of the Resident's skin. They stated, Usually not. They were asked if the weekly skin assessments should be completed by facility staff for residents at risk. They stated every resident should have a weekly skin assessment.</p> <p>On 06/06/24 at 2:16 p.m., Resident # 13's heels were observed with Corp Nurse Consultant #1. They stated the left heel had dry flaky skin and a scabbed area and could use skin prep for treatment. Resident #1 was asked if they had any sores on their bottom, they stated no but their foot was. They were asked which one and they stated the left one.</p> <p>On 06/06/24 at 2:22 p.m., Corp. Nurse Consultant #1 was asked what had they observed. They stated the area was healed over with a small scab left and dry peeling tissue. They were asked if the resident had anything in place for prevention. They stated Those shoes. They were asked if any nurse note documented a description of the residents left foot. They reviewed the skin assessments and stated no skin assessments had been completed since April 2024.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Okemah Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  112 North Woody Guthrie Okemah, OK 74859	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/06/24 at 2:35 p.m., Corp. Nurse Consultant #1 was asked when Resident #13's wound had healed. They stated on 03/28/24. They were asked why the weekly skin assessments had not been completed. They were not sure why they had not been completed since 04/19/24.</p> <p>On 06/06/24 at 2:37 p.m., LPN #1 was asked when was the last time they had assessed Resident #13's skin. They stated they only document if there is an issue with the skin.</p> <p>On 06/06/24 at 2:42 p.m., Corp Nurse Consultant #1 was asked was the policy followed for weekly skin assessments and Braden assessments. They stated no. They were asked if Resident #13's heel was something the wound care doctor would assess. They stated, Yes.</p> <p>On 06/07/24 at 11:09 a.m., LPN #2 was asked if Resident #1 had been seen by the wound care doctor. They stated they had texted pics to the doctor and described the area as rough feeling and mushy. The physician ordered to skin prep the heel two times per day and offload.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45583</p> <p>Based on record review and interview, the facility failed to administer tube feeding bolus according to physician order for one (#32) of one sampled resident reviewed for tube feeding.</p> <p>The administrator identified two residents received tube feeding resided in the facility.</p> <p>Findings:</p> <p>A Intake, Measuring and Recording policy, dated 9/2005, read in part, The purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period. The policy also read, Record the fluid intake as soon as possible after the resident has consumed the fluids. At the end of you shift total the amounts of all liquids the resident consumed . The policy also read, The following should be recorded in the resident's medical record per facility guidelines: . The amount (in mls) of liquid consumed . notify the supervisor if the resident refuses the procedure.</p> <p>Res #32 had diagnoses which included anorexia, cachexia.</p> <p>A physicians order dated 09/02/23 documented mighty shake one time a day for weight loss.</p> <p>A physicians order dated 10/19/23 documented regular diet mechanical soft texture, regular/thin consistency, give drink every 3 bites. Drink from cup side (no straws) sips only. Up 90 degrees in chair for all po intakes.</p> <p>A physician order dated 02/01/24 documented Osmolite give 1(240ml) 4 times a day-hold at meals if eats more than 50% as needed.</p> <p>On 06/06/24 at 9:26 a.m., LPN #2 stated Resident #32's tube feeding order was if they ate less than 50% they get a supplement of Osmolyte 270 ml's and to flush with 100 ml's of water each bolus and every shift. LPN #2 stated they also received a shake because of weight loss before.</p> <p>On 06/06/24 at 9:28 a.m., LPN #2 stated their should not be blanks on the medical record and if there were then it was not done or they were late. They stated there were seven blanks for the task of eating, six blanks for the task of amount eaten, and six blanks for the fluids. The LPN stated there was another sheet used for documenting intake that the CNA's document the meal percentages.</p> <p>On 06/06/24 at 9:49 a.m., the Corporate Nurse Consultant #1 reviewed the meal percentages on paper and documentation in the electronic medical record and stated there was no documentation of meal percentages for May 2024 on the 6th, 9th, 10th, 24th, or 26th. They stated there should be documentation. The Corporate Nurse Consultant #1 stated the resident needed to be fed regardless because the order was confusing.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>41872</p> <p>Based on record review and interview, the facility failed to monitor for side effects related to the use of antidepressants for four (#1, #3, #32 and #40) of five sampled residents reviewed for unnecessary medications.</p> <p>The Administrator identified 43 residents resided in the facility. The Resident Matrix, dated 06/03/24 documented 31 residents received antidepressants.</p> <p>Findings:</p> <p>An undated Monitoring of Antidepressants policy, read in part .Resident receive antidepressant medication routinely only when medically necessary. Every effort is made to ensure that resident who use antidepressants receive the intended benefit if [sic] the medication and to minimize the unwanted effects of the antidepressant medications .</p> <p>1. Resident #1 had diagnoses which included depressive disorder and depression.</p> <p>A physician order, dated 07/06/23, documented to administer Trazadone 100 mg one time at bedtime.</p> <p>A physician order dated 06/25/23 documented to administer Escitalopram Oxalate 20 milligrams by mouth one time a day.</p> <p>An undated Monitoring of Antidepressants policy, read in part .</p> <p>There was no documentation for March, April, may June 2024 the resident had been monitored for the use of antidepressants: Lexapro and Trazadone.</p> <p>On 06/06/24 at 11:23 a.m., Corp Nurse Consultant #1 was asked if Resident #1 had been monitored for side effects related to the use of Trazadone and Lexapro. They stated there was no documentation side effects had been monitored. They were asked what the policy was to monitor. They stated side effects should have been monitored.</p> <p>2. Resident #3 had diagnoses which included recurrent depressive disorder.</p> <p>A physician order, dated 12/18/23, documented to administer Pristiq 50 milligrams one time a day.</p> <p>A physician order, dated 06/27/23, documented to administer Trintellix 20 milligrams one time a day.</p> <p>Resident #3's treatment administration records for April, May and June 2024, did not contain documentation side effects had been monitored for the use of Pristiq and Trintellix.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #3's care plan, dated 02/07/24, read in part, .The resident has depression .Pristiq as ordered: side effects may include Blistering, peeling or loosening of the skin .bloating .blood in the stool or urine .chest tightness, discomfort, or pain .cough .dark urine .Trintellix as ordered: mood swings, headache, muscle stiffness, and runny nose .</p> <p>On 06/06/24 at 10:34 a.m., Corp. Nurse Consultant #1 was asked if Resident #3 had been monitored for side effects related to Pristiq and Trintellix. They stated they had not been monitoring for side effect for Pristiq or Tarantella. The care plan stated to monitor for specific side effects but that had not been done.</p> <p>3. Resident #32 had diagnoses which included unspecified mood (affective) disorder and anxiety.</p> <p>A physicians order, dated 11/02/23, documented to administer Lexapro 10 milligrams one time a day.</p> <p>A physicians order, dated 11/9/23, documented to administer Lamotrigine 25 milligrams two times a day.</p> <p>Resident #32's treatment administration records for April, May and June 2024 did not contain documentation side effect monitoring for the use of Lexapro.</p> <p>Resident #32's care plan, dated 06/03/24, read in part, The resident has a mood disorder .Lomotrigine as ordered: side effects may include dizziness, light headedness, blurred vision. The care plan also read, Lexapro as ordered: side effects may include diarrhea, drowsiness, headache.</p> <p>On 06/06/24 at 11:26 a.m., the Corporate Nurse Consultant #1 stated there was no side effect monitoring.</p> <p>4. Resident #40 had diagnoses which included Bipolar disorder.</p> <p>A physicians order, dated 06/26/23, documented to administer Bupropion 150 milligrams two times a day.</p> <p>A physicians order, dated 07/06/23 , documented to administer Trazodone 50 milligrams at bedtime.</p> <p>On 06/06/24 at 2:34 p.m., LPN #2 stated side effect monitoring was documented on the treatment administration record. They stated they should do side effect monitoring on depression, psychotropic and anxiety medications. LPN #2 stated there was no side effect monitoring for the Trazodone or the Wellbutrin (Bupropion.)</p> <p>45583</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>41872</p> <p>Based on observation, record review, and interview, the facility failed to ensure medication error rate was not greater than 5% for two (#6 and #12) of three sampled residents observed during medication observation</p> <p>The Administrator identified 43 residents resided in the facility.</p> <p>Findings:</p> <p>An undated Medication Administration and General Guidelines policy, read in part .Medications are administered in accordance with written orders of the attending physician .</p> <p>1. Resident #6 had diagnoses which included hypertension and mood disorder.</p> <p>A physician order, dated 02/06/24, documented to administer aspirin 81 milligram chewable tablet one time a day.</p> <p>On 06/05/24 7:58 a.m., CMA #1 was observed to prepare and administer Resident #6's medications. CMA #1 did not instruct Resident #6 to chew the Aspirin tablet when administered.</p> <p>2. Resident #12 had diagnoses which included Atherosclerosis of native arteries of extremities.</p> <p>A physician order, dated 06/27/2, documented to administer aspirin 81 milligrams chewable tablet one time a day.</p> <p>On 06/05/24 at 8:17 a.m., CMA #1 was observed to prepare and administer Resident #12's medications. They did not instruct Resident #12 to chew the Aspirin tablet when administered.</p> <p>On 06/05/24 at 9:27 a.m., Corp. Nurse Consultant #1 was asked if the medication card documents the medication is a chewable aspirin how should it be administered. They stated it should be chewed, unless the doctor stated otherwise.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>45583</p> <p>Based on record review and interview, the facility failed to ensure the person designated to serve as the dietary manager had met the state requirement for dietary management.</p> <p>The Director of Nursing stated 42 residents received food from the kitchen and 43 residents resided in the facility.</p> <p>Findings:</p> <p>There was no documentation the DM was certified as a dietary manager.</p> <p>A Office of Professional and Workforce Development Receipt dated 11/03/22, documented a transaction basket number dated for 03/11/22 for enrollment in the course.</p> <p>A document titled Grades for {name withheld}, documented the grades for the modules. The introduction was dated for 12/20/22. There was no final test score.</p> <p>There was no documentation the dietary manager had taken the test to become a certified dietary manager.</p> <p>On 06/05/24 at 11:22 a.m., the administrator stated the dietary manager had not taken the certification exam. They stated the dietary manager started around 03/11/22.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45583</p> <p>Based on observation and interview, the facility failed to ensure the kitchen was maintained to promote food safety and sanitation.</p> <p>The Director of Nursing identified 42 residents who received services from the kitchen.</p> <p>Findings:</p> <p>A Sanitization policy dated 10/08, read in part, The food service area shall be maintained in a clean and sanitary manner. All .kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodent, roaches, flies and other insects. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corruptions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. The policy also read, Dishwashing machines must operate using the following specifications: .Low-Temperature Dishwasher (Chemical Sanitization) a. wash temperature (120 degree F); b. Final rinse with 50 parts per million(ppm) hypochlorite (chlorine) for at least 10 seconds. The policy also read, The Food Service Manager will be responsible for scheduling staff for regular cleaning of the kitchen . Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.</p> <p>A Food Receiving and Storage policy, dated 07/14, read in part, Foods shall be received and stored in a manner that complies with safe food handling practices. Food services, or other designated staff, will maintain clean food storage areas at all times. The policy also read, Dry foods that are stored in bins will be removed from the original packaging, labeled and dated (use by date). The policy also read, Other opened containers must be dated and sealed or covered during storage.</p> <p>On 06/03/24 at 10:02 a.m., initial tour of the kitchen was conducted, and the following observations were made:</p> <ul style="list-style-type: none"> <li>a. Black substance along the back trim of the sink with the sprayer and the handwashing sink,</li> <li>b. Black wet substance on the floor under the sink and dishwasher,</li> <li>c. Rusty metal box overflow with suds/bubbles and two metal knives and a blue handled wrench on the floor next to the canned goods as well as debris under the shelf with cans,</li> <li>d. Two trays of the dessert for the day in cups/bowls with no label or date,</li> <li>e. Three bags of opened bread (one sandwich bread and two hot dog buns) with no date when opened and not sealed,</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>f. Three more desserts in cups and two bowls with no label or date,</p> <p>g. One gallon of milk was almost empty with no opening date,</p> <p>h. One gallon of milk was almost full of no opening date,</p> <p>i. A three-tiered cart located next to the prep table across from the oven had food debris on all corners and on each shelf as well as debris on top of the items in a cup on the top,</p> <p>j. The dishwasher temp did not get above 112 degrees,</p> <p>k. No dishwashing wash and no dishwasher sanitation fluid. Both were empty and there had been dishes washed.</p> <p>On 06/03/24 at 10:21 a.m., [NAME] #1 stated there was a chore list for weekly and monthly so cleaning was done every day. They stated under the sink was stained then stated it was dirty after saw what was wiped with a paper towel. [NAME] #1 stated the floor in the dry storage room where the cans were was clean and stated it flooded the floor in that area, and also stated under the cans was not clean.</p> <p>On 06/03/24 at 11:03:35 a.m., the dietary manager stated they did not date the bread because it came in weekly.</p> <p>There were blanks throughout the cleaning schedule.</p> <p>The dietary manager was unaware of the need to date the bread when opened.</p> <p>On 06/03/24 at 10:43 a.m., the dietary manager stated the black substance at the sink was maybe mold.</p> <p>On 06/03/24 at 10:45 a.m., the dietary manager stated under the dishwasher was not clean after seeing debris from paper towel when wiped.</p> <p>On 06/03/24 at 10:54 a.m., the dietary manager stated they did not know when the desserts or the milk were prepared or opened because there was no date.</p> <p>On 06/03/24 at 11:21 a.m., the dietary manager stated they had tried to clean the three-tiered cart weekly, it just got back like that.</p> <p>On 06/03/24 at 11:36 a.m., the dietary manager stated the dishwasher was to be at 120 degrees to wash.</p> <p>On 06/03/24 at 11:36 a.m., there was no sanitization detected on the test strip.</p> <p>On 06/03/24 at 11:37 a.m., the dishwasher was restarted and tested again with no sanitization detected on the strip.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/03/24 at 11:40 a.m. observed the sanitizer and wash buckets for the dishwasher were both empty.</p> <p>On 06/03/24 at 11:42 a.m., the dietary manager stated they were told to order from the dishwasher company instead of their other delivery service they used prior. They stated thy requested the assistant administrator to order them.</p> <p>On 06/03/24 at 12:25 a.m., the dietary manager stated the process for reordering dishwasher and sanitizer for the dishwasher was that they ordered at least once a week and they had requested on Wednesday of last week to be there on Thursday. They stated they had no problem when they ordered from the food service but when they ordered from the machine company they were always on back order.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41872</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. staff wore PPE during provision of care for one (#21) of one sampled residents reviewed for EBP and</p> <p>b. failed to ensure a syringe used for tube feeding administration was stored in a manner to prevent cross contamination for one (#32) of one sampled resident reviewed for tube feeding.</p> <p>The Administrator identified 43 residents resided in the facility.</p> <p>The Director of Nursing identified two residents received tube feeding.</p> <p>Findings:</p> <p>An Enhanced Barrier Precautions Policy and Procedure, dated 04/01/24, read in part .EBP will be used for resident with indwelling medical devices, wounds, or those who are colonized by or infected with a multidrug - resistant organism .procedure to use EBP when .other high-contact resident care activities .</p> <p>1. Resident #21 had diagnoses which included, pressure ulcer of right buttock Stage 4, dementia, and depressive disorder.</p> <p>On 06/05/24 at 10:57 a.m., upon entry to the room, the resident was lying in the bed with their shorts pulled down with their buttocks exposed to the hallway. The privacy curtain was not pulled. Two staff CNA were observed in the room CNA #2 was on the side of the bed assisting with positioning of resident. They were not wearing PPE. One staff member left the room and donned PPE. They returned and incontinent care was provided. Wound care was performed by the LPN wearing PPE. After completion of wound care, CNA #2 was observed to assist with changing Resident #21's shorts. CNA #2 was not wearing PPE.</p> <p>On 06/05/24 at 11:21 a.m., LPN #2 was asked why did one staff DON PPE and one did not. They stated they did not know. They were asked if they were providing contact assistance should PPE be worn. They stated it should have been worn.</p> <p>On 06/05/24 1:44 p.m., Corp. Nurse Consultant #1 was informed of the wound care and assistance provided for Resident #21. They were asked would one staff provide care without PPE for enhanced barrier. They stated, I am not sure both staff should have worn PPE.</p> <p>On 06/06/24 at 9:05 a.m., CNA #2 was asked if they assisted on 06/05/24 when wound care was completed for Resident #21. They stated, Yes. They were asked what care was provided for Resident #21. They stated We helped [the Resident #21] change [their] shorts and got [the Resident #21] up for lunch. They were asked what they understood about enhanced barrier precautions. They stated they thought they only had to use PPE if it was on the door. They were asked if they had training on when to use PPE for EBP. They stated they had at their other job but had not had training here.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/07/2024
NAME OF PROVIDER OR SUPPLIER  Okemah Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  112 North Woody Guthrie Okemah, OK 74859	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #32 had diagnoses which included unspecified congestive heart failure.</p> <p>A quarterly assessment, dated 04/04/24, documented assist needed for eating.</p> <p>On 06/05/24 at 10:54 a.m., an observation was made of a tube feeding syringe on the small dresser next to Resident #32's bed without a protective barrier.</p> <p>On 06/06/24 at 9:04 a.m., an observation was made of a tube feeding syringe on the small dresser next to Resident #32's bed with the plunger end on the table and not in a protective barrier with an undated open container of apple sauce next to it.</p> <p>On 06/06/24 at 9:26 a.m., LPN #2 stated the resident received osmolyte tube feeding. They stated Resident #32 should be assisted with everything and had to be fed and staff were to stay with resident to feed them. LPN #2 stated there should not be food left in the room, suppose to pick up the trays. They stated the tube feeding syringe was usually put the sack back over the top of the syringe and should be clean and put on a napkin to let dry.</p> <p>On 06/06/24 at 9:28 a.m., LPN #2 stated the applesauce should have been thrown away if they did not eat it. They stated the concern was the syringe was left open.</p> <p>45583</p>