STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375423	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmwood Manor Nursing Home	300 South Seminole Wewoka, OK 74884

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. 46387 Based on observation, record review, and interview, the facility failed to ensure a care plan was updated to include an order for oxygen for one (#5) of one sampled residents reviewed for oxygen. The corporate nurse consultant identified two residents required oxygen. Findings: 1. Res #5 had diagnoses which included COPD. A physician order, dated 08/15/24, documented Res #5 was to receive oxygen at two to three liters per minute via nasal cannula to maintain oxygen saturation above 90%. On 10/21/24 at 9:57 a.m., Res #5 was observed in bed in their room. The oxygen concentrator was observed at bedside delivering oxygen at two liters per minute via nasal cannula. Res #5's care plan did not document they received oxygen. On 10/24/24 at 10:40 a.m., the MDS coordinator stated oxygen should be on the care plan. Upon review of Res #5's care plan they stated the oxygen was not documented, but should have been.

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure informed consent was obtained prior to the utilization of bed rails for one (#32) of one sampled resident reviewed for bed rails. The administrator identified four residents whose beds were equipped with a bed rail of any type. Findings: A Proper Use of Side Rails policy, revised December 2016, read in part, .Consent for side rail use will be obtained from the resident . Res #32 had diagnoses which included fusion of the cervical spine, central cord syndrome, and muscle weakness. An admission assessment, dated 09/26/22, documented the resident was cognitively intact, required extensive assistance with bed mobility, and had one fall without injury. A physician order, dated 06/28/23, documented the resident could have half rails to their bed for repositioning purposes. A care plan, dated 09/28/23, documented the resident was able to use side rails for repositioning and rolling in bed. On 10/21/24 at 9:56 a.m., Res #32 was observed lying in bed. Bilateral half bed rails were observed on the upper half of the bed in the up position. Res #32 stated the bed rails were used to aide in turning and repositioning. There was no documentation of informed consent for bed rails found in the medical record. On 10/22/24 at 2:00 p.m., the corporate nurse consultant stated informed consent was not obtained prior to use of bedrails.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46582 Based on record review and interview, the facility failed to administer medication as ordered for one (#3) of six sampled residents whose medication records were reviewed. The BOM identified 38 residents who resided in the facility. Findings: Res #3 had diagnoses which included schizophrenia, auditory hallucinations, and bipolar disorder. A Release of Responsibility for Medication record, dated 12/11/23, documented the facility received 125 tablets of clozapine (antipsychotic medication) 100 mg upon Res #3's admission. A physician order, dated 12/11/23, documented to administer two tablets of clozapine 100 mg at bedtime for schizophrenia. A physician order, dated 12/11/23, documented to administer one tablet of clozapine 100 mg twice daily for schizophrenia. A care plan, dated 12/14/23, documented Res #3 received psychotropic medication for schizophrenia and to administer clozapine 100 mg at 8:00 a.m. and 4:00 p.m. The care plan documented to administer clozapine 200 mg at bedtime. A December 2023 MAR documented Res #3 received a total of 83 tablets of clozapine 100 mg. A pharmacy log, dated 01/26/24, documented the facility received 56 tablets of clozapine 100 mg for Res #3. A January 2024 MAR documented Res #3 received a total of 124 tablets of clozapine 100 mg for the entire month. A pharmacy log, dated 02/19/24, documented receipt of 56 tablets of clozapine 100 mg for Res #3. A February 2024 MAR documented Res #3 received a total of 116 tablets of clozapine 100 mg for the entire month. Pharmacy record review documented the facility had received a total of 237 tablets of clozapine 100 mg for Res #3 during the months of December 2023, January 2024, and February 2024. Res #3's medication records documented the resident had received 323 tablets of clozapine 100 mg during the months of December 2023, January 2024, and February 2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 10:23 a.m., CMA #1 was asked about the discrepancy in the number of clozapine tablets available in relation to the number of tablets documented as given for Res #3. CMA #1 stated Res #3 had received a total of 4 tablets of clozapine 100 mg daily during the months of December 2023 through February 2024. They stated having only been responsible for administering one of the three tablets during their shift. CMA #1 stated CMA #2 would have been responsible for administering the other three tablets in the afternoon and at bedtime. They stated CMA #2 may have been administering a discharged resident's leftover clozapine after Res #3's supply of tablets ran out. CMA #1 stated giving Res #3 some other resident's medication was against the rules and should not have happened. On 10/24/24 at 10:40 a.m., the BOM stated CMA #2 was unavailable for interview due to a medical leave absence. Attempts to interview CMA #2 via phone call were made with no success. On 10/24/24 at 11:27 a.m., the administrator was made aware of the medication count discrepancy for Res #3. The administrator stated the concern was never brought to their attention by staff. They stated staff should not have borrowed medications from another resident and there was no way to prove Res #3 had received the medication according to physician orders. On 10/24/24 at 11:43 a.m., the corporate nurse consultant stated Res #3's clozapine had not been administered per physician order.

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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. 46582 Based on record review and interview, the facility failed to ensure the physician responded to a pharmacist MRR and failed to ensure physician rationale was documented related to a declination of a GDR for two (#6 and #26) of five sampled residents reviewed for unnecessary medications. The BOM identified 38 residents who resided in the facility. Findings: A Drug Regimen Review policy, dated 2020, read in parts, .The consultant pharmacist drug regimen reviews are processed as follows: The physician provides a written response of the report to the facility within one month after the report is sent . 1. Res #6 had diagnoses which included dementia, schizophrenia, unspecified psychosis, and insomnia. A physician order, dated 06/08/23, documented to administer ramelteon (hypnotic medication) 8 mg at bedtime for insomnia. A physician order, dated 06/21/23, documented to administer Trintellix (antidepressant medication) 20 mg in the morning for depressive disorders. A physician order, dated 06/21/23, documented to administer desvenlafaxine (antidepressant medication) 100 mg in the morning for depressive disorders. A physician order, dated 07/27/23, documented to administer Vraylar (antipsychotic medication) 6 mg daily for schizophrenia. A physician order, dated 11/10/23, documented to administer olanzapine (antipsychotic medication) 10 mg at bedtime for schizophrenia. An annual assessment, dated 04/01/24, documented the resident was moderately cognitively impaired, had no depression symptoms, had no behaviors, and received hypnotic, antidepressant, and antipsychotic medication. A MRR report, dated 05/07/24, documented the resident was due for consideration of a gradual dose reduction of Trintellix, ramelteon, Vraylar, olanzapine, and desvenlafaxine. There was no documented response from the physician on the MRR report. On 10/24/24 at 9:15 a.m., the DON stated they did not have anything to do with the MRR process and was not familiar with the policy. The DON stated the MDS coordinator was responsible for this task. On 10/24/24 at 9:20 a.m., the MDS coordinator stated the physician had not responded to the pharmacist's request for a gradual dose reduction for Res #6's medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Res #26 was admitted with diagnoses which included dementia, depression, and insomnia. A physician order, dated 02/02/22, documented to administer trazadone (antidepressant medication) 150 mg at bedtime for insomnia. A physician order, dated 06/20/23, documented to administer Lexapro (antidepressant medication) 20 mg daily for depression. A physician order, dated 06/20/23, documented to administer Remeron (antidepressant medication)15 mg daily for depression. A physician order, dated 06/21/23, documented to administer lamotrigine (anticonvulsant medication) 150 mg twice daily for physical debility. A physician order, dated 08/08/23, documented to administer Invega (antipsychotic medication) 234 mg intramuscularly every 21 days for unspecified dementia. An annual assessment, dated 01/11/24, documented the resident was severely cognitively impaired, had no depression symptoms, had no behaviors, and received antipsychotic and antidepressant medication. A MRR report, dated 01/12/24, documented the resident was due for consideration of a GDR for Lexapro, lamotrigine, Remeron, Invega, and trazadone. The physician documented they disagreed with the request. There was no physician documented rationale for the declination of the GDR request on the MRR report. On 10/24/24 at 9:30 a.m., the MDS coordinator stated the physician should have documented a rationale for the declination of a GDR request for Res #26. On 10/24/24 at 11:45 a.m., the corporate nurse consultant stated the physician did not provide rationale for the declination of a GDR request for Res #26, but should have.

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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. 46582 Based on record review and interview, the facility failed to ensure a resident who received psychotropic medications had an acceptable diagnosis/indication for the use of an antipsychotic medication for one (#26) of five sampled residents reviewed for unnecessary medications. The corporate nurse consultant identified 16 residents who received antipsychotic medications. Findings: Res #26 was admitted with diagnoses which included dementia and depression. A physician order, dated 06/20/23, documented to administer cariprazine (antipsychotic medication) 3 mg once daily for unspecified dementia without psychotic or behavioral disturbance. A physician order, dated 08/08/23, documented to administer Invega (antipsychotic medication) 234 mg intramuscularly every 21 days for unspecified dementia. An annual assessment, dated 01/11/24, documented the resident was severely cognitively impaired, had no depression symptoms, had no behaviors, and received antipsychotic medication. On 10/24/24 at 9:30 a.m., the MDS coordinator stated Res #26 should not have antipsychotic medications ordered for a diagnosis of dementia. On 10/24/24 at 11:45 a.m., the corporate nurse consultant stated dementia was not an appropriate diagnosis for the use of antipsychotic medications.

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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. 46387 Based on observation and interview, the facility failed to ensure food was stored in accordance with professional standards for food service safety. The BOM identified 38 residents resided in the facility. Findings: On 10/21/24 at 8:12 a.m., the initial tour of the kitchen was conducted. The following was observed: a. in the two door silver refrigerator a clear gallon bag containing six raw, pre-formed, hamburger patties was observed in a white plastic tote on top of a clear gallon bag containing pre-cooked and sliced sandwich meat labeled Ranch Packs dated 10/03/24, b. in the two door silver refrigerator a clear gallon bag labeled deli-sliced ham was on top of the bag containing raw hamburger patties, c. in the two door silver refrigerator a gallon pour top jug containing a brown liquid was not dated or labeled, d. in the two door silver refrigerator a gallon pour top jug containing an orange liquid was not dated or labeled, e. in the dry storage area an undated and unlabeled blue bag was observed with the top tied in a knot, the staff identified the contents as raisins, f. in the white Frigidaire refrigerator zucchini was observed to have a grey and white fuzzy substance covering the surface of the vegetables, and g. the floor in the kitchen had debris and food particles. On 10/21/24 at 8:16 a.m., [NAME] #1 stated the raw meat should not have been stored with the cooked meat. They stated food should be labeled and dated when they were prepared, stored, or opened. On 10/21/24 at 8:46 a.m., the DM was made aware of the above observations.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 46582 Based on observation, record review, and interview, the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for one (#32) of one sampled resident reviewed for bed rails. The corporate nurse consultant identified four residents whose beds were equipped with a bed rail of any type. Findings: An undated Maintenance policy, read in part, .This facility will conduct preventative maintenance checks periodically and as needed for facility equipment and facility property. This facility will maintain preventative maintenance records pertaining to equipment and facility property . Res #32 had diagnoses which included fusion of the cervical spine, central cord syndrome, and muscle weakness. An admission assessment, dated 09/26/22, documented the resident was cognitively intact, required extensive assistance with bed mobility, and had one fall without injury. A physician order, dated 06/28/23, documented the resident could have half rails to their bed for repositioning purposes. A care plan, dated 09/28/23, documented the resident was able to use side rails for repositioning and rolling in bed. On 10/21/24 at 9:56 a.m., Res #32 was observed lying in bed. Bilateral half bed rails were observed on the upper half of the bed in the up position. Res #32 stated the bed rails were used to aide in turning and repositioning. On 10/22/24 at 1:35 p.m., the administrator was asked to provide documentation of regular bed rail inspections for Res #32. On 10/22/24 at 2:05 p.m., the administrator stated maintenance routinely checked bed rails, but had not maintained records of the inspections.