STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375427	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Fellowship Home for Senior Citizens, Inc	605 East State Road Fairview, OK 73737

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 21731 Based on observation, record review, and interview, the facility failed to ensure residents dependent for meal assistance were treated with dignity during the noon meal for five (#11, 12, 16, 36, 50, 57, and #58) of 13 dependent residents observed during meal assist The MDS coordinator stated 13 residents required assistance with meal intake Findings: 1. Resident #11 had a diagnosis of seizures. A Care Plan, dated 11/27/23, documented Resident #11 had a potential impaired nutritional status and required assistance with meals at times. A Quarterly Assessment, dated 02/29/24, documented Resident #11 was cognitively intact for decision making and independent with eating. 2. Resident #12 had a diagnosis of dementia. A Care Plan, dated 07/20/23, documented Resident #12 had a potential for impaired nutritional status and required assistance with meals at times. A Quarterly Assessment, dated 04/18/24, documented Resident #12 had severe cognitive impairment and required partial to moderate assistance with eating. 3. Resident #36 had a diagnosis of dementia. A Care Plan, dated 11/30/20, documented Resident #36 had a potential impaired nutritional status, could feed themselves if set up assistance was provided. A Significant Change of Status Assessment, dated 03/28/24, documented Resident #36 had severe cognitive impairment, and required substantial to maximum assistance with eating. 4. Resident #57 had diagnoses to include other symptoms and signs involving cognitive function and awareness. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan, dated 09/28/23, documented Resident #57 had a potential for impaired nutritional status, and an ADL self care performance deficit. The care plan documented Resident #57 was able to feed themselves. A Significant Change of Status Assessment, dated 03/07/24, documented Resident #57 had moderate cognitive impairment, and was independent in eating. 5. Resident #58 had a diagnosis of Parkinson's Disease. A Care Plan, dated 10/05/23, doucmented Resident #38 had a potential for impaired nutritional status and staff were to assist with eating as needed. A Significant Change of Condition Assessment, dated 04/11/24, documented Resident #38 had moderate cognitive impairment, and required substantial to maximum assistance with eating. On 05/20/24 at 11:19 a.m., CNA #4 enter the secure unit from an outside hall door. As they walked past residents, seated at the dining tables, CNA #4 stopped and provided a bite of food to #36, while standing next to the resident. On 05/20/24 at 11:21 a.m., the following were observed: a. CNA #4 donned gloves , returned to Resident #36, and while standing next to the resident, provided assistance with eating. b. CNA #4 walked way from Resident #36, to assist Resident #58. c. CNA #5 assisted Resident #57 to be seated at a table, and stood next to the resident while they provided assistance with eating. d. CNA #5 then walked away from Resident #35 to a separate table, and stood while they provided eating assistance with Resident #11. e. CNA #5 walked away from Resident #11 and provided eating assistance for Resident #36, and remained standing to turn as provide eating assistance to Resident #58. f. While still standing, CNA #5 returned to assist Resident #36, to wipe food from inside and around the resident's mouth. On 05/20/24 at 11:27 a.m., CNA #5 stood next to Resident #11 while the CNA provided eating assistance. When CNA #5 walked away from Resident #11, CMA #3 stood next to Resident #11 and provided eating assistance. The staff continued to walk from table to table and stand next to dependent residents to provide eating assistance throughout the meal. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/24 at 12:36 p.m., CNA #5 was asked what the facility policy was in regards to providing eating assistance for dependent residents. They stated, staff are not to walk away from the resident they are assisting. CNA #5 was asked what the policy stated regarding staff standing next to the resident while assisting with eating. They stated it is ok to sit or stand just not to move away from the resident. CNA #5 was asked if standing over a resident that is eating could be a dignity issue. They stated, Yes, but I did not think about that. 36191 6. Resident #16 had diagnoses which included Alzheimer's Disease. A Nutrition care plan, dated 08/29/19, documented Resident #16 had altered nutrition related to cognitive impairment and the need for mechanically altered diet. The care plan intervention, dated 06/21/21, documented Resident #16 ate their meals in the main dining room with staff assistance. Resident #16's significant change assessment, dated 03/07/24, documented they had severe cognitive impairment and required substantial/maximal assistance with eating. 7. Resident #50 had diagnoses which included cerebral infarction (stroke) with aphasia (Damage to specific brain regions causing impaired language.) and dementia. A nutrition care plan, dated 08/17/23, documented Resident #50 was at risk for altered nutritional status due to physical condition after a stroke. The care plan intervention, dated 03/14/24, documented Resident #50 ate their meals in the main dining room with staff assistance. Resident #50's quarterly assessment, dated 02/22/24, documented they had severe cognitive impairment and required substantial/maximal assistance with eating. On 05/20/24 at 12:00 p.m., CNA #3 was observed standing while they assisted Resident #16 and #50 with eating. On 05/20/24 at 12:02 p.m., CNA #3 remained standing with their back to Resident #50, and talking to another staff while they assisted Resident #16 with eating and turning back and forth to Resident #16 and Resident #50 while assisting them with eating. On 05/20/24 at 12:06 p.m., CNA #3 went to other side of the table to assist another resident out of the dining room. Resident #50 remained at the dining room table with food in front of them. There was no staff assisting the resident to eat. On 05/20/24 from 12:09 p.m. through 12:16 p.m., Resident #50 was sitting at the table not feeding themselves and there was no staff assisting the resident with eating. On 05/20/24 at 12:17 p.m., CNA #3 came back to the table to feed Resident #50. The resident ate the food offered by the CNA. CNA #3 remained standing while they assisted the resident with their meal. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/24 at 12:28 p.m., CNA #3 stated Resident #50 would feed themselves every once in a while. CNA #3 stated they knew they were not supposed to stand over the residents while they fed them. CNA #3 was asked why they left Resident #50 with food in front of them and went to care for another resident. They stated they had to assist the other resident back to their hall or they would try to get up on their own and fall.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on interview and record review, the facility failed to ensure OHCA was notified after a resident received a significant mental health diagnosis for two (#12 and #30) of five residents reviewed for Pasarr. The DON identified 56 residents had mental health diagnosis. Findings: 1. Resident #12 was admitted on [DATE] with diagnosis which included vascular dementia with mood disturbance and anxiety. A comprehensive assessment dated [DATE] documented Resident #12's cognition was severly impaired and had Anxiety disorder in section I Active Diagnoses. A quarterly assessment, dated 10/19/23 documented anxiety,depression, and psychotic disorder in section I Active Diagnoses. A Order Summary Report, dated 5/23/24, read in part, .Celexa Oral Tablet 10 mg .related to depression . 9/18/23 .Seroquel Oral Tablet 25 MG---related to unspecified psychosis not due to a substance or known physiological condition . 9/27/23 On 05/22/24 at 01:43 p.m., the DON Tell me about the Seroquel prescribed 9/28/23. The DON stated It was prescribed related to a new diagnosis of unspecified psychosis not due to a substance or known physiological condition. The DON was asked if a PASARR II was completed after a new diagnosis. The DON stated they did not complete A PASARR II. 2. Resident # 30 was admitted on [DATE] with diagnosis which included type 2 diabetes, unspecified intellectual disabilities and personal history of transient ischemic and cerebral infarction. A Oklahoma Health Care authority Nursing Facility Level of Care Assessment assessment, dated 05/04/20, read in part, .No Evidence of serious mental illness including possible disturbances in orientation or mood . A comprehensive assessment, dated 05/07/20, did not documented, Resident #30 had a diagnosis of psychotic disorders and anxiety. A comprehensive assessment, dated 7/13/23, documented, Resident #30 had a diagnosis of depression and anxiety disorder. A Order Summary Report document ,dated 5/21/24 , read in part, .Abilify Tablet 15 MG .related to delusional disorder .10/15/21 .buspirone HCl Tablet 15 MG .related to Anxiety Disorder .12/4/22. On 05/21/24 at 11:51 a.m., the DON stated the facility did not have a Passar policy. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 01:38 p.m., the DON was asked about the PASARR completed after diagnosis of delusional disorder on 10/15/21 and anxiety disorder on 12/05/22. The DON stated there was no PASARR completed after the new diagnosis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36191 Based on observation, record review, and interview, the facility failed to develop a care plan for the use of bed rails for one (#168) of two sampled residents who had bed rails. The DON identified 23 residents who had bed rails. Findings: The facility's MDS and Care Plan Process policy, revised 07/2023, read in part, The plan of care is a road map in how to best care for each resident and the needs each individual resident has. The policy also read, Each care plan is to be accurate in identifying individualized approaches .to assist in providing care to each resident. Resident #168's care plan was reviewed. The care plan did not document the use of bed rails. On 05/22/24 at 12:54 p.m., Resident #168 was observed laying on their side in bed with half bed rails observed in the upright position. On 05/22/24 at 1:53 p.m., Resident #168 observed in bed there were two half rails on bed in the upright position. On 05/22/24 at 2:07 p.m., the DON stated Resident #168 used bed rails for independence and repositioning. They stated they did not find the use of bed rails documented on the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 36191 Based on observation, record review, and interview, the facility failed to ensure the care plan was updated with fall interventions after falls for two (#32 and #36) of four sampled residents reviewed for falls. The DON identified 50 residents had falls in the facility and 65 residents who resided in the facility. Findings: The facilty's Incident Reporting, Information Routing and Follow-Up policy, revised 03/2023, read in part, All incidents are to be reported .so that proper care , interventions, treatment is identified and performed. The policy also read, The Care Plan Coordinator will review for appropriate interventions listed, update the care plan. A MDS and Care Plan Process document, revised 07/2023 read in part, Each care plan is to be accurate in identifying individualized approaches from each discipline to assist in providing care to each resident. The facility's Policy #13 policy, revised 07/2023, read in part, .If a resident is identified at risk for falls the MDS/ Care Plan coordinator will be notified and it will be addressed in the care plan . 1. Resident #32 had diagnoses which included dementia. Resident #32's significant change assessment, dated 04/04/24, documented they had severe cognitive impairment, required partial to moderate assistance for transfers and ambulation, and had two or more falls with no injury and two or more falls with minor injury. The fall care plan for Resident #32 documented the following interventions: a. initiated on 10/10/22 ensure the resident is wearing appropriate footwear when ambulating and follow facility fall protocol; b. initiated on 10/15/22 continue interventions on the at-risk plan; c. initiated on 10/18/22 determine and address causative factors of the fall; d. initiated on 11/10/22 resident is on the bowel and bladder program; and e. initiated on 12/04/22 pharmacy consult to evaluate medications. The care plan documented the resident had been found on the floor and/or had a fall on the following dates: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/11/23 the resident had a fall in the hall 3 sitting area with no injuries; On 11/13/23 the resident was found on the floor with no injuries; On 12/02/23 the resident was found on the floor with skin tear to right elbow; On 12/06/23 the resident was found on the floor with no injuries; On 12/25/23 and 01/22/24 the resident was found sitting on the floor with no injuries; On 02/03/24 the resident had a witnessed fall resulting in a hematoma to the back of their head; On 02/03/24 the resident was found on the floor in the dining room, the resident had the hematoma to the back of the head from a previous fall and had hit their head again; On 02/06/24 the resident was found sitting on the floor in doorway of room with no injuries; On 02/14/24 the resident was found sitting on the floor on hall three with no injuries; On 02/15/24 the resident was found sitting on the floor beside the recliner with a skin tear to the front and back of the left lower leg; On 02/16/24 the resident was found sitting on the floor with no injuries; On 02/18/24 the resident was found laying on the floor in the bathroom with no injuries; On 02/26/22 the resident was found sitting on the floor inside doorway of the room with skin tear to right elbow; On 02/26/24 the resident had a fall in the dining room with no new noted injuries. The resident was sent to the emergency room for evaluation with no injuries; On 03/15/24 the resident was found lying on their back behind their door with a skin tear to jawline and a bump to the right side of their head; On 04/10/24 the resident was found lying on the floor inside the doorway of their room with an abrasion to their left knee; On 05/08/24 the resident was found sitting on the floor in the three/four sitting area with no injuries; On 05/18/24 the resident had attempted to self ambulate and had fallen with no injuries. There were no new interventions documented on the care plan for the above falls. The care plan had not been updated with interventions since 12/2022. On 05/19/24 at 9:28 a.m., Resident #32 was observed with a dressing to left wrist. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/19/24 at 10:08 a.m., RN #2 stated the dressing on Resident #32's left hand was from a fall. On 05/21/24 at 8:14 a.m., Resident # 32 was observed walking in the hall with a staff member next to them providing assistance using the gait belt. On 05/22/24 at 9:37 a.m., the MDS Coordinator stated they had documented a few interventions to prevent falls but had not updated the care plan with each fall. The MDS coordinator was asked about the falls Resident #32 had in February 2024. They stated Resident #32 had Covid-19 and was in and out of isolation. They were asked what interventions had been put in place to prevent falls. They stated they knew staff had increased supervision rounds and the staff would have Resident #32 sit in the common area to be supervised. They stated they had not documented the interventions on the care plan. 46702 2. Resident #36 was admitted with diagnoses which included dementia, psychotic disturbance, and anxiety. Internal Incident Reports documented Resident # 36 had falls on : a. 03/31/24 b. 04/04/24, c. 04/08/24,and d. 05/06/24. On 3/31/2024 at 6:58 p.m., a nurses note read in part, .resident was on floor .lowered bed to floor, placed fall mat . On 4/4/2024 at 4:30 a.m., a nurses note read in part, .Resident was found lying on [their] right side on fall mat at bed side .bed lowered, fall mat put back in place and call light put within reach . On 04/8/2024 at 04:10 a.m., a nurses note read in part, Resident was lying on her right side on fall matt at bedside . Placed wedge behind her left side to attempt to prevent her rolling off bed. Bed in low position with fall matt in place .call light in reach . A comprehensive care plan, intimated 03/28/24, to prevent falls intervention was last updated on 04/01/23 and did not document and new interventions since 11/03/2020. On 05/6/2024 at 04:00 a.m., a nurses note read in part, .Resident found lying on her right side on fall matt at bedside . On 05/19/24 at 01:22 p.m., Resident #36 was observed to have low bed and fall mat at bed side. The interventions were not in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/24 at 09:06 a.m.,CMA #1 was asked what interventions are in place to prevent falls. CMA #1 stated Resident #36 had low bed and a fall mat on the floor. CMA #1 was asked if the low bed and fall mat was care planned. CMA#1 stated the fall mat and low bed was not in the care plan. On 05/21/24 at 09:20 a.m., LPN #2 was asked what interventions were in place to prevent falls. LPN #2 stated they do bed checks frequently, door cracked, and moved resident's room closer to nurse station, resident had a low bed, and a fall mat provided by hospice. LPN #2 stated there were no fall interventions in the care plan for the previous items. On 05/22/24 at 9:32 a.m., the DON was asked how many falls Resident #36 had. The DON stated Resident #36 had 4 falls. The DON was asked what the policy was after a resident falls. The DON stated they discuss new interventions and add them to the care plan. The DON stated the fall mat was not documented in the care plan and no new interventions after the above falls were added to the care plan. The DON stated all interventions after post fall should of been added as soon as possible and no later than 14 days.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 36191 Based on observation, record review, and interview, the facility failed to ensure residents were offered hydration for one (#44) of two sampled residents reviewed for hydration. The MDS coordinator identified 13 residents who required assisted with eating/drinking. Findings: Resident #44 had diagnoses which included dementia, urinary incontinence, and UTI. A dietary note, dated 3/11/24, documented annual nutrition assessment was completed and Resident #44 had the estimated need of 1802 milliliters of fluid, monitor, and to continue the plan of care. A physician's progress note, dated 05/08/24, documented Resident #44 had an abnormal CT which indicated possible old stroke, Resident #44 had a UTI and to continue antibiotics for five days, culture pending, push fluids, and monitor. Resident #44's electronic record documented the resident had 600 ml of fluid on 05/09/24, 720 ml on 05/10/24, 360 ml on 05/11/24 and 05/12/24, 600 ml on 05/13/24 and 05/14/24, 1190 ml on 05/15/24, 360 ml on 05/16/24 and 05/17/24, 480 ml on 05/18/24, and 680 ml on 05/19/24. On 05/19/24 at 10:35 a.m., Resident #44's family member stated they had a camera in the room and had not observed the staff offering the resident anything to drink while the resident was in the room. The resident's family member was observed assisting the resident with drinking water. On 05/21/24 at 8:14 a.m., Resident # 44 in bed asleep, note on door documents do not wake up until after 10:00 a.m. On 05/21/24 at 8:30 a.m., Resident # 44 was observed in bed. The resident's water was on the table at the bed not within reach. On 05/21/24 at 8:59 a.m., Resident # 44 remained in bed, lights off, cup in same position. On 05/21/24 at 9:25 a.m., a staff member walked in and out of the resident's room. On 05/21/24 at 9:31 a.m., CNA #2 was observed while they provided incontinent care to Resident #44. They did not offer the resident a drink. On 05/21/24 at 10:11 a.m., CNA #2 came in to assist Resident #44 out of bed. CNA #2 assisted the resident out of bed with CMA #4's assistance. The staff finished providing personal hygiene to the resident. The staff did not offer the resident a drink. On 05/21/24 at 10:38 a.m., the staff took Resident #44 to exercise room, they did not offer the resident a drink. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/24 at 11:25 a.m., staff were feeding Resident #44. On 05/21/24 at 11:48 a.m., CMA #4 stated Resident #44 drank 375 ml of water. On 05/21/24 at 1:46 p.m., the staff were observed transferring Resident #44 into their recliner. The staff did not offer the resident a drink. On 05/21/24 at 1:48 p.m., Resident #44 was asked if they were thirsty. The resident did not answer. On 05/22/24 at 7:49 a.m., CNA #2 and CNA #7 were observed repositioning Resident #44. The staff did not offer the resident a drink. On 05/22/24 at 7:52 a.m., CNA #2 stated they checked the resident at 6:00 a.m. They stated we made sure Resident #44 was dry and repositioned the resident on their back. On 05/22/24 at 7:53 a.m., CNA #2 placed a water cup at the end of the resident's bed on the over bed table. The CNA did not offer the resident a drink. On 05/22/24 at 8:02 a.m., the MDS coordinator stated Resident #44 had a significant decline and was receiving hospice care. They stated the staff should check the resident for incontinence, change the resident if needed, reposition them, offer fluids, and make sure the resident's belongings and call light were within reach every two hours. They were made aware of the observations and stated the expectation was for the staff to offer fluids whenever they were in Resident #44's room. On 05/22/24 at 8:17 a.m., CNA #2 stated they had to assist Resident #44 with eating and drinking because they had a stroke. CNA #2 stated sometimes they offered Resident #44 a drink when the resident was awake and responsive. CNA #2 was asked if there was any reason they did not offer Resident #44 a drink while they were in the resident's room. They stated, No. They were asked what interventions they would do for a resident who had a UTI. They stated the CMA gave medications and they made sure the residents were offered plenty of fluid.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 36191 Based on observation, record review, and interview, the facility failed to ensure bed rails were assessed for risk of entrapment, reviewed the risks and benefits of the bed rails with the resident or resident representative, or obtained informed consent prior to installation of the bedrail for two (#43 and #168) of two sampled residents assessed for accident hazards. The DON identified 23 residents who utilized bed rails. Findings: 1. Resident #43 had diagnoses which included dementia, history of right femur, and protein calorie malnutrition. Resident #43's significant change assessment, dated 03/19/24, documented they had severe cognitive impairment and required partial to substantial assistance with ADL care. An ADL care plan, dated 01/04/24, documented Resident #43 required extensive assistance with ADLs and utilized half bed rails. On 05/19/24 at 12:49 p.m., Resident # 43 had a half bedrail in place on their bed in the upright position. 2. Resident #168 had diagnoses which included heart failure, altered mental status, and non-displaced chip fracture of the right talus. (A small break in the ankle bone.) A document titled, Side Rail Review, dated 05/03/24, documented half side rails were indicated. The risks and benefits were not documented on the form. Resident #168's admission assessment, dated 05/10/24, documented they had severe cognitive impairment, required partial to moderate assistance with bed mobility and transfers, and had one fall prior to admission. There was no assessment for entrapment or consent for the bed rails in Resident #43's or Resident #168's record. On 05/22/24 at 12:54 p.m., Resident #168 was observed in bed, laying on side, bedrails observed in the upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/24 at 2:07 p.m., the DON stated Resident #168 utilized half rails on their bed. They stated the bed rails were used for independence and repositioning. The DON was asked if they had tried an alternative prior to installing the bed rails, assessed the resident for entrapment with the bed rails, had informed the resident and/or resident representative of the risks and benefits of the bed rails and obtained a signed consent prior to the use. They stated, No. The DON stated they had not done an entrapment assessment for any of the residents who had bed rails. On 05/23/24 at 1:38 p.m., the DON stated they did not have a consent or entrapment assessment for Resident #43.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 21731 Based on record review and interview, the facility failed to ensure RN coverage for eight consecutive hours a day, seven days a week. Census: 65 The PBJ Staffing Data Report, for 10/01/23 thru 12/31/23, documented the facility did not identify RN hours for 10/1/23, 12/22/23, 12/25/23, and 12/30/23 On 05/21/24 at 9:15 a.m., requested HR to provide documentation an RN had worked eight consecutive hours, in the building on 10/1/23, 12/22/23, 12/25/23, and 12/30/23. On 05/21/24 at 1:40 p.m., HR reported the facility did not have RN coverage in the building on 10/01/23.

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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. 36191 Based on observation and interview, the facility failed to provide a separately locked, permanently affixed compartment for storage of controlled drugs for one of two refrigerators utilized for storage of drugs. The DON identified 65 residents who resided in the facility. Findings: On 05/21/24 at 3:20 p.m., the medication mini refrigerator was observed at the nurse's station on hall five. The medication refrigerator was sitting on the counter not permanently affixed and there was a small metal lock box inside the refrigerator not affixed. The lock box was observed with LPN #2. The lock box contained two plastic bags with the following medication: Lorazepam 0. 5mg 30 syringes and Lorazepam 0. 5mg 22 syringes. The nurses' station where the mini refrigerator was observed had an open window area to the hall. On 05/22/24 at 10:02 a.m., the nurse's station on hall five was observed with the door propped open, the black mini fridge was observed on the counter not affixed. On 05/22/24 at 10:05 a.m., RN #2 stated the door was closed and locked most of the time. On 05/23/24 at 1:38 p.m., the DON was notified of the observation of the mini refrigerator containing controlled medication not being permanently affixed and the door to the nurses' station open and unlocked.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 21731 Based on record review and interview, the facility failed to ensure the Payroll Based Journal accurately reflected RN coverage. Census: 65 Findings: The PBJ Staffing Data Report, for 10/01/23 thru 12/31/23, documented the facility did not identify RN hours for 10/1/23, 12/22/23, 12/25/23, and 12/30/23 On 05/21/24 at 9:15 a.m., requested HR to provide documentation an RN had worked in the building on 10/1/23, 12/22/23, 12/25/23, and 12/30/23. On 05/21/24 at 1:40 p.m., HR provided documentation RN coverage for the facility on 12/22/23, 12/25/23 and 12/30/23. They stated the PBJ report not did not accurately reflect the RN coverage on three of the four days in question.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 21731 Based on observation, record review, and interviews, the facility failed to ensure: a. hand hygiene was maintained during eating assistance for seven (#11, 36, 55, 56, 57, 58, and #64) of 15 sampled residents observed during noon meal assistance on the secure unit; b. enhanced barrier precautions were implemented for a resident with an indwelling catheter and the urinary catheter bag was not on the floor for one (#12) of one sampled resident reviewed for infection control with a catheter; and c. oxygen tubing and humidification bottles were labeled for one (#34) of one sampled residents reviewed for the use of oxygen equipment. Census: 65 Findings: A Hand Washing Policy, updated on 03/15/11, read in parts, .Hands should be thoroughly washed before and after providing resident care .hand washing techniques must be followed at all times . The facilty's Evaluation for Justification of Indwelling Catheter Use policy, dated 10/2023, read in part, . STEPS TO PREVENT INFECTIONS IN CATHETER RESIDENTS .Catheter should never touch the floor, neither tubing or bag . 1. On 05/20/24 at 11:19 a.m., the following was observed in the dining area of the secured unit: a. CNA #4 enter the secure unit from an outside hall door, provided a bite of food to Resident #36, then went to the sink and washed their hands. b. CNA #4 donned gloves, and assisted Resident #36. c. With the same gloved hands, CNA #4, moved to next table to assist Resident #58. d. CNA #5, while wearing gloves, assisted Resident #57 to ambulate to a table, assisted to move a chair Resident #57 to be seated, removed the resident's walker, return to Resident #57, removed plate cover and placed on the tray cart, returned to Resident #57, to provide bites of food from the plate. e. With the same gloved hands, CNA #5 walked to Resident #36, and provided bites of food. f. With the same gloved hands, CNA #5 assisted Resident #11 with bites of food, returned to Resident #36 to provide a few bites of food, then assisted Resident #58 with bites of food. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. With the same gloved hands, CNA #5 picked up eating utensils to cut bread into bite sizes for Resident #58 and handed the utensils to Resident #58, then returned to Resident #36, wiped food from resident's mouth, placed napkin in trash, open a cabinet to obtain new napkin, returned Resident #36 to wipe the resident's mouth again and remove food particles. CNA #5 disposed of the napkins in trash, and returned to Resident #36 and continued to wipe the resident's mouth. h. With the same gloved hands, CNA #5 provided eating assistance for Resident #11 On 05/20/24 11:27 at a.m., CMA #3 was observed as follows: a. CMA #3 donned gloves and assisted Resident #11 with bites of food. b. With the same gloved hands, CMA #3 went to the food cart, obtained additional cake, opened a wrapper of cookies into their hand and handed the cookies to Resident #55. c. With the same gloved hands, CMA #3 then served cake to Residents #57, #56, and #64. d. With the same gloved hands, CMA #3 obtained dirty dishes from Resident #64, and without changing their gloves, served cake to Resident #11. Staff did not change gloves or sanitize hands when changing from one resident to another, when touching foods to be eaten, or after picking up dirty dishes from residents. On 05/20/24 at 12:30 p.m., CNA #5 what was the policy for when staff were to wash their hands. They stated hands were to be washed after they deal with resident, toileting, after meals, and after going to the bathroom. On 05/20/24 at 12:35 p.m., CNA #4 was asked if they had washed their hands during the time provided the entered the dining area and provided meal assistance to the residents. They stated, I washed my hands when I came in. I have on gloves. CNAs #4 and #5, were asked if staff had followed the policy to wash their hands after assistance with each resident. CNA #5 stated, No. 2. Resident #34 had diagnoses to include pneumonia and UTI. A Physician Order, dated 04/30/24, documented Resident #34 was to be administered oxygen at two to four liters per nasal cannula, continuously to maintain oxygen saturation at or above 90 percent, staff were to initial and date all oxygen equipment, and to change the tubing and humidification bottle every seven days. A Discharge -Return Anticipated Assessment, dated 04/30/24, documented resident #34 had a memory problem and required modified independence with cognitive skills for daily decision making, and did not indicate resident #34 had utilized oxygen supplement. A Care Plan, dated 04/30/24, documented Resident #34 has shortness of breath and lethargy, oxygen at 2 to 4 liters continuously to maintain sats above 90 percent. The interventions documented, an update on 05/01/24, to monitor for worsening of signs/symptoms; oxygen at 2 to 4 liter continuously to maintain oxygen saturations above 90%, and provide medications as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Entry Assessment, dated 05/03/24, documented Resident #34 had re-entered the facility from a critical access hospital. On 05/19/24 at 10:37 a.m., an oxygen concentrator was in the resident's room. There was no label on tubing or humidification bottle. The nasal cannula was draped over edge of recliner next to the resident's bed. On 05/22/24 at 12:40 p.m. Resident #34 stated have been sick and in the hospital, had used oxygen for a few days but had not used oxygen today. Resident #34 stated the staff moved the concentrator to the foot of the bed. The oxygen concentrator was positioned at the foot of the bed. There was no label or date on the oxygen tubing or the humidification bottle. The tubing was rolled and placed between the handle and the concentrator. The nasal cannula is not covered or protected. On 05/22/24 at 12:51 p.m., LPN #1 stated Resident #34 had been in the hospital a week or two ago for pneumonia and a UTI, and the resident had only recently been on oxygen. LPN #1 stated, I don't see a label on the tubing or the water bottle, and there should have been. 46702 3. Resident #12 was admitted with diagnoses which included unspecified fracture of shaft of humorous, cerebral infarction, and urinary tract infection. A comprehensive assessment, dated 07/24/23 documented Resident #12's cognition was severly impaired. A document titled, Facility Monthly Infection Control Report Infection Rate, dated 01/2024, documented one residents who had an indwelling catheter had a UTI. A document titled, Facility Monthly Infection Control Report Infection Rate, dated 02/2024, documented four residents with an indwelling catheter had a UTI. A document titled, Facility Monthly Infection Control Report Infection Rate, dated 03/2024, documented three residents who had an indwelling catheter had a UTI. A document titled, Facility Monthly Infection Control Report Infection Rate, dated 04/2024, documented two residents who had an indwelling catheter had a UTI. A document titled, Urinary Tract Infection, dated 05/15/24, documented Resident #12 met the criteria for antibiotic therapy for UTI. A physician's order, dated 05/20/24, documented to administer Augmentin 875 mg-125 mg one tablet two times a day for seven days for UTI. A Order Summary report, dated 5/23/24, read in part, .Foley Catheter to straight drainage as needed . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/24 at 10:09 a.m., RN #2 and CNA #1 were observed providing perineal care for Resident #12. RN #2 and CNA #1 did not don an isolation gown before providing perineal care. The catheter bag was placed on the bed during care and fell into the floor. The catheter bag remained on the floor while the care was provided and the bed was moved. The catheter bag was drug across the floor before being picked up and hooked to the bed frame by the RN. On 05/22/24 at 1:57 p.m., the DON was asked what was the policy when emptying a catheter bag for placement and infection control. The DON stated the bag goes to below the bladder hanging on the side of bed. The DON was asked would the bag be on the floor. The DON stated,No, it shouldn't be on the floor. The bag should be replaced or the spout cleaned if the bag was on the floor. On 05/23/24 at 8:51 a.m., the DON stated they had not implemented enhanced barrier precautions for every resident who had a wound or indwelling catheter. They stated they implemented enhanced barrier precaution if the resident was colonized with a multidrug resistant organism and had an indwelling catheter or open wound.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 36191 Based on record review and interview, the facility failed to ensure residents were administered the pneumonia vaccination for two (#12 and #49) of five sampled residents reviewed for immunizations. The administrator identified 65 residents who resided in the facility. Findings: The facility's undated Immunizations and Vaccinations policy, read in part, .Pneumonococcal [sic]vaccines will be offered between Oct and March each year The policy also documented, The puemonococcal [sic] vaccine will be offered every five .years unless otherwise specified by the primary physician. 1. Resident #12 had diagnoses which included dementia. A document titled, Vaccine Information, dated 07/19/23, documented the resident's representative gave permission for the resident to receive the pneumonia vaccine. There was no documentation in the resident's record the pneumococcal vaccine had been administered. 2. Resident #49 had diagnoses which included pneumonia and diabetes. A document titled, Vaccine Information, dated 09/29/23, documented the resident gave permission to receive the pneumonia vaccine. There was no documentation in the resident's record the pneumococcal vaccine had been administered. On 05/23/24 at 11:18 a.m., the MDS Coordinator stated the consents were signed to receive the pneumococcal vaccine. They stated there was no documentation the vaccines had been administered and there was not a record in the Oklahoma State Immunization Information System of the vaccine being previously administered.