STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375437	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Family Care Center of Kingston	701 Highway 32 Kingston, OK 73439

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 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. Based on observation, record review, and interview, the facility failed to provide dignity for 1 (#1) of 1 sampled resident reviewed an indwelling urinary catheter. The DON identified three residents with indwelling urinary catheters. Findings: On 07/28/25 at 2:23 p.m., Res #1 was observed lying in bed with their eyes closed. The resident's indwelling urinary catheter bag was hanging from the bedside uncovered. On 07/29/25 at 9:53 a.m., Res #1 was observed lying in bed watching television. The resident's indwelling urinary catheter bag was hanging from the bedside and did not have a privacy cover. On 07/30/25 at 12:21 p.m., Res #1's indwelling urinary catheter bag was observed hanging from the bedside uncovered and was in full view from the resident's doorway. A facility policy titled Quality of Life - Dignity, revised 08/2009, read in part, Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered An undated transfer/discharge report showed Res #1 had diagnoses which included cerebral infarction, chronic pain, urinary tract infection, and benign prostatic hyperplasia. An annual assessment, dated 07/07/25, showed Res #1's memory was ok and was independent for daily decision making. The assessment showed the resident had an indwelling catheter. On 07/30/25 at 1:33 p.m., certified nursing assistant #1 stated Res #1's indwelling urinary catheter bag was not covered and should be placed in a privacy bag. On 07/30/25 at 1:39 p.m., LPN #1 stated indwelling urinary catheter bags should be in a privacy bag. On 07/30/25 at 2:33 p. m., the DON stated residents with indwelling urinary catheters should have their catheter bags in a privacy bag.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were offered the opportunity to create an advance directive for 2 (#38 and #43) of 3 sampled residents reviewed for advanced directives.The administrator identified 38 residents resided in the facility.Findings: An Advance Directive policy, revised 12/2016, read in part, Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.Written information will include a description of the facility's policies to implement advance directives.Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directive.Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. 1. An undated Transfer/Discharge report for Resident #38 showed the resident was admitted to the facility on [DATE]. A review of Resident #38's electronic health record showed no advance directive information had been provided. 2. An undated Transfer/Discharge report for Resident #43 showed the resident was admitted to the facility on [DATE]. A review of Resident #43's electronic health record showed no advance directive information had been provided. On 07/30/25 at 11:36 a.m., the MDS coordinator stated, As of right now we do not have an advance directive for [Resident #38] or [Resident #43].

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on record review and interview, the facility failed to complete a significant change assessment for 1 (#30) of 12 sampled residents whose assessments were reviewed. The administrator identified 38 residents resided in the facility.Findings:An undated discharge/transfer report showed Res #30 had diagnoses which included acute kidney failure, dementia, and disorder of the skin and subcutaneous tissue. A physician order, dated 06/13/25, showed Res #30 had an order to admit to hospice service for a diagnosis of heart disease with heart failure. The electronic record for Res #30 showed a significant change assessment, dated 06/18/25, was in progress. On 08/04/25 at 11:22 a.m., the MDS coordinator was interviewed regarding a significant change assessment still in progress dated 06/18/25 for Resident #30. The MDS coordinator stated a significant change assessment was to be completed 14 days after a resident was admitted for hospice services. The MDS coordinator stated a significant change assessment was not completed in the required time frame and was an oversite.

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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. Based on record review and interview, the facility failed to ensure care plans were revised for 2 (#3 and #25) of 12 sampled residents reviewed for care plans.The administrator identified 38 residents resided in the facility.Findings:1. A physician's order for Resident #3, dated 04/16/25, showed to admit the resident to hospice for diagnosis of dementia.A review of Resident #3's care plan showed no documentation of the resident being on hospice.On 07/30/25 at 1:22 p.m., the MDS coordinator stated Resident #3's care plan did not reflect the resident was on hospice.2. Resident #25's Order Summary Report, dated 07/31/25, showed the resident had diagnosis of gastro-esophageal reflux disease.A review of Resident #25's electronic health record showed the resident weighed 190 pounds on 05/29/25 and 163.4 pounds on 07/30/25. This was a 14% weight loss in two months.A review of Resident #25's care plan showed no documentation or interventions for Resident #25's weight loss.On 08/04/25 at 11:24 a.m., the MDS coordinator stated Resident #25's care plan had not been updated to reflect the resident having weight loss.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to implement their policy for enhanced barrier precautions and hand hygiene for 1 (#19) of 1 sampled resident reviewed for enhanced barrier precautions.The DON identified seven residents on enhanced barrier precautions. Findings:On 07/31/25 at 10:34 a.m., LPN #1 was observed providing wound care for Resident #19. No signage was posted at the door for enhanced barrier precautions. LPN #1 gathered wound care supplies per the physician orders and placed them on the barrier on the bedside table. LPN #1 donned a pair of gloves and removed the old dressing. LPN #1 did not wash their hands prior to donning gloves. LPN #1 changed their gloves and used gauze with wound wash to clean the wound. LPN #1 placed the calcium alginate dressing (wound dressing) on the wound to the right foot. LPN #1 did not wash their hands with each glove change. LPN #1 was not wearing a gown.An undated facility form titled Enhanced Barrier Precautions (EBP) Decision Making-Algorithm showed if a resident had a wound or indwelling medical device and was not infected, enhanced barrier precautions should be used. The form showed chronic wounds included, but were not limited to: pressure ulcers, diabetic foot ulcers, unhealed/dehisced surgical wound, and venous stasis ulcers. Undated facility signage titled ENHANCED BARRIER PRECAUTIONS EVERYONE MUST, read in part, Wear gloves and a gown for the following High-Contact Resident Care Activities.Wound Care: any skin opening requiring a dressing A facility policy titled Handwashing/Hand Hygiene, revised 08/2015, read in part, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:. Before and after direct contact with residents.Before donning sterile gloves.Before handling clean or soiled dressings, gauze pads, etc.After removing gloves An undated transfer/discharge report showed Res #19 had diagnoses which included altered mental status, morbid obesity, and encounter for change or removal of surgical wound. A physician order, dated 07/17/25, showed staff were to clean a stage 3 pressure ulcer to the right lateral ankle with saline, pat dry, apply calcium alginate, wrap with Kerlix (gauze bandage roll), and secure with an ACE wrap (elastic bandage) every other day. On 07/31/25 at 10:50 a.m., LPN #1 stated enhanced barrier precautions were not required for Res #19 with a wound because it was not a chronic wound. LPN #1 was asked when handwashing was to be performed. LPN #1 stated handwashing should be with glove changes, when visibly soiled, and when moving from clean to unclean surfaces. LPN #1 stated they did not wash their hands when entering Res #19's room or with each glove change and should have. On 07/31/25 at 10:55 a.m., the DON stated enhanced barrier precautions were used for chronic unhealing wounds, not wounds that could be healed. On 07/31/25 at 11:14 a.m., the DON reviewed the facility policy for enhanced barrier precautions and stated they had misread the policy. The DON stated enhanced barrier precautions should be used for wounds with an open healing area and dressing. On 07/31/25 at 11:40 a.m., the DON stated staff should wash their hands when entering a resident room for care and with each glove change.