STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER: El Reno Post-Acute Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2100 Townsend Drive El Reno, OK 73036	

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48344 Based on observation, record review, and interview, the facility failed to provide privacy covers for indwelling catheters for two (#8 and #15) of two sampled residents reviewed for dignity. The DON identified three residents with indwelling catheters resided in the facility. Findings: The Catheter Care policy, revised 09/21/23, read in part, Residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. The policy also read, .Catheter drainage bags will be covered at all times while in use. 1. Resident #8 had a diagnosis of retention of urine. A physician's order, dated 02/16/24, documented to change catheter once monthly. On 05/19/24 at 8:35 a.m., Resident #15 was observed on the hallway in a wheelchair. There was no privacy cover on the catheter drainage bag. On 05/19/24 at 11:56 a.m., Resident #15 was sitting in the dining room waiting for lunch. There was no privacy cover on the catheter drainage bag. On 05/20/24 at 11:26 a.m., Resident #15 was sitting by the nurse's station. There was no privacy cover on the catheter drainage bag. 2. Resident #8 had diagnoses which included urinary incontinence and frequency of micturition. A physician's order, dated 05/17/24, documented to change suprapubic catheter every day shift starting on the 1st and ending on the 5th of every month for infection prevention. On 05/20/24 at 9:29 a.m., Resident #8 was observed going out to smoke. The Resident was holding the catheter in their hand. There was no privacy cover on the drainage bag. On 05/20/24 at 1:31 p.m., Resident #8 was observed at the nurse's station holding the catheter in their hand. There was no privacy cover on the drainage bag. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/24 at 1:55 p.m., LPN #1 stated Resident #8 and Resident #15 did not have a privacy cover for their catheter drainage bag. They stated not having a privacy cover could affect a resident's dignity.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48344 Based on record review and interview, the facility failed to notify the physician of an abnormal blood sugar level as ordered for one (#36) of five sampled residents reviewed for unnecessary medications. The Administrator identified 40 residents resided in the facility. Findings: The Physician, Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Lab Notification policy, revised 11/24/21, read in part, The facility must promptly notify the attending physician .of lab results that fall outside of clinical reference ranges in accordance with facility policies and procedures .or per ordering physician's orders. Resident #36 had a diagnosis of type two diabetes mellitus. A physician's order, dated 09/01/23, documented novolog injection solution 100 units per milliliter subcutaneously four times a day related to type two diabetes mellitus. Inject as per sliding scale, if FSBS is greater than 451 notify physician. Resident #36's May 2024 TAR documented FSBS of 476 and the number four on 05/18/24. On 05/23/24 at 9:03 a.m., the DON stated Resident #36's blood sugar was 476 on 05/18/24. They stated the order was to notify the physician if blood sugar was above 451. On 05/23/24 at 9:08 a.m., the DON stated the number four on the TAR meant outside of parameters. On 05/23/24 at 9:42 a.m., the DON stated they could not locate any documentation the physician was notified of Resident #36's abnormal blood sugar level.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583 Based on record review and interview, the facility failed to ensure MDS assessments were accurate for two (#42 and #43) of 12 sampled residents MDS were reviewed. The Administrator identified 40 residents who resided in the facility. Findings: 1. Resident #43 discharged to an assisted living facility. The discharge assessment, dated [DATE], documented discharge return anticipated, planned discharge, and that there was no discharge planning occurring. On [DATE] at 9:33 a.m., the Administrator stated planning for the discharge started months ago and they had been working with a third party agency. On [DATE] at 2:26 p.m., the Administrator stated they had worked on the discharge and did not anticipate Resident #43 to return to the facility. On [DATE] at 2:45 p.m., MDS Coordinator #1 stated they anticipated the resident to return to the facility and stated they did not document information that stated the resident was anticipated to return. MDS Coordinator #1 further stated there was active discharge planning occurring for the resident and that it was not accurately coded on the discharge MDS and they were to do a correction. 2. Resident #42 was transferred to the hospital on [DATE]. The discharge assessment, dated [DATE], documented discharge return anticipated. A nurse's note, dated [DATE] at 4:17 p.m., documented the hospital called the facility to let them know the resident expired. A death in the facility resident assessment, dated [DATE], documented Resident #42 was deceased on [DATE]. Resident #42 did not expire in the facility. On [DATE] at 2:41 p.m., MDS Coordinator #1 stated a death in the facility was to be completed if the resident was admitted to the hospital and expired within 3 days. 48344

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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. 45583 Based on observation, record review, and interview, the facility failed to ensure a care plan was revised: a. quarterly and as needed to include wound care for one (#9); and b. to include the use of side rails for one (#12) of 12 sampled residents whose care plans were reviewed. The Administrator identified 40 residents resided in the facility. Findings: A Care Plan Revisions Upon Status Change policy, dated 05/23, documented the comprehensive care plan will be revised as necessary, when a resident experiences a status change. 1. Resident #12 had diagnoses which included unsteadiness on feet and mild cognitive impairment. A bed rail assessment, dated 08/14/23, documented left and right side bed rail use. A bed rail informed consent, dated 08/14/23, documented the resident was bed bound. Resident #12's care plan, revised 05/19/24 did not document the use of side rails. On 05/19/24 at 11:36 a.m., Resident #12 was observed in bed with two round shaped rails on each side of the upper part of the bed. The Resident stated staff put them up so they can use them to assist with positioning. On 05/22/24 at 1:37 p.m., CNA #1 stated Resident #12 used the rails [name withheld] for turning left and right during care. On 05/22/24 at 1:56 p.m., the DON stated the side rails [name withheld] were not documented on the Resident's care plan. 2. Resident #9 had diagnosis which included pneumonia, COPD, dm type 2. There was no diagnosis of a wound on the diagnosis section of the EMR. A care plan, dated 06/13/23, had a revision date of 11/03/23. There was no care plan for a wound found. A skin assessment, dated 12/8/23, documented a popped blister to left heel. There were no measurements. An MDS assessment, dated 03/18/24, documented diabetic foot ulcer. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physicians' order, dated 05/13/24, documented wound care to left heel Monday, Wednesday, Friday, and prn. On 05/21/24 at 11:29 a.m., MDS Coordinator #1 stated all the care plans had been updated. On 05/21/24 at 1:26 p.m., MDS Coordinator #1 stated they did not know the policy and procedure for updating care plans. They stated their process for updating care plans was quarterly and as needed. On 05/21/24 at 1:35 p.m., MDS Coordinator #1 stated the care plan for Resident #9 was not done quarterly. MDS Coordinator #1 stated there was not a care plan for the wound and the care plan was not accurate to Resident #9 level of care. 48344

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45583 Based on observation, record review, and interview, the facility failed to ensure food items in the refrigerator were properly labeled and had identified use by dates during the initial kitchen tour. The Administrator identified 40 residents resided in the facility and the DON verified all 40 residents received food from the kitchen. A Date Marking for Food Safety policy, revised 04/24, read in part, The facility adheres to a date marking system to ensure the safety of ready-to-eat, tie/temperature control for safety food. The policy also read, The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for date marking the food at the time of the food is opened or prepared. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. On 05/19/24 at 8:13 a.m., during the initial tour of the kitchen, the refrigerator was observed to have a white plastic bin which contained 10 cups with clear liquid inside and six cups with a red liquid inside and two empty cups, at the back of the bin, with residue at the bottom. None of the cups had a cover, date, or identification on them. On 05/19/24 at 8:22 a.m., the Dietary Manager stated the drinks were prepared that morning and the cups should have a date and there was no date. They stated the policy was they should have been dated. They took the cups while stating they were going to dump them and was observed to empty them into the sink.