STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375457	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Betty Ann Nursing Center	1400 South Main Street Grove, OK 74344

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 35474 Based on observation and interview, the facility failed to ensure survey results were posted and accessible for residents and visitors. The DON identified 47 residents who resided in the facility. Findings: An undated Survey Results policy, read in parts, .survey results are in the front lobby of the facility. The location of the facility survey results is identified with a sign posted on the cabinet. Any resident and or visitor will have access to the results if desired . On 10/01/24 at 2:57 p.m., four residents in the resident council meeting stated they did not know where survey results were located. On 10/01/24 at 3:15 p.m., survey results, or signage on where survey results were located, was not observed in the facility. On 10/01/24 at 3:17 p.m., the activities director stated they did not know where survey results were located. On 10/01/24 at 3:18 p.m., the administrator stated the survey results were located in the lobby, which was a locked area, away from resident rooms and common areas. On 10/01/24 at 3:20 p.m., the administrator stated some survey results were in the DONs office for review, but they normally kept them in the front lobby. They stated if a resident from the locked units wanted access to the survey results they would need to knock on the door to the front lobby and staff would assist them. On 10/01/24 at 3:23 p.m., the DON stated the binders with the survey results had been on the book shelf in their office for approximately four months. They stated they were not aware the survey results were to be made accessible to residents and visitors. On 10/01/24 at 3:43 p.m., the administrator stated residents and visitors were made aware of the location of the survey results with posted signage, but the sign had been removed.

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

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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. 41809 Based on observation, record review, and interview, the facility failed to ensure resident mobility was included in the resident assessment and the plan of care for one (#29) of one sampled residents who was reviewed for mobility and positioning. The DON identified seven residents with limited range of motion. Findings: Resident #29 had diagnoses which included cerebral vascular accident, osteoarthritis, and hemiplegia/hemiparesis. An admission assessment, dated 08/02/24, did not document the impairment to the left upper extremity. Review of the clinical record revealed the comprehensive care plan had not been developed. On 08/03/24 at 2:00 a.m., a Health Status Note, documented Resident #29 admitted to the facility with a noted weak left hand and did not have a grasp due to a CVA. A Functional Abilities and Goals Assessment, dated 08/03/24, documented Resident #29 had no impairment to the upper or lower body. A Functional Abilities and Goals Assessment, dated 09/23/24, documented Resident #29 had impairment to the upper and lower left side. On 09/30/24 at 10:32 a.m., the left hand of Resident #29 appeared to be contracted. The resident was able to open their left hand slightly, but no devices were in place and Resident #29 denied any restorative therapy. On 10/02/24 at 8:30 a.m., CNA #1 stated Resident #29 did not allow staff to do anything with the left hand. They stated they had not seen anything in the room for the left hand. CNA #1 stated the resident would pull their left hand away in the shower when asked to wash it. On 10/02/24 at 8:35 a.m., LPN #1 stated Resident #29 was new to them. They stated Resident #29 did not have any limitation in range of motion and did not have interventions for contractures. On 10/03/24 at 11:36 a.m., the DON stated the dominate hand of Resident #29 was functional, the left hand was not completely functional, but was not contracted. They stated it should be on the assessment and in the care plan. On 10/03/24 at 12:17 p.m., the DON stated the impairment to the left hand should have been added and was not captured. They stated they did not do the assessment and could not say the reason it was not done.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 35474 Based on record review and interview, the facility failed to ensure baseline care plans were completed for one (#150) and failed to ensure residents and/or resident representatives were provided a summary of the baseline care plan for one (#29) of 14 sampled residents whose care plans were reviewed. The DON identified 47 residents who resided in the facility. Findings: The Care Plans-Baseline policy, dated December 2016, read in part, .A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission . The resident and their representative will be provided a summary of the baseline care plan . 1. Resident #150 had diagnoses which included chronic obstructive pulmonary disease, congestive heart failure, and pressure ulcer. On 09/30/24 at 11:23 a.m., Resident #150 stated they had recently admitted to the facility. Resident #150 stated they had not had a care plan meeting or received a summary of their baseline/initial plan of care. Review of the clinical record did not reveal a baseline care plan had been completed. On 10/03/24 at 8:28 a.m., the DON stated the baseline care plan for Resident #150 should have been completed within 48 hours of admission to the facility. The DON stated they had reviewed the clinical record and did not know why a baseline care plan had not been completed. 2. Resident #29 had diagnoses which included diabetes, anxiety, and chronic pain. The baseline care plan, dated 08/03/24, was left blank on the resident/resident representative signature spaces. On 10/02/24 at 11:11 a.m., the DON stated they were not sure who was to receive a summary of the baseline care plan. They stated they contacted resident representatives 10-14 days after admission for a care plan meeting. On 10/03/24 at 8:47 a.m., the DON stated they had reviewed the clinical record, but had not found documentation a summary of the baseline care plan had been provided to the resident or the resident representative. On 10/03/24 at 9:36 a.m., Resident #29 stated staff had not discussed their baseline care plan with them upon admission.

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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. 35474 Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed for one (#29) of 23 sampled residents who were reviewed for comprehensive care plans. The administrator identified 47 residents who resided at the facility. Findings: Resident #29 had diagnoses which included cerebral vascular accident, osteoarthritis, and hemiplegia/hemiparesis. A Care Plan, initiated 08/02/24, documented focus for DNR status and indwelling catheter. No other concerns were documented on the comprehensive care plan. An admission assessment for Resident #29, dated 08/15/24, documented ten areas of concern for care planning as follows: cognitive loss/dementia, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, behavioral symptoms, falls, nutritional status, dehydration fluid maintenance, dental care, pressure ulcer, and psychotropic drug use. Only one of the concerns were included in the comprehensive care plan. On 10/03/24 at 8:47 a.m., the DON stated a comprehensive care plan should have been developed and did not know the reason it was not. They stated they had not been monitoring, but would start. 41809

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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. 41809 Based on observation, record review and interview, the facility failed to ensure the care plan was revised and updated for one (#14) of 12 sampled residents whose care plans were reviewed. The administrator identified 47 residents who resided at the facility. Findings: Resident #14 had diagnoses which included pressure ulcer of left heel and diabetes type II. The care plan for Resident #14 documented a wound to the left heel was initiated 02/21/24 and resolved 04/24/24. The care plan did not document any further updates for pressure ulcers or deep tissue injuries. A Physician's Order, dated 09/06/24, documented to cleanse the wound with wound cleanser, pat dry then apply Santyl External Ointment 250 UNIT/GM (Collagenase) to the right heel topically one time a day for wound care, and cover with silicone border dressing daily until resolved. A quarterly assessment, dated 09/24/24, documented Resident #14 had no deep tissue injuries or pressure wounds. On 10/02/24 at 9:53 a.m., wound care was observed for Resident #14. The left heel wound was observed to be a closed wound, dark in color, and approximately the size of the tip of a finger. On 10/02/24 at 3:10 p.m., the DON stated the MDS coordinator was responsible to ensure the care plan was revised/updated. They stated the wound should have pulled over from the quarterly assessment. They reviewed the quarterly assessment and care plan and stated the care plan should have been updated.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on observation, record review and interview, the facility failed to ensure interventions were in place to prevent reduction in range of motion/mobility for one (#29) of one sampled residents who were reviewed for range of motion/mobility. The DON identified seven residents who had limited range of motion. Findings: Resident #29 had diagnoses which included hemiplegia and hemiparesis following a cerebral infarction. The admission assessment, dated 08/02/24, documented no impairments to the upper or lower body. A Progress Note, dated 08/03/24 at 2:00 a.m., documented Resident #29 admitted to the facility on [DATE] with noted left hand weakness and without grasp due to a cerebral vascular accident. On 10/02/24 at 8:30 a.m., CNA #1 stated Resident #29 did not allow them to do anything with their hand. They stated they had not seen anything in their room for the left hand. On 10/02/24 at 8:35 a.m., LPN #1 stated Resident #29 was new to them. They stated the resident had no limitation in range of motion and had no interventions for any impairments. On 10/03/24 at 11:36 a.m., the DON stated Resident #29 had a functional dominate right hand, the left hand was not completely functional, but was not contracted. They stated the impairment should be on the assessment and the care plan. On 10/03/24 at 12:17 p.m., the DON stated the impairment should have been added and was not captured. They stated they did not do the assessment so they could not say why it was not done.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35474 Based on record review and interview, the facility failed to ensure supplements were offered/documented for one (#29) of one sampled residents who was reviewed for nutrition. The dietary manager identified 14 residents who was ordered supplements in the facility. Findings: Resident #29 had diagnoses which included moderate protein calorie malnutrition. The Dietician's Recommendation for Primary Care Providers form, dated 08/17/24, documented the resident was 26% below ideal body weight, had a diagnosis of protein calorie malnutrition, and recommended a supplement twice daily between meals. The physician agreed with the dietician recommendation. The electronic clinical record, dated 08/02/24, documented the resident's weight was 145 pounds. A Physician's Order, dated 08/20/24, documented the resident was ordered a dietary supplement between meals. A Physician's Order, dated 08/23/24, documented the resident was ordered Ensure three times per day. The electronic clinical record, dated 09/05/24, documented the resident's weight was 135.2 pounds, which indicated a 6.76 % weight loss in one month. Review of the Task-Nutrition, dated 09/02/24 through 10/01/24, revealed supplements were documented as provided/offered 36 times out of 72 opportunities. Some entries documented response not required. On 10/01/24 at 3:52 p.m., CMA #2 stated the dietary department provided supplements. On 10/01/24 at 3:54 p.m., Drink Aide #1 stated they provided supplements on the snack cart, but they did not document. On 10/01/24 at 3:57 p.m., the dietary manager stated the nursing department documented the amount of the supplements consumed. On 10/01/24 at 4:01 p.m., the DON stated the dietary department provided the supplements on the snack cart and the CNAs documented the amount consumed or refusals in the nutrition task. On 10/02/24 at 11:05 a.m., the DON stated response not required was documented on the task if the resident ate 76-100% of their meal. They stated the resident was offered a supplement between meals at snack time and if they ate less than 76%. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 12:28 p.m., Resident #29 stated they were offered snacks and shakes two to three times per day. The resident stated they refused snacks and supplements at times. On 10/03/24 at 8:41 a.m., the DON stated they changed the documentation requirements in tasks to document the supplements offered/provided for meal replacement and those offered/provided between meals, to monitor nutritional intake, for residents with significant weight loss who were ordered supplements as a nutritional intervention.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 35474 Based on record review and interview, the facility failed to ensure labs were obtained as ordered by the physician for one (#36) of five sampled residents who were reviewed for unnecessary medications. The DON identified 47 residents who resided in the facility. Findings: Resident #36 had diagnoses which included dementia, mood disorder, and unspecified psychosis. The Physician's Order, dated 04/23/24, documented to obtain a lipid panel and PSA for annual labs. The Progress Note, dated 04/26/24, documented the resident had refused lab for three days. Review of the clinical record revealed the resident had complied with obtaining labs twice in June 2024 and three times in July 2024. The labs obtained did not include a PSA for annual labs per the physician's order. On 10/01/24 at 9:35 a.m., the ADON stated the lipid panel was completed in June 2024, but they would need to look for the lab results for the PSA. The ADON stated the resident would initially refuse labs, but after they talked to the resident and explained the lab to them they were compliant and agreeable to obtaining labs ordered by the physician. On 10/01/24 at 10:02 a.m., the DON stated when the resident complied with obtaining labs in June and July 2024 they had not obtained the PSA because it was no longer in the electronic clinical record. The DON stated they did not find documentation staff had spoken to the resident and explained the lab to the resident in April 2024. The DON stated they had not been monitoring to ensure labs, ordered by the physician, had been obtained or follow up had been done if the resident had a history of initially refusing labs until they were explained to them.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 35474 Based on observation, record review, and interview, the facility failed to ensure holding temperatures were obtained for one (noon meal) of one meal observed for meal service. The DON identified 47 residents who received nourishment from the kitchen. Findings: The undated Food Temperatures policy, read in part, .The temperatures of the food items will be taken and properly recorded for each meal . On 10/01/24 at 11:20 a.m., the noon meal service was observed. The Daily Food Temperature Log, dated 10/01/24 at 11:30 a.m., documented the noon meal food temperatures had been obtained. On 10/01/24 at 11:49 a.m., cook #1 was observed to plate the noon meal. Holding temperatures were not observed to be obtained by dietary staff from 11:20 a.m. through 11:49 a.m. [NAME] #1 stated they had obtained the temperature of the foods when they removed the food from the oven. [NAME] #1 stated they did not obtain holding temperatures before serving foods. On 10/01/24 at 12:11 p.m., the dietary manager stated food temperatures were to be obtained before they served every meal and they were to document the food temperatures on the log. The dietary manager asked cook #1 when they had obtained the documented temperatures on the log. [NAME] #1 stated they obtained the temperatures when they removed the food from the oven. On 10/01/24 at 12:17 p.m., cook #1 stated they had removed the food from the oven at approximately 10:40 a.m. [NAME] #1 stated they could tell the food was still hot because of the steam from the steam table. On 10/01/24 at 1:25 p.m., the dietary manager stated they did not know the why cook #1 had not obtained holding temperatures for the noon meal or why they had documented they obtained them at 11:30 a.m. The dietary manager stated, You were in the kitchen at that time.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35474 Based on observation, record review, and interview, the facility failed to ensure hot foods were served at palatable temperatures for one (#29) of one sampled resident who was reviewed for food. The DON identified 47 residents who received nourishment from the kitchen. Findings: The undated Food Temperatures policy, read in part, .Temperatures should be taken periodically to ensure hot foods stay above 140 [degrees] F and cold foods stay below 40 [degrees] F during the portioning, transporting and serving process until received by the resident . On 09/30/24 at 10:35 a.m., Resident #29 stated hot foods were served cold all the time. The resident stated they ate their meals in their room. On 10/02/24 at 11:51 a.m., the hall trays were observed to be prepared and ready for service on a metal cart with a plastic zippered cover. A test tray was placed on the hall cart. The noon meal consisted of penne pasta with chicken and alfredo sauce, green beans, bread, and spiced apples. On 10/02/24 at 12:04 p.m., CNA #2 was observed to obtain the hall cart from the dining room and begin delivering meal trays. On 10/02/24 at 12:15 p.m., CNA #2 had delivered the last meal tray on the hall cart to Resident #29 and the test tray was obtained. The penne pasta with chicken and alfredo and the green beans were observed to be slightly warm when tasted. On 10/02/24 at 12:31 p.m., the dietary manager stated they were to obtain food holding temperatures before serving, utilize insulated lids, and use insulated food carts to ensure foods were served at a palatable temperature. On 10/03/24 at 8:50 a.m., the DON stated they could not say if hot foods were served hot to residents who ate meals in their rooms.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 35474 Based on observation and interview, the facility failed to ensure pureed foods were a smooth consistency for one (noon meal) of one meal observed for pureed foods. The DON identified two residents who received pureed diets. Findings: On 10/01/24 at 11:20 a.m., cook #1 was observed to puree the noon meal which consisted of turkey with gravy, dressing, mixed vegetables, bread, and lemon pudding. On 10/01/24 at 11:22 a.m., cook #1 was observed to place turkey and gravy into a food processor. The turkey and gravy was observed to contain visible pieces of food. The turkey with gravy was not observed to be a smooth consistency. [NAME] #1 stated, This is how I will serve it. On 10/01/24 at 11:28 a.m., cook #1 was observed to place dressing with gravy into a food processor. The dressing was observed to contain visible pieces of food, some the size of a pencil eraser. The dressing was not observed to be a smooth consistency. [NAME] #1 placed the dressing onto the steam table. On 10/01/24 at 11:32 a.m., cook #1 was observed to place mixed vegetables (which consisted of green beans, carrots, green peas, and corn) with their juices, into the food processor. The mixed vegetables were observed to be of a thin, runny consistency with pieces of the vegetables remaining. [NAME] #1 placed the mixed vegetables on the steam table. On 10/01/24 at 11:50 a.m., cook #1 plated the noon meal for the two residents on a pureed diet and dietary aide #2 placed the trays on the meal cart. On 10/01/24 at 12:02 p.m., cook #1 stated the meal cart was ready to be delivered to the dining room for service. Dietary aide #2 began taking the cart to the dining room. [NAME] #1 was asked to remove the two trays that contained the pureed diets. [NAME] #1 stated they processed foods for residents on pureed diets until the food resembled something like baby food. They stated they ensured pureed meals were smooth by visually observing the food items after processing for any remaining food pieces. On 10/01/24 at 12:04 p.m., the dietary manager stated pureed foods were to be the consistency of smooth mashed potatoes. The dietary manager observed the two meals of pureed food and stated the turkey, dressing, and mixed vegetables were a little clumpy and the mixed vegetables were too thin. They stated they ensured pureed foods were served at a smooth consistency by having the cooks sample the foods after processing.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on observation, record review, and interview, the facility failed to ensure: a. foods were covered and dated in the refrigerator for one of three refrigerators observed in the kitchen; b. infection control was maintained during meal service for one (the noon meal) of one meal observed during meal service; c. infection control was maintained when meals were delivered to residents who ate in their rooms for one of two meals observed during dining; and d. the ice machine was maintained in a sanitary manner for one of one ice machines observed. The DON identified 47 residents who received nourishment from the kitchen. Findings: The undated Food Storage policy, read in parts, .Refrigeration .All foods should be covered, labeled, and dated . The undated, Cleaning Instructions Cleaning Ice Machine and Scoop policy, read in part, .The ice machine and equipment [scoops] will be cleaned on a regular basis to maintain a clean, sanitary condition . The Assisting the Resident with In-Room Meals policy, dated December 2013, read in part, .Employees must wash their hands before serving food to residents. It is not necessary to wash hands between each resident tray; however, if there is contact with soiled dishes, clothing or the resident's personal effects, the employee must wash his/her hands before serving food to the next resident . The Preventing Foodborne Illness - Food Handling policy, dated July 2014, read in part, .Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing . 1. On 09/30/24 at 9:23 a.m., eleven dessert dishes with sliced peaches were observed uncovered and not dated, on a tray, in the refrigerator. The dietary manager stated the dietary staff had prepared the peaches earlier, but had not covered or dated them. The dietary manager stated foods stored in the refrigerator were to be covered and dated. 2. On 10/01/24 at 11:52 a.m., cook #1 was observed to don gloves and touch plates, the counter top, plate covers, ladle handles, trays, meal tickets, and bagged sandwiches. [NAME] #1 was observed to obtain chips from a bag with the same gloved hands and place them on plates. [NAME] #1 was observed to obtain small bowls of dessert over the top of the bowl with the same gloved hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375457	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Betty Ann Nursing Center	1400 South Main Street Grove, OK 74344

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/24 at 12:13 p.m., cook #2 was observed to touch meal tickets, the counter top, ladle handles, plates, trays, plate covers and then obtain chips from a bag and plate them with their bare hands. [NAME] #2 was observed to don gloves and touch meal tickets, the counter top, ladle handles, plates, trays, plate covers and then obtain chips from a bag and plate them with the same gloved hands. [NAME] #2 was then observed to obtain a slice of turkey from the steam table and place on a plate with the same gloved hands. [NAME] #2 was observed to obtain small bowls of dessert with their thumb inside the bowl with the same gloved hands. On 10/01/24 at 1:19 p.m., cook #1 stated they were supposed to wash their hands and utilize gloves if they had to touch food. [NAME] #1 stated they should have changed their gloves before obtaining chips from the bag. [NAME] #1 stated they were supposed to transport dessert cups to meal trays by the sides, not over the top of the bowl. On 10/01/24 at 1:23 p.m., cook #2 stated they should have poured the chips from the bag. [NAME] #2 stated they were to plate bowls of dessert by picked them up on the sides. On 10/01/24 at 1:25 p.m., the dietary manager stated if staff touched food they were to don gloves to maintain infection control. They stated bowls of dessert should be transported by the sides of the bowls, not over the top or with fingers in the bowls. On 10/02/24 at 11:59 a.m., the dietary manager stated they had thought about plating chips and the staff should have utilized tongs or another utensil to plate them. 3. On 09/30/24 at 12:16 p.m., CNA #3 was observed to deliver meal trays to residents who ate in their rooms. CNA #3 was observed to enter room [ROOM NUMBER], obtained a soda pop from the resident's personal refrigerator, and poured it into their cup. CNA #3 was not observed to sanitize their hands. On 09/30/24 at 12:20 p.m., CNA #3 was observed to enter room [ROOM NUMBER], moved personal items from the bedside table, uncovered the resident, assisted the resident to sit up in bed, and moved the bedside table over the resident. CNA #3 was not observed to sanitize their hands. On 09/30/24 at 12:28 p.m., CNA #3 was observed to enter the code to the memory care unit and without sanitizing their hands delivered a meal tray to room [ROOM NUMBER]. CNA #3 was observed to move the bedside table and provide meal set up. CNA #3 was not observed to sanitize their hands. On 10/03/24 at 10:30 a.m., CNA #3 stated they were to sanitize their hands if they handled personal items during meal delivery. They stated they had not sanitized their hands on 09/30/24 and did not know why they forgot to sanitize after touching personal items and assisting a resident with positioning. On 10/03/24 at 10:55 a.m., the DON stated staff were to sanitize their hands between each resident when delivering meal trays. 4. The Bi-Monthly Ice Machine Cleaning Log, dated 2024, documented the ice machine had last been cleaned on 09/09/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375457	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Betty Ann Nursing Center	1400 South Main Street Grove, OK 74344

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/24 at 9:30 a.m., the ice machine was observed with the dietary manager. A slimy pink substance was observed on the lower deflector panel in the bin. The dietary manager stated they did not know what the substance was. They stated the ice machine was cleaned monthly. Around and on the deflector panel in the upper portion of the ice machine, brown, black, and yellow substances were observed. On 10/02/24 at 7:14 a.m., the maintenance supervisor stated they cleaned the ice machine with a chemical solution once a month and twice a month it was checked and wiped down.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on observation, record review, and interview, the facility failed to ensure infection control protocols for enhanced barrier precautions were maintained during medication administration and wound care. The DON identified nine residents who were on enhanced barrier precautions. Findings: On 10/01/24 at 12:02 p.m., LPN #2 and LPN #3 were observed during medication administration for insulin and blood sugar monitoring. LPN #2 donned PPE for room [ROOM NUMBER], Resident A, who was on EBP. LPN #2 was given the supplies to check the blood sugar for Resident B. After LPN #2 obtained the blood sugar results, they handed the used supplies to LPN #3 who discarded them, donned new gloves, and provided LPN #2 with the supplies needed for checking the blood sugar for Resident A. LPN #2 did not remove their gloves, or sanitize their hands prior to checking the blood sugar of Resident A. The used supplies were then handed back to LPN #3. LPN #3 then provided supplies and drew up the insulin for LPN #2, who observed the insulin being drawn into the syringe. The amount was verified as correct. LPN #2 then administered the insulin to Resident A without changing their gloves or sanitizing their hands. On 10/02/24 at 7:15 a.m., CMA #1 was observed during medication administration for room [ROOM NUMBER] B. CMA #1 came out of a resident room, approached the medication cart, did not sanitize their hands, then began to prepare medications to administer for room [ROOM NUMBER] B. CMA #1 did not sanitize their hands prior to administering the medications. On 10/03/24 at 9:25 a.m., CMA #1 stated they were to sanitize/wash their hands between residents when administering medications. On 10/03/24 at 9:28 a.m., the DON and infection preventionist stated staff were expected to wash hands or sanitize their hands anytime a resident was touched and between residents. The infection preventionist stated LPN #2 should have washed/sanitized their hands. The DON stated the nurse who drew the insulin should have given the insulin. The DON stated the expectation was for staff to follow protocol and policy when providing wound care regarding infection control.