| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375462 | A. Building<br>B. Wing | 01/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fountain View Manor, Inc | 107 East Barclay<br>Henryetta, OK 74437 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents and/or representatives were offered the opportunity to create an advance directive for 2 (#9 and #18) of 18 sampled residents reviewed for advance directives.The DON identified 80 residents resided in the facility. Findings:1.An undated admission record showed Resident #9 admitted to the facility on [DATE].A review of electronic health records for Resident #9 showed no advance directive acknowledgment form in the record.2. An undated admission record showed Resident #18 admitted to the facility on [DATE].A review of electronic health records for Resident #18 showed no advance directive acknowledgment form in the record.On 01/14/26 at 11:33 a.m., social services #1 stated there were no advance directive acknowledgement forms in the residents' charts. Social Services #1 stated the form must have been left out of the admission packet when they made more copies. |

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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| NAME OF PROVIDER OR SUPPLIER: Fountain View Manor, Inc | | STREET ADDRESS, CITY, STATE, ZIP CODE: 107 East Barclay, Henryetta, OK 74437 | |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on record review and interview, the facility failed to complete criminal history background checks for 2 (LPN #1 and LPN #2) of 5 sampled employees reviewed for criminal history background checks. The administrator identified 80 residents resided in the facility. Findings: An undated Compliance with Reporting Allegations of Abuse/Neglect/Exploitation policy, read in part, Screening: The facility will screen employees for a history of abuse, neglect or mistreating residents by attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries.1.An undated and untitled employee list showed LPN #1 was hired on 10/08/24.A review of the employee file for LPN #1 showed no criminal history/background check results. 2. An undated and untitled employee list showed LPN #2 was hired on 06/25/25. A review of the employee file for LPN #2 showed no criminal history/background check results. On 01/14/26 at 12:34 p.m., the administrator stated they were told they did not have to do background checks on nurses. They stated the Oklahoma nursing board managed the licenses. The administrator stated if they had a valid license nurses were free to work in Oklahoma. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on record review and interview, the facility failed to ensure assessments were accurate for antipsychotic medications for 1 (#18) of 18 sampled residents reviewed for resident assessments.The DON identified 80 residents resided in the facility. Findings:A physician order, dated 11/12/25, showed Resident #18's Olanzapine (an antipsychotic) was discontinued.A quarterly assessment, dated 11/25/25, showed Resident #18 had a BIMS score of 10 which showed the resident's cognition was moderately impaired for daily decision making. The assessment showed diagnoses which included dementia and depression. The assessment showed Resident #18 had received an antipsychotic medication daily during the seven day look back period.On 01/20/26 at 10:39 a.m., the DON stated the assessment was inaccurate. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, record review, and interview, the facility failed to date and change oxygen equipment as ordered by the physician for 1 (#55) of 1 sampled resident reviewed for oxygen use. The ADON identified five residents with orders for oxygen use. Findings: On 01/12/26 at 2:17 p.m., Resident #55 was observed lying in bed with their eyes closed. The resident had humidified oxygen in place per nasal cannula. Resident #55's nasal cannula was not dated. The humidifier bottle and storage bag taped to the oxygen machine showed was dated 11/26/25. On 01/13/26 at 10:25 a.m., Resident #55 was observed resting with their eyes closed. Resident #55 had a nasal cannula with humidified oxygen in place. The nasal cannula was not dated, and the humidifier bottle was dated 11/26/25. A storage bag was taped to the side of the oxygen machine and was dated 11/26/25. On 01/13/26 at 4:10 p.m., Resident #55 was observed lying in bed with oxygen per nasal cannula in place. The oxygen tubing was not dated and the humidifier bottle and a storage bag hanging from the oxygen machine was dated 11/26/25. An undated facility policy titled FOUNTAIN VIEW MANOR OXYGEN POLICY, read in part, OXYGEN TUBING IS TO BE CHANGED OUT AT LEAST MONTHLY OR AS NEEDED FOR INFECTION CONTROL. A physician order for Resident #55, dated 10/16/23, showed to replace oxygen tubing/humidifier monthly related to a diagnosis of acute respiratory failure. An annual assessment, dated 10/15/25, showed Resident #55 had a BIMS of 9, which indicated they were moderately impaired for daily decision making. The assessment showed the resident was not receiving oxygen therapy. The assessment showed diagnoses which included dependence on supplemental oxygen, acute upper respiratory infection, major depressive disorder, anxiety disorder, and need for assistance with personal care. A care plan, dated 01/13/26, showed Resident #55 had an activity intolerance related to a disease process. The care plan showed Resident #55 was administered oxygen continuously at 2 to 3 liters per minute by nasal cannula and concentrator. On 01/13/26 at 4:15 p.m., LPN #2 stated Resident #55 received oxygen at 4 liters per nasal cannula. LPN #2 stated the oxygen tubing was not dated and should be dated. LPN #2 stated the humidifier bottle and storage bag taped to the side of the oxygen machine was dated 11/26/25. LPN #2 stated the medication/treatment administration record would indicate when the humidifier bottle, oxygen tubing, and storage bag should be changed. LPN #2 stated they thought the order was to change everything once a week. On 01/14/26 at 1:39 p.m., the DON stated the oxygen tubing for Resident #55 should have been dated. The DON stated the humidifier bottle and storage bag should have been changed monthly per the physician orders and was not. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to prepare food in a manner to minimize the risk of infection/cross contamination for 1 (the noon meal) of 1 meal services observed. The DM identified 80 residents received meals from the kitchen. Findings: On 01/13/26 at 12:12 p.m., a tour of the kitchen was conducted. [NAME] #1was observed to prepare the puree dessert. DA #1 was observed to carry a bucket with sanitizing water to the sink in the cooking area, beside the prep table, used to prepare puree food. DA #1 was observed to dump the contents of the bucket in the sink, then they set the bucket on the prep table beside the food processor. On 01/13/26 at 12:39 p.m., DA #1 was observed to wipe down a prep table with a rag from the sanitizing bucket. DA #1 was then observed handling food trays without washing their hands. On 01/13/26 12:45 p.m., cook #1 was observed to take a large sheet pan of burritos out of the oven using a sanitizing rag as a potholder. They were observed to prepare trays without washing hands. On 01/20/26, at 1:40 p.m., the DM stated the staff should have washed their hands and not had the sanitizing bucket or rag by the area where the food was prepared. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review, and interview, the facility failed to implement enhanced barrier precautions during wound care for 2 (#49 and #75) of 3 sampled residents reviewed for wound care.The administrator identified three residents with open wounds and three residents with urinary catheters for the use of enhanced barrier precautions. Findings: 1. On 01/14/26 at 9:05 a.m., LPN #3 was observed to provide wound care for Resident #49. LPN #3 gathered the supplies and entered the room of Resident #49. LPN #3 was observed to don a pair of gloves, but was not observed to don a gown. An undated facility policy titled Enhanced Barrier Precautions, read in part, PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities .Wound Care: any skin opening requiring a dressing. An annual assessment, dated 12/17/25, showed Resident #49 was severely impaired for daily decision making and had memory problems. The assessment showed the resident did not have pressure ulcers. The assessment showed Resident #49 had diagnoses which included dementia, depressive disorder, anxiety disorder, chronic pain, and disorder of the skin and subcutaneous tissue. A physician order, dated 01/02/26, showed to apply Betadine (antiseptic used to prevent and treat wounds) to Resident #49's right and left heels until resolved. The order showed to cleanse the right buttock with wound wash, pat dry, apply Santyl (a topical debriding agent) or Anasept (an antimicrobial agent to clean/debride), calcium alginate (a wound dressing), and cover with bordered gauze until resolved. 2. On 01/14/26 at 9:30 a.m., LPN #3 was observed to provide wound care for Resident #75. LPN #3 gathered supplies and entered the room of Resident #75. LPN #3 was observed to don a pair of gloves, but was not observed to don a gown. An annual assessment, dated 11/22/25, showed Resident #75 was not cognitively impaired with a BIMS 14. The assessment did not show Resident #75 had pressure ulcers. The assessment showed Resident #75 had diagnoses which included congestive heart failure, anxiety disorder, pain, and an open wound of the left buttock. A physician order for Resident #75, dated 01/12/26, showed to cleanse area to the left buttock, pat dry, and apply Medihoney (a wound medication) and calcium alginate to area. The physician order showed to cover the area with a bordered gauze once a day and as needed. On 01/14/26 at 9:37 a.m., LPN #3 stated protective personal equipment such as gowns and face shields were needed if the resident had hepatitis C or an active infection. LPN #3 stated only gloves were needed for wound care. On 01/14/26 at 9:40 a.m., the DON stated enhanced barrier precautions were used when a resident had an active infection. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure call lights were operational and available for 14 of 14 rooms occupied by residents on the memory care unit.The DON identified 22 residents resided in the memory care unit. Findings:On 01/13/26 at 9:00 a.m., a tour of the memory care unit was conducted. On 01/13/26 at 9:01 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:02 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:03 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:04 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:05 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:06 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:07 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:08 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:09 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:10 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:11 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:12 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:13 a.m., room [ROOM NUMBER] was observed to have no call light.On 01/13/26 at 9:14 a.m., room [ROOM NUMBER] was observed to have no call light.An undated Call Light Policy, read in part, A calling system must be available for each resident in the nursing home.On 01/13/26 at 9:50 a.m., CNA #5 stated they were told the rooms did not have call lights because they were a strangulation risk. CNA #5 stated if the resident needed staff they would have to holler out.On 01/20/26 at 10:15 a.m., the ADON stated the memory care unit did not have call lights because they were a safety hazard. |