

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Pauls Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1413 South Chickasaw Street Pauls Valley, OK 73075	

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)
<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873</p> <p>Based on record review and interview, the facility failed to complete and submit quarterly reviews of the minimum data set in the required timeframe's for eight (#3, 7, 11, 12, 14,16, 17, and #23) of 10 residents whose clinical records were reviewed for completion/submission of the resident assessments.</p> <p>The administrator identified 34 residents.</p> <p>Census: 34</p> <p>Findings:</p> <p>The facility's MDS Completion and Submission Timeframe's policy, dated 10/01/10, read in part our facility will conduct and submit resident assessments in accordance with federal and state submission timeframe's .</p> <p>On 04/16/24 at 11:30 a.m., the corporate regional director documented the following as the last completed/submitted minimum data set assessments for the following residents:</p> <ul style="list-style-type: none"> - a quarterly assessment dated [DATE] for Resident #3 - a quarterly assessment dated [DATE] for Resident #7. - an admission assessment dated [DATE] for Resident #11. - a significant change assessment dated [DATE] for Resident #12. - a quarterly assessment dated [DATE] for Resident #14. - a quarterly assessment dated [DATE] for Resident #16. - an admission assessment dated [DATE] for Resident #17. - a quarterly assessment dated [DATE] for Resident #23. <p>(continued on next page)</p>

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/24 at 10:10 a.m., the regional director stated the residents listed above did not have a complete/submitted minimum data set assessment in the last 120 days. The regional director stated they were aware of the delay but had not completed/submitted all residents' assessments that were delayed.		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>41873</p> <p>Based on observation, record review, and interview the facility failed to develop a comprehensive person-centered care plan for two (#1 and #80) of 12 residents reviewed for care plans. The facility failed to develop care plans related to:</p> <p>a) smoking for resident #1 and #80, and</p> <p>b) falls for one resident #80.</p> <p>The Administrator reported 34 residents resided in the facility.</p> <p>Findings:</p> <p>The facility's Care Plans - Comprehensive policy, dated 10/01/10, read in part An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident .Each residents comprehensive care plan is designed to: a. incorporate identified problems area; b. incorporate risk factors associated with identified problems .</p> <p>1. Resident #1 had diagnoses which included paraplegia and neurological conditions.</p> <p>A smoking assessment, dated 05/16/23, documented resident #1 is a supervised smoker d/t inability to light cigarette and difficulty disposing of cigarette into receptacle.</p> <p>A smoking assessment, dated 04/01/24, documented resident #1 is a supervised smoker.</p> <p>On 04/16/24 at 5: 30 p.m., the resident was observed outside smoking with a staff member present.</p> <p>On 04/17/24 at 11:22 a.m., the DON reported smoking should have been included on resident #1's care plan and will get it updated.</p> <p>2. Resident #80 had diagnoses which included hemiplegia and dementia.</p> <p>A. A smoking assessment, dated 02/23/24, documented resident #80 was safe to smoke unsupervised.</p> <p>An incident report, dated 02/27/24, documented resident #80 singed hair while lighting a cigarette. The incident report documented the resident was immediately placed on supervised smoking and all smoking items removed from his possession.</p> <p>A smoking assessment, dated 02/27/24, documented resident #80 resident was not safe to smoke unsupervised.</p> <p>Resident #80's care plan, dated 03/14/24, contained no documentation of smoking status.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/15/24 at 9:30 a.m., resident #80 was outside smoking with staff present.</p> <p>B. A fall risk assessment, dated 02/23/24, documented resident #80 was at risk for falls.</p> <p>A nurse's note, dated 02/23/24, documented resident #80 had a fall from wheelchair while attempting to transfer himself from his bed to his wheelchair. Resident #80 was instructed to call for assistance when trying to transfer.</p> <p>Resident #80's care plan, dated 03/14/24, contained no documentation of fall risk.</p> <p>On 04/15/23 at 9:43 resident # 80 was observed using a rolling walker to ambulate.</p> <p>A MDS assessment, dated 04/17/24, documented resident #80 had moderate cognitive impairment, required assistance with most activities of daily living, and used a wheelchair or walker to ambulate.</p> <p>On 04/17/24 at 11:22 a.m., the DON reported smoking and falls should have been included on resident #80's care plan.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>41873</p> <p>Based on record review and interview the facility failed to ensure the resident's representative was included in discharge planning for one (#30) of three residents reviewed for discharges.</p> <p>The Administrator reported 34 residents resided in the facility.</p> <p>Finding:</p> <p>The facility's Resident/Family Participation - Assessment/Care Plans policy dated 12/01/2006, read in part The resident and his/her family, and/or legal representative, are invited to attend and participate in the resident's assessment and care planning conference .The social services director or designee is responsible for contacting the resident's family and maintaining records of such notices .</p> <p>1. Resident #30 had diagnoses which included heart failure, respiratory failure, and diabetes mellitus.</p> <p>A care plan, dated 08/25/23, documented Discharge planning: Resident, family and staff are in agreement for discharge planning .Planned discharge date is 09/01/23 .Goal: able to return home with supportive services 09/01/23 .Intervention: Notify provider of concerns. Assist with obtaining community services. Assist in ordering discharge supplies .The care plan documented no evidence the care plan had been signed and a copy given to the resident or resident's representative.</p> <p>On 04/15/24 at 5:27 p.m., family member #1 reported being resident #30's power of attorney and was not included in the discharge care plan meeting. Family member #1 reported not being aware of the discharge date or plan until 48 hours before the resident's benefits ran out.</p> <p>On 04/17/24 at 5:16 p.m., the administrator reported the resident's representative family member #1 had not given them paperwork that she was the POA she just told them she was. The administrator reported family member #2 came to the facility to see the residents and was listed as a contact. The administrator reported family member #2 was present for the care plan meeting. The administrator reported family member #1 was contacted 48 hours before his skilled benefits ran out and informed family member #1 the resident could stay in the facility but would have to be private pay.</p> <p>Resident #30's medical record was reviewed by the surveyor on 04/18/24 and contained a signed durable power of attorney for family member #1, dated 09/29/22.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>30267</p> <p>Based on observation and interview, the facility failed to provide wound care in a manner to reduce the risk of infection or cross contamination for one (#17) of two residents observed for wound care.</p> <p>The director of nursing identified 4 residents with wounds.</p> <p>Resident census: 34</p> <p>Findings:</p> <p>On 04/16/24 at 11:00 a.m., LPN #1 was observed to perform wound care on Res #17. The LPN washed hand and donned gloves. With gloved hands, the LPN borrowed an overbed table from the resident's roommate, removing the roommates personal possessions from the overbed table but not sanitizing the table. With the same gloves, the LPN opened and clear plastic shoe box shaped container, laying the lid on the inside facing up. With the same gloves, the LPN remove the contents needing for the dressing change and laid them atop the overbed table. With the same gloves, the LPN removed a positioning pillow from under the resident's hip/leg. One side of the pillow case appeared brown and wet with fecal incontinence. The LPN observed the condition of the pillow case and stated to the resident that after wound care, they would find the nurse aides to clean and freshly dress the resident. With the same gloves, the LPN folded and positioned the soiled pillow under the resident's right calf. With the same gloves, the LPN removed the old dressing from the resident's right foot, cleansed the wounds on the resident's right heel and toes with normal saline and gauze, applied the new dressing to each, wrapped the foot in kerlix, and secured the dressing with coban, all without changing gloves or sanitizing hands. When cleaning the wounds, LPN #1 swept across intact skin and wound beds alike, in a manner which had the potential to sweep bacteria from the resident's intact skin and onto the wound bed.</p> <p>On 04/16/24 at 11:15 a.m., LPN #1 stated they should sanitize their hands before donning gloves, change gloves when they were visibly soiled, and when moving from dirty task to a clean task. The LPN stated it was only after the dressing change did they recognize the potential cross contamination with touching the roommates personal belongings and using the roommates overbed table without sanitizing the surface; touching and using a soiled positioning pillow to prop the extremity for wound care; removing the old dressing, cleaning, applying, and securing the new dressing, all without further changing gloves and sanitizing hands.</p> <p>On 04/16/24 at 11:30 a.m., the DON stated LPN #1 was fairly new to the facility and they had not had the opportunity to observe the LPN perform wound care. The DON stated the LPN should sanitize hands and change gloves when the gloves were visibly soiled or when moving from a dirty task to a clean task.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>30267</p> <p>Based on observation, record review, and interview, the facility failed to store hazardous chemicals in a secure manner.</p> <p>The director of nursing identified one wandering resident who ambulated throughout the facility.</p> <p>Facility census: 34</p> <p>Findings:</p> <p>The facility policy entitled Storage Areas, Maintenance, documented hazardous/harmful chemicals were to be stored as instructed on the labels of such products and in a locked storage area.</p> <p>The MSDS (Material Safety Data Sheet) for Virex II - 256 disinfectant documented the chemical was corrosive to eyes, nose, throat, and respiratory tract. The MSDS documented the chemical was combustible and was intended for commercial or industrial use only. It documented to keep the chemical out of reach of children.</p> <p>The MSDS for Good Sense Liquid Air Freshener documented the chemical caused serious eye irritation and not to breath in vapors, taste, or swallow the chemical.</p> <p>The MSDS for Spraybuff, an industrial cleaning chemical, documented the chemical may be harmful if swallowed, may cause eye, skin, and respiratory irritation, and to keep out of children.</p> <p>The MSDS for Bounce Back, a floor finish restorer, documented the chemical may be harmful if swallowed, may cause eye, skin, and respiratory irritation, and to keep out of children.</p> <p>The MSDS for Soft Scrub Cleanser with Bleach, documented the chemical may cause permanent damage to eyes, irritation or severe burns possible on skin, to contact the poison control center if ingested, and to remove from exposed area to fresh air and to contact the poison control center if inhaled.</p> <p>The MSDS for Clorox Clean-Up Cleaner with Bleach, documented the chemical causes serious eye irritation, to avoid contact with skin, and to keep out of reach of children and pets.</p> <p>On 04/14/24 at 4:00 p.m., the following chemicals were observed in the bathroom of an unsecured resident room located on the north hall and used for the storage of equipment:</p> <ul style="list-style-type: none"> - Bounce Back (floor finisher restorer); - Spraybuff (water based shine maintainer); and, - Soft Scrub with Bleach (cleanser). <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/14/24 at 4:12 p.m., in the unsecured shower room on the north hall, the following chemicals were observed:</p> <ul style="list-style-type: none"> - Virex II 256 (disinfectant). <p>On 04/14/24 at 4:18 p.m., in the unsecured hopper room on the south hall the following chemicals were observed:</p> <ul style="list-style-type: none"> - Good Sense (air freshener), and - Clorox Clean-Up with Bleach (disinfectant cleanser). <p>On 04/14/25 at 4:25 p.m., LPN #1 stated the staff were to lock up stored chemicals.</p> <p>On 04/14/24 at 5:00 p.m., the administrator was shown the above chemicals and their locations. The administrator stated chemicals were to be stored in a secured manner such as in a locked cabinet or locked room.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30267</p> <p>Based on observation and interview, the facility failed to maintain sanitary conditions in the kitchen. There was standing water in the kitchen, an active water leak from the three compartment sink, and broken/missing floor tiles. This had the potential to effect all residents.</p> <p>The administrator identified 34 residents resided in the facility.</p> <p>Findings:</p> <p>On 04/14/24 at 12:46 p.m., the kitchen was observed. There was an active water leak from under the three compartment sink. There were several saturated bath sheets and towels on the floor between the three compartment sink and the food prep table. There were several missing, cracked, and broken floor tiles observed. The back door was opened wide and there was no screen door present.</p> <p>On 04/14/24 at 12:50 p.m., cook #1 stated when they arrive each morning to start their shift, there was always standing water all through the kitchen that they would have to mop up before starting breakfast. The cook stated the leak from under the three compartment sink had been there awhile and maintenance had been notified.</p> <p>On 04/16/23 at 4:34 p.m., the kitchen was observed. There was an active water leak from under the three compartment sink. There were several saturated bath sheets and towels on the floor between the three compartment sink and the food prep table. There were several missing, cracked, and broken floor tiles observed.</p> <p>On 04/16/24 at 4:45 p.m., the dietary manager stated the leak under the three compartment sink and the subsequent standing water on the floor had been ongoing for some time. The dietary manager stated maintenance had been aware.</p> <p>On 04/16/24 at 5:30 p.m., the administrator stated the facility was without a maintenance person now. The administrator stated they were aware of the condition of the kitchen floor and there was a plan in place for the repairs.</p>