STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375464	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ada Care Center	931 North Country Club Road Ada, OK 74820

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 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. 34333 Based on observation, record review, and interview, the facility failed to revise care plans related to smoking interventions for two (#2 and #43) of two residents sampled for smoking safety. The administrator identified 20 residents who smoked. Findings: An undated Smoking Policy, read in parts, Purpose: to provide maximum safety to all residents at all times . Smoking will be allowed in smoking areas ONLY .Any restrictions will be noted in the resident's record . Smoking privileges will be addressed in the Care Plan .Smoking materials will be kept in a designated area accessible only by staff .Residents assessed as likely to drop ashes on their clothing or self will wear a smoking apron provided by the Center. A Care Plans, Comprehensive Person-Centered policy, dated March 2022, read in parts, The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 1. Resident #43 had diagnoses which included diabetes, seasonal allergies, anxiety, and chronic pain. A Smoking Assessment, dated 11/22/24, documented Resident #43 could smoke independently and the facility did not need to store the resident's lighter and cigarettes. An MDS assessment for Resident #43, dated 11/23/24, documented the resident was cognitively intact. A Care Plan for Resident #43, dated 12/03/24, documented the resident was a smoker. The care plan did not address smoking safety or interventions. The care plan documented the resident had a self-care performance deficit related to impaired mobility. On 02/02/25 at 2:55 p.m., Resident #43 reported they smoked independently. They stated they kept their cigarettes and lighter in their room and could go out to smoke anytime they wished. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375464	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ada Care Center	931 North Country Club Road Ada, OK 74820

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/03/25 at 2:40 p.m., Resident #43 was observed smoking on the back porch, approximately four to five feet from the back door, which was not the designated smoking area. The resident was observed sitting on their scooter smoking and visiting with another resident. On 02/04/25 at 9:02 a.m., Resident #43 was observed outside on the back porch sitting on their scooter and smoking. An unidentified resident was observed to join them and sat down to smoke also. A sign was observed on the back door which reminded residents this area was not a designated smoking area and to go to the covered awning to smoke. On 02/04/25 at 9:08 a.m., maintenance staff reported there was not a receptacle on the back porch for smokers to dispose of their cigarettes because they were not supposed to be smoking there. They stated there was adequate receptacles under the awning in the designated smoking area and residents had been told numerous times not to smoke on the back porch. On 02/04/25 at 3:16 p.m., the DON reported all smokers should be going to the designated smoking area, but it had been an ongoing problem with them smoking on the back porch. The DON reported residents were assessed individually and then determined whether they could keep their smoking materials or if they would need to be kept at the nurse's desk. The DON stated the resident's care plan should include interventions and safety measures related to smoking. 41873 2. Resident #2 had diagnoses which included cerebrovascular accident. A smoking assessment, dated 11/18/24, documented Resident #2 required supervision and a smoking apron while smoking for safety. A care plan, dated 01/15/25, documented no intervention related to Resident #2 requiring a smoking apron while smoking. An MDS assessment, dated 01/30/25, documented Resident #2's range of motion was impaired on one side of the upper and lower extremities. The assessment documented the resident's cognition was severly impaired. On 02/04/25 at 3:45 p.m., Resident #2 was observed smoking without a smoking apron. On 02/04/25 3:54 p.m., CNA #5 reported they were not aware of any current resident in the facility who required a smoking apron. On 02/05/25 at 12:45 p.m., the MDS coordinator reported smoking and smoking interventions should be included on the resident's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375464	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ada Care Center	931 North Country Club Road Ada, OK 74820

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34333 Based on observation, record review, and interview, the facility failed to ensure adequate safety for smokers for two (#2 and #43) of two residents sampled for smoking safety. The administrator identified 20 residents who smoked. Findings: An undated Smoking Policy, read in parts, Purpose: to provide maximum safety to all residents at all times . Smoking will be allowed in smoking areas ONLY .Any restrictions will be noted in the resident's record . Smoking privileges will be addressed in the Care Plan .Smoking materials will be kept in a designated area accessible only by staff .Residents assessed as likely to drop ashes on their clothing or self will wear a smoking apron provided by the Center. 1. Resident #43 had diagnoses which included diabetes, seasonal allergies, anxiety, and chronic pain. A Smoking Assessment, dated 11/22/24, documented Resident #43 could smoke independently and the facility did not need to store their lighter and cigarettes. An MDS assessment for Resident #43, dated 11/23/24, documented the resident was cognitively intact. A Care Plan for Resident #43, dated 12/03/24, documented the resident was a smoker. The care plan did not address smoking safety. The care plan documented the resident had a self-care performance deficit related to impaired mobility. On 02/02/25 at 2:55 p.m., Resident #43 reported they smoked independently. They stated they kept their cigarettes and lighter in their room and could go out to smoke anytime they wished. On 02/03/25 at 2:40 p.m., Resident #43 was observed smoking on the back porch, approximately four to five feet from the back door, which was not the designated smoking area. On 02/04/25 at 9:02 a.m., Resident #43 was observed outside on the back porch sitting on their scooter and smoking. An unidentified resident was observed to join them and sat down to smoke also. A sign was observed on the back door which reminded residents this area was not a designated smoking area and to go to the covered awning to smoke. On 02/04/25 at 9:08 a.m., maintenance staff reported there was not a receptacle on the back porch for smokers to dispose of their cigarettes because they were not supposed to be smoking there. They stated there was adequate receptacles under the awning in the designated smoking area and residents had been told numerous times not to smoke on the back porch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375464	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ada Care Center	931 North Country Club Road Ada, OK 74820

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/04/25 at 3:16 p.m., the DON reported all smokers should be going to the designated smoking area, but it had been an ongoing problem with them smoking on the back porch. The DON reported residents were assessed individually and then determined whether they could keep their smoking materials or if they would need to be kept at the nurse's desk. 41873 2. Resident #2 had diagnoses which included cerebrovascular accident. A smoking assessment, dated 11/18/24, documented Resident #2 required supervision and a smoking apron while smoking for safety. A care plan, dated 01/15/25, documented Resident #2 required assistance from staff with smoking materials. An MDS assessment, dated 01/30/25, documented Resident #2's range of motion was impaired on one side of the upper and lower extremities. The assessment documented the resident's cognition was severly impaired. On 02/03/25 at 9:47 a.m., Resident #2 was followed by an unknown staff member outside the facility to the smoking area to smoke. The unknown staff member had the resident's cigarettes and lighter and lit the resident's cigarette. The staff member was observed helping the resident put ashes in the ashtray. The resident was observed not wearing a smoking apron for safety. On 02/04/25 at 3:45 p.m., CNA #5 was observed outside with Resident #2 while the resident smoked. The resident was observed not wearing a smoking apron. On 02/04/25 3:54 p.m., CNA #5 reported not being aware of any current resident in the facility that required a smoking apron. On 02/04/25 3:56 p.m., the DON reported Resident #2 was required to wear a smoking apron for safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375464	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ada Care Center	931 North Country Club Road Ada, OK 74820

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 30875 Based on record review and interview, the facility failed to ensure an as needed (PRN) medication for anxiety had a documented rational for continued use beyond 14 days for one (#11) of five residents sampled for unnecessary medications. The DON reported 14 residents received anti-anxiety medications. Findings: A Psychotropic Medication Use policy, dated July 2022, read in part, Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotic's: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, [they] will document the rational for extending the use and include the duration for the PRN order. Resident #11 had diagnoses which included heart failure, hypertension, and anxiety/depression. A care plan, dated 03/18/22, documented the resident received anti-anxiety medications r/t anxiety. A Physician Order, dated 11/15/24, documented Ativan (benzodiazepine) 0.5 mg tablet by mouth in the morning for anxiety and give 0.5 mg tablet by mouth every eight hours as needed for anxiety. A pharmacy report, dated 12/06/24, read in parts, CMS requires that orders for non-antipsychotic psychotropic medications that are given on a PRN basis be limited to 14 days unless otherwise indicated .If extended use is required, the clinical rationale for continued need and duration of therapy must be provided to be in compliance with regulatory requirements .May we attempt to D/C or change this order to routine? The report documented the physician disagreed with the recommendation and documented, adds to routine dose. An MDS assessment, dated 12/13/24, documented the resident had moderate cognitive impairment. On 02/04/25 at 10:40 a.m., the ADON reported the PRN order for Ativan was part of the routine Ativan order. On 02/04/25 at 10:45 a.m., the DON reported the PRN order for Ativan was part of the routine order. The DON reported they knew if the Ativan was ordered PRN it had to be evaluated every two weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375464	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ada Care Center	931 North Country Club Road Ada, OK 74820

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 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. 30875 Based on observation, record review, and interview, the facility failed to ensure food was completely covered while being served. The administrator reported 57 residents received meals from the kitchen. Findings: A Preventing Foodborne Illness-Food Handling policy, dated July 2014, read in part, Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. On 02/02/25 at 11:40 a.m., residents were observed during the noon meal. Dessert was observed to be served on a saucer with a plastic lid sitting on top of the dessert. The plastic lid did not completely cover the cake being served for dessert. On 02/03/25 at 8:17 a.m., cook #2 was asked about serving the desserts on an uncovered saucer the previous day. The cook stated they were out of bowls and the plastic wrap was not the proper size. On 02/03/25 at 8:19 a.m., the dietary manager was asked about the cake that was served uncovered the previous day. They stated the administrator had ordered some dessert dishes and they were waiting on them to come in.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375464	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ada Care Center	931 North Country Club Road Ada, OK 74820

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 30875 Based on observation, record review, and interview, the facility failed to: a. ensure proper disposal of the lancet and blood contaminated glucometer strip for one (#105) of two sampled residents reviewed for blood glucose monitoring; b. to properly dispose of soiled PPE supplies for two (#2 and #204); and c. failed to use proper PPE for enhanced barrier precautions for one (#2) of five sampled residents reviewed for infection control. The administrator reported 59 residents resided in the facility. The DON reported 12 residents with blood glucose monitoring. Findings: A Obtaining a Fingerstick Glucose level policy, dated October 2011, read in part, Dispose of lancet in the sharps disposal container, Discard disposable supplies in the designated containers. A Enhanced Barrier Precautions policy, dated 04/01/24, read in part, EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room. 1. A physician's order for Resident #105, dated 01/29/25, documented the resident would receive Novolog insulin per sliding scale instructions related to diabetes. A care plan for Resident #105, dated 01/30/25, documented the resident had diabetes mellitus. On 02/03/25 at 10:45 a.m., LPN #1 was observed to prepare supplies for Resident #105's finger stick blood sugar test. After the finger stick blood sugar was obtained, the LPN removed their gloves and rolled the strip and the lancet up in the glove and disposed of it in the trash in the resident's room. On 02/03/25 at 11:17 a.m., LPN #1 reported they usually disposed of biohazard materials in the sharps container. The LPN was asked about the facility policy for proper disposal and they stated the lancet/strip should have been put in the biohazard. On 02/03/25 at 11:24 a.m., the administrator reported the facility policy was to dispose of biohazard in the sharps container. On 02/03/25 at 11:29 a.m., the ADON reported staff should dispose of all biohazard in the sharps container. 41873 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375464	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ada Care Center	931 North Country Club Road Ada, OK 74820

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #204 had diagnoses which included neuromuscular dysfunction of the bladder. A physician's order, dated 04/22/22, read in part, Cleanse suprapubic catheter site with normal saline solution, pat dry, apply a split dressing, and secure with tape daily. A care plan intervention, dated 04/20/24, read in parts, Use enhanced barrier precautions (EBP) .Wear at least gloves/gown .EBP is employed when performing high-contact device care or use: urinary catheter and any skin opening requiring a dressing or other devices/conditions recommended by the CDC. On 02/04/25 at 2:00 p.m., Resident #204's door to their room was observed with enhanced barrier signage. On 02/04/25 at 2:00 p.m., LPN #3 was observed donning a gown and gloves before entering Resident #204's room to provide catheter care. The LPN exited the resident's room with used catheter care supplies and wearing a used gown. The LPN was observed to discard used supplies and PPE used for catheter care in the trash can on the treatment cart in the hallway. 3. Resident #2 had diagnoses which included peripheral vascular disease. A care plan, dated 04/01/24, read in parts, Use enhanced barrier precautions (EBP). Wear at least gloves/gown .EBP is employed when performing high-contact device care or use: wound care - any skin opening requiring a dressing or other devices/conditions recommended by the CDC. Physician orders, dated 02/03/25, read in part, Clean with normal saline, apply collagen, cover with bordered gauze 3 times weekly and as needed. The orders also read, Clean with normal saline, apply Medihoney to right lateral ankle topically, cover with bordered foam 3 times weekly and as needed. On 02/04/25 at 2:45 p.m., LPN #3 was observed to provide wound care to resident #2's right shin, right heel, and right ankle. The wounds on the right ankle and shin were observed to be open wounds that required dressings. The LPN was observed performing wound care with gloves, but failed to don a gown for enhanced barrier precautions. The LPN was observed to discard used wound care supplies and used gloves in the trash can on the side of the nurses treatment cart in the hallway outside the resident's room. On 02/04/25 at 2:50 p.m., LPN #3 reported they had not seen the EBP sign on Resident #2's door and should have worn a gown to perform the wound care. The LPN reported using the trash can on the treatment cart to discard their used supplies after exiting a resident's room was normal routine. The LPN reported they made sure the trash can was emptied two to three times a shift. On 02/04/25 at 2:59 p.m., the DON reported staff should follow enhanced barrier precautions (using a gown and gloves) when providing care for all residents with wounds and catheters. The DON reported used PPE and used treatment supplies should be discarded in a trash can in the resident's room before exiting.