

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/09/2024
NAME OF PROVIDER OR SUPPLIER  Drumright Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  Pine & Bristow Drumright, OK 74030	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33148</p> <p>Based on record review and interview, the facility failed to ensure a resident's code status was accurate for one (#7) of one sampled resident reviewed for advance directives.</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>Res #7 was admitted to the facility on [DATE] with diagnoses which included heart disease, COPD, presence of a pace maker, chronic pain, and CKD,</p> <p>A DNR consent form, dated [DATE], documented the resident gave consent for DNR.</p> <p>A physician order, dated [DATE], documented CPR.</p> <p>On [DATE] at 10:02 a.m., the ADON and DON were asked to verify the resident's code status.</p> <p>On [DATE] at 11:05 a.m., the ADON stated the resident had a DNR on file and they were supposed to be a DNR.</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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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure a resident discharged from Part A skilled services, with benefit days remaining, was issued a SNF ABN and/or NOMNC notice for one (#53) of four sampled residents reviewed for beneficiary notices.</p> <p>The Beneficiary Notice worksheet identified eight residents were discharged from Part A skilled services with benefit days remaining in the past six months.</p> <p>Findings:</p> <p>Res #53 was admitted to the facility for skilled services on 02/27/24 with diagnoses which included COPD, heart failure, CKD, type 2 diabetes mellitus, amputation of toes, and history of falling.</p> <p>An undated Benefit Eligibility Details report, documented as of 04/01/24 the resident had five days of skilled service remaining.</p> <p>Health status notes, dated 04/01/24, documented the resident's oxygen saturation dropped and the breathing treatment administered was ineffective. It was documented the nurse listened to the resident's lung sounds and wheezing was noted to the right lower lobe and the left lobe was diminished. It was documented the resident was sent out to the hospital and admitted .</p> <p>A social service note, dated 04/02/24, documented the resident's family member was contacted and advised the the resident was in the hospital past their discharge date from skilled nursing services. It was documented it would be up to the resident's family member and the hospital to arrange the resident's transportation home.</p> <p>There was no documentation a SNF ABN and/or NOMNC notice was provided to the resident and/or their legal representative.</p> <p>On 05/08/24 at 10:01 a.m., the ADON and DON were asked when was the resident's last day of skilled service and if beneficiary notice forms were provided to the resident and/or their legal representative.</p> <p>On 05/08/24 at 11:38 a.m., the ADON stated the resident had five days of skilled service left when they went to the hospital. They stated they did not know the reason the resident's family member was informed they had no skilled service days remaining. They stated once the resident returned to the facility they should have been provided beneficiary notice forms. They stated they were to give a two day notice.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure a discharged resident's clinical record contained a discharge summary for one (#54) of one sampled resident reviewed for facility initiated discharge.</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>Res #54 had diagnoses which included COPD, heart failure, type 2 diabetes mellitus, panic disorder, and major depressive disorder.</p> <p>A physician order, dated 02/29/24, documented the resident was discharged home.</p> <p>There was no documentation a discharge summary was completed.</p> <p>On 05/07/24 at 11:07 a.m., the ADON was asked if a discharge summary had been completed for the resident.</p> <p>On 05/07/24 at 11:57 a.m., the ADON stated they had 30 days to complete a discharge summary and a discharge summary was not completed.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33148</p> <p>Based on record review and interview, the facility failed to notify a resident and/or their representative of the resident's discharge in writing 30 days before the resident was discharged for one (#54) of one sampled resident reviewed for discharge.</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>Res #54 was admitted to the facility on [DATE] with diagnoses which included COPD, heart failure, type 2 diabetes mellitus, panic disorder, and major depressive disorder.</p> <p>A social service note, dated 01/24/24, documented the resident had been denied nursing home Medicaid due to not sending in verification. It was documented the resident's family member was notified.</p> <p>A social service note, dated 02/22/24, documented the facility contacted DHS about the resident's long term care. It was documented the resident's case was still pending.</p> <p>A health status note, dated 02/29/24, documented the resident was discharged home.</p> <p>On 05/07/24 at 11:57 a.m., the ADON was asked the reason for the resident's discharge. They stated the resident did not have payer source. They were asked if a discharge notice was provided to the resident and/or their representative.</p> <p>On 05/07/24 at 12:08 p.m., the ADON stated there was no written notice provided. They stated the administrator gave a verbal 30 day notice.</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure a resident was permitted to return to the facility after they were hospitalized for one (#53) of one sampled resident reviewed for hospitalization .</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>An undated Notice of Bed Hold policy, read in part, .It will be the facility's policy that any resident who is transferred to a hospital for a period of less than five days will have the right to return and expect the bed and room which he/she resided at the time of his/her transfer .If a resident who is transferred with an expectation of returning to the facility cannot return to the facility, the resident will be discharged according to policy .</p> <p>Res #53 was admitted to the facility for skilled services on 02/27/24 with diagnoses which included COPD, heart failure, CKD, type 2 diabetes mellitus, amputation of toes, and history of falling.</p> <p>Health status notes, dated 04/01/24, documented the resident's oxygen saturation dropped and the breathing treatment administered was ineffective. It was documented the nurse listened to the resident's lung sounds and wheezing was noted to the right lower lobe and the left lobe was diminished. It was documented the resident was sent out to the hospital and admitted .</p> <p>A social service note, dated 04/02/24, documented the resident's family member was contacted and advised the the resident was in the hospital past their discharge date from skilled nursing services. It was documented it would be up to the resident's family member and the hospital to arrange the resident's transportation home.</p> <p>05/08/24 at 11:38 a.m., the ADON was asked about the resident's discharge and their bed hold policy.</p> <p>They stated the resident had five days of skilled service left when they went to the hospital. They stated they did not know the reason the resident's family member was informed they had no skilled service days remaining. They stated their bed hold policy was five days. They stated the resident had no payer source after skilled days.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to refer a resident with a newly evident or possible serious mental illness to the OHCA for a level II PASRR evaluation for one (#28) of two sampled residents reviewed for PASRR's.</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>A level I PASRR, dated 06/27/23, documented Res #28 did not have evidence or diagnosis of a serious mental illness.</p> <p>On 07/28/23, the resident had a new diagnosis of bipolar type schizophrenia disorder.</p> <p>On 07/29/23, the resident had new diagnosis of borderline personality disorder and mood disorder due to known physiological condition with depressive features.</p> <p>There was no documentation the resident had been referred to the OHCA for a level II PASRR evaluation.</p> <p>On 05/08/24 at 10:04 a.m., the ADON and DON were made aware the resident had a negative level I pre-screen and was later identified with newly evident of possible serious mental illness. They were asked if the resident was referred to the OHCA for a level II PASRR evaluation.</p> <p>On 05/08/24 at 11:36 a.m., the ADON stated the resident was not referred to the OHCA for a level II PASRR evaluation.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>46387</p> <p>Based on record review and interview, the facility failed to include a care plan regarding dietary preferences for one (#28) of one sampled resident reviewed for care planning.</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>Res #28 had diagnoses which included vitamin D deficiency and depression.</p> <p>A physician order, dated 04/01/24, documented the resident required a no added salt vegetarian diet. The order specified to make smoothies with super greens powder with meals as a supplement.</p> <p>On 05/07/24 at 9:24 a.m., the ADON stated the resident's food preferences should have been included in the care plan, but were not.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46387</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received treatment and monitoring of a newly developed pressure ulcer for one (#51), and provide treatment and services to prevent worsening of a pressure ulcer for one (#49) of three sampled residents reviewed for pressure ulcers. This resulted in worsening of both resident's pressure ulcers.</p> <p>The DON identified six residents with pressure ulcers.</p> <p>Findings:</p> <p>A facility POLICY AND PROCEDURE FOR THE PREVENTION AND TREATMENT OF PRESSURE ULCERS, revised 08/28/08, read in part, .Should a resident have an existing pressure ulcer or develop a pressure ulcer post admission, the facility will implement procedures to evaluate the ulcer regularly .The facility will evaluate the ulcer at least weekly, utilizing a flow sheet that notes the location of the ulcer, the stage, presence of eschar, size, color odor, drainage, tunneling/sinus tract/undermining if present .The facility will notify the physician upon the onset of the ulcer an obtain treatment orders .The facility will notify the physician if the ulcer appears to be deteriorating or if no improvement is noted in 2-4 weeks of the initial treatment orders .</p> <p>1. Res #49 admitted to the facility on [DATE] with diagnoses which included peripheral vascular disease and amputation of right lower leg.</p> <p>A skin assessment, dated 03/13/24, documented a new stage II pressure ulcer measuring 1.0 cm x 1.0 cm x 0 cm to the left heel as facility acquired.</p> <p>A physician order, dated 03/14/24, documented to cleanse wound on left heel with normal saline, pat dry, apply Betadine, and leave open to air every day shift.</p> <p>A wound assessment, dated 03/20/24, documented the wound to the heel was a stage I pressure ulcer facility acquired measuring 0.5 cm x 0.5 cm x 0.1 cm.</p> <p>A wound assessment, dated 03/27/24, documented the wound to left heel was a stage I facility acquired measuring 0.5 cm x 0.4 cm x 0.1 cm.</p> <p>The resident was admitted to the hospital from 04/01/24 through 04/19/24.</p> <p>A wound assessment, dated 04/19/24, documented the resident readmitted with a SDTI to the left heel with 85% slough/necrosis tissue measuring 0.5 cm x 0.5 cm x 0 cm.</p> <p>A wound assessment, dated 04/26/24, documented the heel wound as an admitted SDTI with 40% slough/necrosis measuring 0.5 cm x 0.5 cm x 0 cm.</p> <p>A physician order, dated 04/26/24, documented to cleanse the wound to the heel with normal saline, pat dry, apply collagen silver and cover with bandage each day shift.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>The TAR and skilled nursing notes for April 2024 were reviewed. There was no documentation wound care was performed 04/26/24 through 04/28/24.</p> <p>A wound assessment, dated 05/01/24, documented an admission SDTI wound to the left heel with 75% slough/necrosis measuring 0.25 cm x 0.5 cm x 0 cm.</p> <p>The TAR and skilled nursing notes for May 2024 were reviewed. There was no documentation wound care was performed 05/01/24 through 05/06/24.</p> <p>A wound assessment, dated 05/06/24, documented an admission SDTI to the left heel with 75% necrosis measuring 0.5 cm x 0.5 cm x 0.25 cm.</p> <p>A nurse progress note, dated 5/6/2024 at 7:16 p.m., documented staff attempted to send the resident to the hospital for significant changes to the left heel wound. It was documented the resident declined transfer.</p> <p>On 05/07/24 at 9:30 a.m., LPN #3 was observed performing wound care to the resident's left heel. The wound was not covered with a dressing upon removal of the sock. The wound bed was pink with approximately 50% yellow slough covering. The wound was not measured, but was approximately the diameter of a dime with depth.</p> <p>On 05/07/24 at 11:26 a.m., LPN #3 stated wound care was documented on the TAR.</p> <p>On 05/07/24 at 11:32 a.m., the DON stated the wound care was not completed according to the documentation for 04/26/24 through 05/01/24. They stated based on the measurements of the wound it had worsened.</p> <p>On 05/07/24 at 11:39 a.m., the ADON stated the wound could not be a SDTI if it was open.</p> <p>33097</p> <p>2. Res #51 had diagnoses which included type 2 diabetes mellitus, pain, pressure induced deep tissue damage of the right heel, and a stage I pressure ulcer of the right heel.</p> <p>An admit/readmit screener, dated 02/14/24, documented the resident had bruising to the right antecubital and right hand. It was documented the resident had an abrasion to the right elbow and redness to the chest and left and right iliac crest. It was documented the resident had a stage II pressure wound measuring 3 cm x 1.5 cm x 0.2 cm to the coccyx.</p> <p>A weekly wound observation tool, dated 02/18/24, documented the resident had a stage I pressure wound to the right heel. It was documented the wound measured 4.5 cm x 4 cm x 0 cm. It was documented the wound was acquired during the resident's stay at the facility.</p> <p>A five day admission assessment, dated 02/20/24, documented the resident was dependent for assistance to roll from their back and side to side. It was documented the resident was frequently incontinent of urine and was always incontinent of bowel. The assessment documented the resident had one stage I pressure ulcer and one stage II pressure ulcer that was present on admission.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A weekly wound observation tool, dated 02/22/24, documented the resident had a stage II pressure wound to their coccyx measuring 1 cm x 1.5 cm x 0.1 cm. It was documented the resident's wound had worsened.</p> <p>A health status note, dated 03/08/24, documented treatment was to continue to the open coccyx wound measuring 2.0 cm x .5 cm x 0.1 cm. It was documented staff was to continue treatment for the abrasion to the left posterior knee 0.8 cm x 1.3 cm x 0.1 cm. and to the right heel with dark hard necrotic tissue measuring 4.5 cm x 4.0 cm x no depth.</p> <p>A weekly wound observation, dated 03/13/24, documented the resident had an in facility acquired pressure wound stage I measuring 4.5 cm x 4.0 cm x unknown.</p> <p>A physician order, dated 04/01/24, documented the resident was to use turn rails if able to assist with bed mobility and turning every two hours.</p> <p>A health status note, dated 04/07/24, documented a 0.5 cm x 0.5 cm round pressure wound was found below the existing coccyx wound. It was documented treatment was in place and every two hour repositioning.</p> <p>There was no treatment order or weekly wound assessment for the pressure wound found on 04/07/24 below the coccyx wound.</p> <p>A weekly wound assessment, dated 04/09/24, documented the stage II to the right heel had been resolved.</p> <p>A physician order, dated 04/24/24, documented Calmoseptine Externam Ointment 0.44 - 20.6% was to be applied to the buttocks topically every shift for preventative.</p> <p>A physician order, dated 04/25/24, documented staff were to cleanse the area to the coccyx with normal saline, apply collagen alginate to the wound bed, and cover with a dressing every day. It was documented staff were to remove the dressing and brief at bedtime to allow for airing out.</p> <p>On 05/06/24 at 10:55 a.m., the resident was observed lying in bed. They were moaning and stated their buttocks hurt. They rated their pain at a nine on a pain scale from zero to 10. Staff stated the resident had a wound on their buttock.</p> <p>On 05/07/24 at 9:20 a.m., LPN #2 performed wound care for the resident. They gathered their supplies to perform the treatment. They measured the coccyx wound. LPN #2 was asked about the wound to the buttock and the wound to the right heel observed. They did not respond to the question.</p> <p>There was no documentation regarding the coccyx treatment or the identified wound to the buttock and right heel.</p> <p>On 05/09/24 at 10:15 a.m., the ADON conducted a skin assessment for the resident. They stated the resident had two pressure ulcers. A stage II pressure ulcer to the buttocks and the right heel pressure ulcer had returned. The ADON stated no assessments or treatment orders had been documented or obtained.</p> <p>(continued on next page)</p>		

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F 0686  Level of Harm - Actual harm  Residents Affected - Some	On 05/09/24 at 12:52 p.m., the ADON stated there was no documentation regarding repositioning the resident every two hours. The ADON stated they relied on staff to reposition the residents every two hours per physician orders.		

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<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46387</p> <p>Based on record review and interview, the facility failed to ensure verification from the nurse aide registry before allowing a CNA to work for two (CNA #4 and CNA #5) of 30 CNAs reviewed for certifications.</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>1. CNA #4's certification expired on [DATE].</p> <p>A Time &amp; Attendance - Employee Timecard documented CNA #4 worked on [DATE], [DATE], [DATE], and [DATE].</p> <p>2. CNA #5's certification expired on [DATE].</p> <p>A Time &amp; Attendance - Employee Timecard documented CNA #5 worked on [DATE], [DATE], and [DATE].</p> <p>On [DATE] at 3:19 p.m., the ADON stated the IP nurse was responsible for ensuring the staff have current licenses and certifications. The IP was unavailable for interview.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure a PRN psychotropic medication was limited to 14 days for one (#3) of five sampled residents reviewed for unnecessary medications.</p> <p>The DON identified five residents who had orders for PRN psychotropic medications.</p> <p>Findings:</p> <p>Res #3 had diagnoses which included anxiety and agitation.</p> <p>A physician order, dated 12/01/23, documented Ativan suspension (benzodiazepine medication) 1 mg/ml. Give 0.5 ml sublingually every fours hours as needed for 14 days.</p> <p>The February 2024 MAR document Ativan was administered on 02/26/24 and 02/28/24.</p> <p>The March 2024 MAR documented Ativan was administered on 03/03/24, 03/11/24, and 03/21/24.</p> <p>On 05/08/24 at 10:07 a.m., the ADON and DON were made aware of the resident's Ativan order. The ADON stated the order should have stopped and been reassessed.</p> <p>)</p>		

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NAME OF PROVIDER OR SUPPLIER  Drumright Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  Pine & Bristow Drumright, OK 74030	

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>33097</p> <p>Based on observation, record review, and interview, the facility failed to follow the menu approved by the facility's dietitian for one of one meal service observed.</p> <p>The DM identified 52 residents received services from the kitchen. Two residents received nutrition and hydration solely through a feeding tube.</p> <p>Findings:</p> <p>The lunch menu for 05/07/24 documented residents were to have one pork chop, a half cup of broccoli rice casserole, six pieces of breaded squash, one dinner roll, chocolate cream desert, and a beverage of choice. The chocolate cream desert was marked out and devil cake was written in its place.</p> <p>On 05/07/24 at 11:00 a.m., a tour of the kitchen was conducted. Two pans of meatloaf were observed being removed from the oven.</p> <p>On 05/07/24 at 11:10 a.m., the DM stated they did not have enough pork chops for all of the residents. They stated the menu was changed to meatloaf. The DM stated the facility dietitian was not notified of the changes. The DM stated the administrator made changes as needed.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>33097</p> <p>Based on observation and interview, the facility failed to ensure food was served at an appetizing temperature and palatable.</p> <p>The DM identified 52 residents received services from the kitchen. Two residents received nutrition and hydration solely through a feeding tube.</p> <p>Findings:</p> <p>33148</p> <p>1. A quarterly resident assessment, dated 02/20/24, documented Res #5's cognition was intact.</p> <p>On 05/06/24 at 7:45 a.m., the resident was asked how was the food. They stated some of the food was not good. They stated they ate in their room and sometimes the food was cold.</p> <p>2. A quarterly resident assessment, dated 04/29/24, documented Res #7 was moderately impaired in cognition.</p> <p>On 05/06/24 at 9:27 a.m., the resident stated the food was not good. They stated the food was cold all the time and sometimes it was so salty it would cross your eyes. They stated the facility would provide a sandwich as an alternative. They stated the biscuit served for breakfast was so hard they could not eat it.</p> <p>3. A quarterly resident assessment, dated 04/28/24, documented Res #14's cognition was intact.</p> <p>On 05/06/24 at 8:17 a.m., the resident was asked how was the food. They stated they ate in their room and the food was cold when they received it.</p> <p>4. A quarterly resident assessment, dated 02/17/24, documented Res #22's cognition was intact.</p> <p>On 05/06/24 at 8:41 a.m., the resident was asked how was the food. They stated the food was always cold.</p> <p>5. A quarterly resident assessment, dated 02/28/24, documented Res #30's cognition was intact.</p> <p>On 05/06/24 at 7:57 a.m., the resident was asked how was the food. They stated the food was always cold.</p> <p>6. An admission assessment, dated 04/22/24, documented Res #40's cognition was intact.</p> <p>On 05/06/24 at 8:23 a.m., the resident was asked how was the food. They stated the food was not good. They stated they ate in their room and their food was cold by the time they got it.</p> <p>7. An annual assessment, dated 04/27/24, documented Res #155's cognition was intact.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/06/24 at 9:33 a.m., the resident was asked how was the food. They stated the food was not good.</p> <p>On 05/07/24 at 1:01 p.m., a food test tray was received from the kitchen. The breaded squash served was luke warm and had no flavor. The temperature of the breaded squash was 108 degrees Fahrenheit with a hand held thermometer.</p> <p>46387</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>33097</p> <p>Based on observation, record review, and interview, the facility failed to prepare and serve food in a sanitary manner.</p> <p>The DM identified 52 residents received services from the kitchen. Two residents received nutrition and hydration solely through a feeding tube.</p> <p>Findings:</p> <p>An undated Spectrum Advance Hand Sanitizer Gel safety data sheet, read in part, .Flammable liquid and vapor .Keep away from heat/sparks/open flames/hot surfaces .Keep product and empty container away from heat and sources of ignition .Do not eat, drink or smoke when using this product .</p> <p>On 05/07/24 at 11:45 a.m., dietary aide #1 was observed preparing drinks for the lunch meal in the dining room. They entered the kitchen for a container of coffee, then returned to the dining room to prepare drinks. They did not wash their hands when entering the kitchen. Dietary aide #1 was observed entering the kitchen and preparing the coffee maker to make more coffee. They exited the kitchen and continued to prepare drinks for the meal. They did not wash their hands when entering the kitchen. Dietary aide #1 was observed entering the kitchen for a third time and obtained a gallon of milk from the refrigerator. They exited the kitchen and continued preparing drinks. They did not wash their hands when entering to kitchen.</p> <p>On 05/07/24 at 11:55 a.m., dietary cook #2 was observed serving the lunch meal. They were working from a steam table and the oven was to their left with food items being heated on top of the stove. A dispenser of Spectrum Advance Sanitizer was hung on the wall between the oven and the steam table. Dietary cook #2 was observed wiping their nose and the sweat from their forehead, then used the hand sanitizer from the dispenser on the wall. They repeated this process two times, did not wash their hands, and continued to serve the meal. Dietary cook #1 stated the sanitizer was an alcohol based hand cleaner.</p> <p>On 05/07/24 at 12:04 p.m., the DM stated they did not know hand sanitizer could not be used in the kitchen. The DM stated everyone who entered the kitchen should wash their hands with soap and water.</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure the individual functioning as the social worker met the required qualifications for a facility with more than 120 beds.</p> <p>The administrator identified 54 resident resided in the facility.</p> <p>Findings:</p> <p>An Oklahoma State Department of Health Nursing Facility License, issued on 11/07/22, documented the facility was licensed for a maximum of 133 beds.</p> <p>On 05/08/24 at 10:00 a.m., the ADON and DON were asked if they had a qualified social worker on a full time basis. They stated they did have a full time social worker and they would check on their qualifications.</p> <p>On 05/08/24 at 12:06 a.m., the DON stated their social worker had an associate in arts and had six years of experience as a case manager at a prison. They stated they did not have a bachelors degree. They stated they were licensed for 133 beds, but they did not have that many beds.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure the QAA committee met at least quarterly.</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>There was no documentation the QAA committee met October 2023 through December 2023.</p> <p>On 05/07/23 at 9:33 a.m., the DON was asked to provide documentation the QAA committee met October 2023 through December 2023.</p> <p>On 05/07/23 at 10:37 a.m., the DON stated there was no documentation the QAA committee met during the quarter of October 2023 through December 2023. They stated the QAA committee meets quarterly and they should have met that quarter.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>33097</p> <p>Based on observation, record review, and interview, the facility failed to maintain an infection control program to help prevent the transmission of infections for two (#2 and #51) of three sampled residents reviewed for pressure ulcers.</p> <p>The DON identified six residents with pressure ulcers.</p> <p>Findings:</p> <p>An undated facility WOUND DRESSINGS policy, read in part, .Gather supplies: 3 or more pairs of Gloves; Wax paper; .Anything brought into the room must be cleaned or discarded .Place wax paper on a clean, dry surface next to where you will be working. Set up supplies on waxed paper .</p> <p>1. Res #2 had diagnoses which included severe sepsis, need for assistance with personal care, pain, and personal history of other diseases of the musculoskeletal system and connective tissue.</p> <p>A physician order, dated 04/01/24, documented cleanse the area to the inner left foot with Betadine and cover with a protective dressing daily.</p> <p>On 05/08/24 at 9:40 a.m., LPN #2 was observed performing wound care for the resident. They gathered their supplies, placed them in a metal pan, and entered the resident's room. They moved a box of markers off a stack of coloring pages and placed the metal pan on the coloring sheets sitting on the resident's bedside table. LPN #2 completed the wound care, gathered their supplies, and washed their hands. They placed the metal pan used in the resident's room on the treatment cart. They charted on the computer and placed the metal pan in the third drawer of the treatment cart with other supplies. LPN #2 did not clean the surface of the metal pan that touched the resident's personal belongings and bedside table.</p> <p>On 05/08/24 at 10:30 a.m., the DON stated LPN #2 should have cleaned the pan when leaving the resident's room and with contact with the resident's personal belongings.</p> <p>2. Resident #51 had diagnoses which included type 2 diabetes mellitus, pain, pressure induced deep tissue damage of the right heel, and a stage I pressure ulcer of the right heel.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/07/24 at 9:20 a.m., LPN #1 was observed performing wound care for the resident. Near the resident's door there was a three drawer container that contained PPE supplies. A sign on the container documented enhanced barrier precautions. LPN #1 stated gloves, a gown, and a mask must be worn when wound care was performed for infection control. They gathered their supplies and placed them in a metal pan. They entered the resident's room and placed the metal pan on the resident's bedside table. They did not clean the bedside table or provide a clean barrier. LPN #1 completed the wound care and placed the metal pan on the resident's bed to gather the trash. They exited the room and placed the metal pan on the three drawer container, then on top of the treatment care, and then in the third drawer of the treatment cart with clean supplies. LPN #1 did not clean the surface of the metal pan that touched the resident's bedside table and bed before returning it the supply drawer.</p> <p>On 05/07/24 at 10:40 a.m., LPN #1 stated they should have cleaned the metal pan after touching the resident's personal belongings.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46387</p> <p>Based on record review and interview, the facility failed to offer an influenza vaccine for one (#15) of five sampled residents reviewed for vaccinations.</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>Res #15 was admitted to the facility on [DATE].</p> <p>A vaccination record review documented the resident had not received an influenza vaccine.</p> <p>On 05/09/24 at 12:16 p.m., the IP stated there was a vaccination clinic for the residents at the end of 2023. They stated they had not offered vaccinations to the residents who admitted after the clinic.</p>