Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Pointe Living Center	101 Sherrard Drive Colbert, OK 74733

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 38495 Based on record review and interview, the facility failed to ensure resident's rights to allow/receive visitors of the resident's choice for one (#33) of one sampled resident reviewed for visitation. The DON identified 42 resident who resided in the facility. Findings: An undated facility policy titled VISITING REGULATIONS, read in part, .Establish a measurable goal for active participation and social interaction with visitors of the resident's choice . Res #33 had diagnoses which included chronic pain syndrome, chronic kidney disease, and adjustment disorder with depressed mood. A five day assessment, dated 03/16/24, documented the resident was intact with cognition and required supervision or touch assistance with most ADLs. On 04/01/24 at 10:22 a.m., the resident councel president stated the can have visitors of choice. They stated Res #33 had talked to them about not being allowed visitor of choice. The resident councel president stated they had talked to the administrator and the ombudsman had been to the facility and now Res #33 can have the visitor of their choice. On 04/02/24 at 9:00 a.m., Res #33 stated when they were in the hospital their friend was the only person who came to see them. Res #33 stated their friend came to see them after they got out of the hospital. Res #33 stated the visitor came on a Sunday to her room and brought a gown and robe. Res #33 stated the friend was asked to leave the facility by the facility staff. Res # 33 stated they had talked to the administrator and they were told the friend was not allowed in the facility anymore. Res #33 stated they told the administrator that was their friend and they wanted to see them. Res #33 stated the ombudsman had been in the facility and visited with them and the administrator. Res #33 stated her friend had been a wonderful friend, someone they could talk to and share their dreams with. (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: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Sherrard Drive Colbert, OK 74733	

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 2:34 p.m., CNA #1 stated they were told by the administrator Res #33's friend could not be in the facility without the administrator being there. CNA #1 stated the administrator told them to ask the friend to leave the facility. CNA #1 stated the friend left the facility as asked. CNA #1 stated they were told the friend was not allowed on the premises. 04/03/24 02:43 p.m., CNA #2 stated their boss had asked CNA #1 to ask Res #33's friend politely to leave the facility. CNA #2 stated they were in the residents room when the visitor was asked to leave. CNA #2 stated they were not aware of why the friend was not able to visit. On 04/03/24 at 2:47 p.m., the DON stated they did not know much about the visitation issue. The DON stated they were not aware of why the person was not allowed to visit the resident. She stated she did not have a concern of the person visiting Res #33. On 04/03/24 at 2:54 p.m., the administrator stated the visitor was an previous employee which ended working at the facility on bad terms. The administrator stated they knew the resident could have visitors of their choice but from their point of view they were trying to protect the resident of things the resident may not be aware of. The administrator stated they did not want to upset the resident and knows they can not control who visits but felt they were acting in the best interest of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Sherrard Drive Colbert, OK 74733	

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38495 Based on record review and interview, the facility failed to ensure resident assessments were accurate for two (#4 and #7) of 12 sampled residents whose resident assessments were reviewed. The DON identified 42 residents who reside in the facility. Findings: 1. Res #7 had diagnosis which included COPD, Bipolar disorder, Schizoaffective disorder, and dementia. A significant change assessment, dated 03/06/24, documented the resident was severly impaired with cognition and required partial to moderate assistance with most ADLs. The assessment documented a GDR had not been contraindicated. A MRR request, dated 09/27/23, documented the following medications are due for consideration of a GDR for clonazepam, Vraylar, and Risperdal. On 10/02/23 the physician did not wish to reduce the medication. The physician documented the resident was on hospice. On 04/03/24 at 2:12 p.m., the corporate nurse consultant #1 stated the contraindication should have been dated 09/27/23 on the MDS. 45913 2. Res #4 had diagnoses which included osteoporsis. Progress notes dated 02/06/24 at 1:09 a.m., through 02/07/24 at 10:00 a.m., documented Res #4 fell in their bathroom and sustained a left hand fracture. The discharge resident assessment, dated 02/25/24, documented in error Res #4 had a fall with injury. Fall with major injur should have been documented. On 04/04/24 at 4:07 p.m., the MDS Coordinator reported they did not think a fractured finger/hand would be considered a major injury especially because no treatment was required. The MDS Coordinator reported they thought a major injury would be considered a hip fracture or another major bone. The MDS Coordinator reported not being sure what the RAI manual documented regarding falls with major injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER: Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 Sherrard Drive Colbert, OK 74733	

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on record review and interview, the facility failed to notify OHCA of a new diagnoses of serious mental illness for one (#7) of one sampled resident whose PASRR I was reviewed. The DON identified 42 residents who resided in the facility. Findings: Res #7 was admitted to the facility on [DATE] and had diagnoses which included Schizoaffective disorder and major depressive disorder. On 11/07/22 A PASRR I was completed. The PASRR I did not document the resident had a serious mental illness. On 12/30/22, the resident received a new diagnosis of Bipolar disorder, unspecified. OHCA was not contacted regarding the new diagnoses. On 04/04/24 at 8:45 a.m., corporate nurse #1 confirmed OHCA was not called when the resident got a new diagnoses in December of 22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Sherrard Drive Colbert, OK 74733	

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on record review and interview, the facility failed to complete a PASRR I for a newly admitted resident who remained in the facility for one (#7) of one sampled resident whose PASRR I was reviewed. The DON identified 42 residents who resided in the facility. Findings: Res #7 had was admitted to the facility on [DATE] and had the diagnoses of Schizoaffective disorder. A PASRR I was not located as completed on admission. On 02/14/22 the resident received the diagnosis of major depressive disorder, recurrent, moderate. On 11/07/22 A PASRR I was completed. The PASRR I did not document the resident had a serious mental illness. On 12/30/22, the resident received a new diagnosis of Bipolar disorder, unspecified. On 04/04/24 at 8:47 a.m., corporate nurse #1 stated the PASRR I was completed late they were not able to fine a PASRR I on admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375469	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Pointe Living Center	101 Sherrard Drive Colbert, OK 74733

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 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38495

Based on observation, record review, and interview the facility failed to develop a comprehensive care plan related to nutrition and elopement for two (#22 and #50) of 12 residents reviewed for care plans.

The DON identified 42 residents who resided in the facility.

Findings:

1. Res #22 had diagnoses which included muscle wasting and atrophy, hypokalemia, and vitamin deficiency.

An admission assessment dated [DATE], documented the resident was intact with cognition and had frequent pain. The assessment documented the resident weight was 241 pounds.

The CAA area of the MDS triggered to care plan nutritional status.

A quarterly assessment, dated 03/11/24 documented the resident was intact with cognition and documented the resident's weight was 205 pounds and was not on a physician prescribed weight loss program.

On 04/01/24 at 12:53 p.m., the resident was observed in the recliner in their room. The noon meal had been served and he was not eating it. The resident stated they eat breakfast then they start having stomach pain. The resident stated they do not want to eat lunch they would just want to sleep. Res #22 stated they were not hungry at all and had lost about 30 pounds. The resident stated they really did not have an issue with the weight loss.

On 04/04/24 at 2:21 p.m., the MDS coordinator stated the the resident did not have a nutrition care plan.

45913

2. Res #50 had diagnoses which included dementia and mood disorder.

The Elopement policy, undated, read in part, .Upon admission, quarterly and with significant change in status, the nurse will complete an Elopement Screen. Those residents at risk for elopement will have an Elopement Risk Alert completed .

An LTC - Admission Assessment/Observation Documentation, dated 11/01/23, documented Res #50 was an elopement risk.

A progress note, dated 11/28/23 at 2:35 a.m. documented the resident eloped from the facility through a torn window screen.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375469	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Pointe Living Center	101 Sherrard Drive Colbert, OK 74733

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 11/28/23 at 1:57 p.m., documented the resident was located at 5:45 a.m. and would be transferred to a geri-psych facilty. A progress note, dated 12/18/23, documented the resident returned to the facility from geri-psych. Res #50's comprehensive care plan did not include an elopement risk care plan at the time the admission assessment documented Res #50 was an elopement risk. On 04/04/24 at 4:15 p.m., RN #2 reported they did not initiate an elopement risk care plan until the resident returned from the geri-psych facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER: Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 Sherrard Drive Colbert, OK 74733	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38495 Based on record review and interview, the facility failed to follow physician orders for three (#1,#22, and #34) of 12 resident reviewed for following physician orders. The DON identified 42 residents who resided in the facility. Findings: 1. Res #22 had diagnoses which included muscle wasting and atrophy, hypokalemia, and vitamin deficiency. A quarterly assessment, dated 03/11/24 documented the resident was intact with cognition. The assessment documented the resident's weight was 205 pounds and was not on a physician prescribed weight loss program. Physician orders, dated 12/09/24, documented to document the amount consumed by the resident for breakfast, lunch, dinner and the amount of fluids consumed with the meals. The meal % documentation was not completed for all meals daily. The documentation was observed for the month of March and to April 4th. On 03/07/23, 03/09/24, 03/14/24, and 03/23/24 there was no meal % documented. On 04/04/24 at 1:30 p.m., The DON stated the meal % were just not being charted as ordered. 45913 2. Res #1 had diagnoses which included diabetes A physician's order, dated 08/22/23, read in part, Novolog U-100 Insulin .per Sliding Scale; If Blood Sugar is less than 70, call MD. If Blood Sugar is 70 to 179, give 0 Units. If Blood Sugar is 180 to 200, give 2 Units. If Blood Sugar is 201 to 230, give 3 Units. If Blood Sugar is 231 to 260, give 4 Units. If Blood Sugar is 261 to 290, give 5 Units. If Blood Sugar is 291 to 300, give 6 Units. If Blood Sugar is 301 to 350, give 7 Units. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Sherrard Drive Colbert, OK 74733	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If Blood Sugar is greater than 350, give 8 Units. If Blood Sugar is greater than 350, call MD. subcutaneous Twice A Day . The Diabetic Flowsheet for March 2024 documented the following: On 03/03/24 at 4:30 p.m., Res #1's blood sugar was 362. There was no documentation the physician was notified of the out of parameter blood sugar. On 03/04/24 at 4:30 p.m., Res #1's blood sugar was 439. There was no documentation the physician was notified of the out of parameter blood sugar. On 03/05/24 at 4:30 p.m., Res #1's blood sugar was 401. There was no documentation the physician was notified of the out of parameter blood sugar. The Diabetic Flowsheet for February 2024 documented the following: On 02/10/24 at 4:30 p.m., Res #1's blood sugar was 358. There was no documentation the physician was notified of the out of parameter blood sugar. On 02/21/24 at 4:30 p.m., Res #1's blood sugar was 369. There was no documentation the physician was notified of the out of parameter blood sugar. 3. Res #34 had diagnoses which included diabetes. A physician's order, dated 03/13/24, read in part, Insulin aspart U-100 insulin pen; 100 unit/mL .per Sliding Scale: If Blood Sugar is less than 70, call MD. If Blood Sugar is 180 to 200, give 4 Units. If Blood Sugar is 201 to 230, give 5 Units. If Blood Sugar is 231 to 260, give 6 Units. If Blood Sugar is 261 to 290, give 9 Units. If Blood Sugar is 291 to 320, give 12 Units. If Blood Sugar is 321 to 350, give 15 Units. If Blood Sugar is greater than 350, give 18 Units. subcutaneous Before Meals and At Bedtime . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER: Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 Sherrard Drive Colbert, OK 74733	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Diabetic Flowsheet, for March 2024, documented the following: On 03/25/24 at 11:00 a.m. Res #34's blood sugar was 356. There was no documentation the physician was notified of the out of parameter blood sugar. On 03/30/24 at 11:00 a.m., Res #34's blood sugar was 354. There was no documentation the physician was notified of the out of parameter blood sugar On 03/18/24 at 8:00 p.m., Res #34's blood sugar was 356. There was no the physician was notified of the out of parameter blood sugar. On 04/04/24 at 12:45 p.m., the DON reported the nurses should document either on the back of the Diabetic Flowsheet or in the progress notes when they notify a physician of an out of parameter blood sugar. The DON reported the nurses didn't call the physician but should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER: Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 Sherrard Drive Colbert, OK 74733	

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45913 Based on record review and interview, the facility failed to ensure a resident at risk for elopement was properly assessed and monitored to prevent elopement from the facility for one (#50) of two residents reviewed for elopement risk. Findings: The Elopement policy, undated, read in part, .Upon admission, quarterly and with significant change in status, the nurse will completed an Elopement Screen. Those residents will have an Elopement Risk Alert completed . Res #50 had diagnoses which included dementia and mood disorder. An LTC - Admission Assessment/Observation Documentation, dated 11/01/23, documented Res #50 was an elopement risk. A progress note, dated 11/28/23 at 2:35 a.m., documented the resident eloped from the facility through a torn window screen. A progress note, dated 11/28/23 at 1:57 p.m., documented the resident was located at 5:45 a.m. and would be transferred to a geri-psych facility. A progress note, dated 12/18/23, documented the resident returned to the facility from geri-psych. Res #50's comprehensive care plan did not include an elopement risk care plan at the time the admission assessment documented Res #50 was an elopement risk. On 04/04/24 at 4:15 p.m., RN #2 reported they did not initiate an elopement risk care plan until the resident had returned from geri-psych. RN #2 reported they did complete an elopement risk alert but wasn't sure if it was before or after Res #50's elopement. RN #2 reported a wander guard was placed on the resident but could not recall if placement was done before or after Res #50's elopement. RN #2 was unable to provide any documentation regarding Res #50's wander guard. RN #2 reported an elopement risk assessment has not be completed on Res #50 since their return from geri-psych. RN#2 reported they would be working on completing elopement risk assessments as per their policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER: Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 Sherrard Drive, Colbert, OK 74733	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 38495 Based on observation, record review and interview the facility failed to conduct pain assessments for two (#10 and #24) of two resident reviewed for pain. The DON identified 42 residents who resided in the facility. Findings: The Pain - Clinical Protocol policy, last revised October 2010, read in part, .2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is an onset of new or worsening of existing pain. 3. The staff will staff and physician will identify the nature (characteristics such as location, intensity, frequency, pattern, etc.) and severity of pain. 1. Res #10 had diagnoses which included pain. An annual assessment, dated 01/17/24, documented the resident was moderately impaired with cognition and was independent with most ADLs. The assessment documented the resident had occasionaly pain that affected sleep and interfered with activities. The assessment documented the resident received PRN pain medication. The resident did not have any pain assessments in the EHR. The residents care plan, last revised 01/29/24, documented the resident complained of pain prn with muscle spasms. The care plan documented to monitor and record any complaints of pain, location, frequency effect on function, intensity, alleviating factors, aggravating factors. On 04/01/24 at 12:45 p.m., Res #10 was observed in the dining room rubbing their right knee. Res #10 reported they were having pain in their knee. The resident stated, I heard and felt something pop in my knee and ever since it has been hurting. Reported topical pain medication helped with pain. Received as needed oral pain medication and reports it helps but that her knee was not getting better. Resident reported they had told staff and denied receiving an X-Ray or any evaluation of pain. On 04/01/24 at 1:00 p.m., Res #10 was observed to sit down in recliner in the television room. The resident cried out in pain, grabbed right knee and was rubbing it and stated, Something sure is wrong with my knee! Reported she has been hurting for several days like this. 04/01/24 at 1:10 p.m., Res #10 was observed in the lobby getting up from a seated position. Res #10 was grimacing in pain during observation. On 04/04/24 at 11:07 a.m., the DON stated they just started a new system this month and they would perform a pain assessment quarterly to co inside with the MDS. On 04/04/24 at 10:35 a.m., the DON and MDS coordinator could not provide a pain assessment that wasn't the MDS. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Sherrard Drive Colbert, OK 74733	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45913 2. Res #24 had diagnoses which included chronic pain, peripheral autonomic neuropathy, and peripheral vascular disease Res #24's moderate chronic pain care plan, dated 07/12/21, read in part, .Assess characteristics of pain; location, duration, aggravating/alleviating factors, radiation and intensity . There were no pain assessments in Res #24's clinical record. 04/01/24 at 1:15 p.m. Res #24 reported they had pain not relieved by their current medication regime. Res #24 reported they received their pain medication every six hours and have requested their pain medication be given more frequently, at least every three to four hours. Res #24 reported they have asked the charge nurses and the physician to get their pain medication more often, but the administration times have not changed. Res #24 reports break through pain between 6:00 p.m. and midnight and midnight and 6:00 a.m. Res #24 reported they could not get relief from their pain around the clock. Res #24 reported their pain was related to an old right foot fracture and neuropathy. On 04/04/24 at 2:35 p.m., the DON and MDS Coordinator reported they were unaware Res #24 was having pain not relieved by their current medication regime. They reported the DON just started doing pain assessments in March. The DON and MDS reported the MDS was a form of a pain assessment, but acknowledged it did not include the components required by their policy and care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER: Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 Sherrard Drive Colbert, OK 74733	

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38495 Based on record review and interview the facility failed to complete a MRR in the required time frame for one (#7) of five residents reviewed for unnecessary medications. The DON identified 42 residents who resided in the facility. Findings: An undated facility policy Medication Monitoring Medication Regimen Review and Reporting, read in part . The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon within 30 calendar days . Res #7 had diagnoses which included bipolar disorder, major depressive disorder, and schizoaffective disorder. A MRR, dated 02/21/24, documented lorazepam 1 mg every six hours PRN anxiety or lorazepam 2 mg/ml 0. 25 ml (0. 5mg) every two hours PRN anxiety/restlessness. The MRR documented are both of the above orders needed at this time or could one be stopped. The physician documented to discontinue the lorazepam 2 mg/ml every two hours PRN anxiety/restlessness. The MRR was dated 04/02/24. The GDR request was not completed in the 30 time frame in the facilities MRR policy. A significant change assessment, dated 03/06/24, documented the resident was severly impaired with cognition and had inattention and altered level of consciousness that comes and goes. the assessment documented the resident received an antipsychotic, antianxiety, antidepressant , and a hypnotic during the look back period. On 04/03/24 at 10:28 a.m., the DON stated the physician did not respond to the 02/21/24 MRR request with in the 30 day time frame.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Sherrard Drive Colbert, OK 74733	

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. 38495 Based on record review and interview the facility failed to ensure residents did not receive psychotropic medication, unless for a specific diagnoses condition for one (#7) of five residents reviewed for unnecessary medication. The DON identified 42 residents who resided in the facility. Findings: Res #7 had diagnoses which included bipolar disorder, major depressive disorder, and schizoaffective disorder. A significant change assessment, dated 03/06/24, documented the resident was severly impaired with cognition and had inattention and altered level of consciousness that comes and goes. the assessment documented the resident received an antipsychotic, antianxiety, antidepressant , and a hypnotic during the look back period. A physician order, dated 05/03/23, documented risperidone 0. 5 mg daily for major depressive disorder. A physician order, dated 05/03/23, documented Vraylar 1.5 mg administer daily for major depressive disorder. A physician order, dated 05/19/23, documented clonazepam administer 0.5 mg TID for schizoaffective disorder. A physician order, dated 02/21/24, documented lorazepam administer 1 mg every six hours PRN for bipolar disorder. On 04/03/24 at 10:28 a.m., the DON stated the diagnoses for the antipsychotic medications needed to be changed. On 04/03/24 at 12:53 p.m., the pharmacist stated the diagnoses for the antipsychotic medications needed to be clarified.

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Sherrard Drive Colbert, OK 74733	

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 38495 Based on observation, record review, and interview, the facility failed to ensure menus were followed for one meal service for the puree meals. The DM identified three residents who eat a puree diet. Findings: On 04/03/24 11:18 a.m., the DM started the puree with cherry cobbler. At 11:27 a.m. the cabbage was pureed, at 12:04 pm., the sausage was pureed, and at 12:11 p.m. the potatoes were pureed. Corn bread for the puree meal was not observed. The menu for 04/03/24 was Kielbasa, fried potatoes, cabbage, cornbread, and fruit cobbler. The puree menu documented the residents were to receive a #10 scoop of cornbread. On 04/03/24 at 1:04 p.m., the DM stated the residents who have the pureed meals should have also received cornbread with their meal. The DM stated they were nervous and missed the corn bread.