

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Epworth Villa Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 14901 North Penn Avenue Oklahoma City, OK 73134	

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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>48344</p> <p>Based on observation, record review, and interview, the facility failed to obtain an informed consent prior to the installation of bed rails for one (#39) of one sampled resident reviewed for bed rails.</p> <p>The DON identified 14 residents had bed rails in the facility.</p> <p>Findings:</p> <p>Resident #39 had diagnoses which included unspecified osteoarthritis and pain in unspecified joint.</p> <p>On 09/30/24 at 1:46 p.m., Resident #39's bed was observed with a bed rail on each side of the head of the bed. Resident #39 stated they used the rails to assist in positioning and getting out of bed.</p> <p>There was no documentation an informed consent for the use of the bed rails was obtained.</p> <p>On 10/02/24 at 1:08 p.m., the DON stated there was no consent for the use of the assistive bar.</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 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389</p> <p>Based on observation and interview, the facility failed to ensure snacks were offered to all residents in the facility for one of one snack observation.</p> <p>The DON identified 65 residents received meal services from the kitchen.</p> <p>Findings:</p> <p>An undated Frequency of Meals & Snacks policy, read in part, Evening snacks will be offered routinely to all residents.</p> <p>1. On 10/01/24 at 2:14 p.m., the resident council group stated they had to ask for snacks to get them. They stated staff did not pass snacks at bedtime.</p> <p>On 10/02/24 at 6:02 p.m., a tour of household three was completed. There were apples, oranges, and eight bananas on the kitchenette counter. One resident was observed in the common area.</p> <p>On 10/02/24 at 6:06 p.m., a tour of household four was completed. There were apples, oranges, eight bananas, two cookies, and two fruit bars on the kitchenette counter. One resident was observed in the common area by the nurse's station.</p> <p>On 10/02/24 at 7:17 p.m., CNA #6 was observed cleaning dining tables and the kitchenette.</p> <p>On 10/02/24 at 7:29 p.m., CMA #4 informed CNA #6 a resident in room [ROOM NUMBER] wanted a PBJ sandwich and milk.</p> <p>On 10/02/24 at 7:44 p.m., CNA #7 warmed a resident's food and took it to them along with a drink.</p> <p>On 10/02/24 at 7:45 p.m., CNA #6 made the PBJ sandwich and took it to the resident in room [ROOM NUMBER]. They stayed in the room to assist the resident with feeding.</p> <p>Staff were not observed going room to room offering snacks to all residents in households three and four.</p> <p>On 10/02/24 at 8:13 p.m., CNA #5 stated CNAs were responsible for passing out snacks to residents.</p> <p>On 10/02/24 at 8:14 p.m., CNA #5 stated they did not pass snacks to any residents in household three.</p> <p>On 10/02/24 at 8:43 p.m., CNA #6 stated they only gave a snack to the resident in room [ROOM NUMBER].</p> <p>On 10/02/24 at 8:50 p.m., CNA #7 stated they offered snacks to two residents in household four.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 10/02/24 at 5:53 p.m., household one was observed for the passing of snacks. There was a large bowl of bananas and other fruit observed on the counter of the dining room kitchenette. There was also a brown tray with cookies, pastry desserts, and a pudding cup observed on the counter.</p> <p>On 10/02/24 at 5:59 p.m., CNA #11 was observed picking up dinner meal trays from resident rooms.</p> <p>On 10/02/24 from 6:08 p.m. through 6:43 p.m., there were no observations of snacks being passed on household one.</p> <p>On 10/02/24 at 6:44 p.m., CNA #12 was observed passing out meal tickets to residents for the 10/03/24 breakfast.</p> <p>On 10/02/24 from 6:58 p.m. through 7:12 p.m., CNA #1 was observed offering ice/water to residents in rooms 1807, 1809, 1811, 1813, 1816, 1818, 1820, and 1822 . No snacks were observed being offered to the residents. Household one continued to be observed for the passing of snacks through 8:01 p.m. There were no snacks observed being offered/passed to residents on household one.</p> <p>On 10/02/24 at 8:04 p.m., there were no residents observed in the halls or common areas on household one.</p> <p>On 10/02/24 at 8:14 p.m., CNA #1 was asked the process of offering a snack to residents at bedtime. They stated if a resident asked for a snack at night they would ask the nurse. If the nurse stated they could have one, they would give the resident a snack. They stated they believed the residents received food at 5:00 p.m. , and the facility had snacks (they pointed to the snacks on the counter at the kitchenette) and stated the residents could get a snack there as long as they were allowed to have snacks. CNA #1 stated at night, they were already asleep. They stated they checked on residents to see if they needed a shower and if they needed something.</p> <p>On 10/02/24 at 8:27 p.m., CNA #5 exited room [ROOM NUMBER] and walked toward the dining room kitchenette on household three, obtained a cup, then walked onto household four.</p> <p>On 10/02/24 at 8:29 p.m., there were no observations of snacks being offered/passed to residents on household three. There was a bowl containing oranges, apples, and bananas observed on the counter in the kitchenette. There were no residents observed out of their room.</p> <p>On 10/02/24 at 8:30 p.m., CNA #5 returned to household three and carried a glass of clear liquid into room [ROOM NUMBER].</p> <p>On 10/02/24 at 8:36 p.m., CNA #5 exited room [ROOM NUMBER], took a bag of items into the door labeled exit, then entered room [ROOM NUMBER], and asked if they could change the resident. CNA #5 did not offer the resident a snack. Continued observations were made of household three through 8:45 p.m. There were no observations of staff offering/passing snacks to the residents on the unit.</p> <p>3. On 10/02/24 at 6:04 p.m., household two was observed for passing snacks. A large bowl of bananas, oranges, and apples were observed on the counter in the dining room kitchenette.</p> <p>On 10/02/24 at 6:54 p.m., CNA #4 was observed offering ice/water to the resident in room [ROOM NUMBER]. There were no snacks observed being offered/passed to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/02/24 from 7:49 p.m. through 8:10 p.m., CNA #3 was observed offering water/ice to residents in rooms 1830, 1831, 1833, 1834, 1835, and 1839. There were no snacks observed being offered to the residents.</p> <p>On 10/02/24 at 8:11 p.m., CNA #3 stated snacks were passed at the beginning of their shift when ice/water was passed.</p> <p>On 10/02/24 at 8:22 p.m., CMA #2 stated snacks were offered when ice was being offered.</p> <p>46216</p> <p>48344</p>		