

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Anadarko Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 300 West Washington Anadarko, OK 73005	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>A past noncompliance Immediate Jeopardy (IJ) was determined to exist effective 11/13/24 related to the facility's failure to ensure a resident was free from accident hazards. The facility failed to safely secure Resident #1 in their wheelchair during transport which resulted in serious injury/harm.</p> <p>On 11/18/24 at 2:48 p.m., the Oklahoma State Department of Health verified the existence of the past noncompliance related to the facility's failure to safely secure a resident in a wheelchair during transport.</p> <p>The past noncompliance IJ was removed effective 11/14/24 after the facility put measures in place to prevent recurrence. On 11/14/24 the facility maintenance supervisor inspected the facility transport van to ensure all safety straps and harnesses were in working order and implemented monthly inspections to ensure proper working order, all drivers were inserviced on proper uses and placement of safety straps in the facility transport van and they will be inserviced quarterly, a QAPI improvement plan was initiated, and CNA #1 was suspended on 11/13/24 and then terminated on 11/14/24.</p> <p>On 11/18/24 at 11:55 a.m., the facility's transport van was inspected. All harnesses and safety straps were observed to be in good repair with no issues.</p> <p>An IJ was identified from 11/13/24 through 11/14/24.</p> <p>Based on observation, record review, and interview, the facility failed to safely secure a resident in a wheelchair during transport for one (#1) of three sampled residents reviewed for safe transportation.</p> <p>Findings:</p> <p>An undated facility policy/job description titled Transportation Aide, read in part, Has completed a facility orientation on functioning facility transport vehicle and proper placement of straps for resident transport. The policy also read, At any point that it is discovered that any safety mechanism is not functioning properly that the maintenance/ administrator be notified immediately and transportation will be suspended until repairs are made.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease, hypertensive heart disease, and dependence on renal dialysis.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1's admission assessment, dated 10/15/24, documented Resident #1 was not cognitively impaired, ambulated with the assist of a wheelchair and required extensive assistance with ADLs.</p> <p>A facility Incident/Accident Report, dated 11/13/24 at 3:40 p.m., read in part, Reported to me by [CNA#1] that resident fell out of wheel chair in van during transport. Knot to back of head and upper back pain noted. Resident sent to ER.</p> <p>A Nurse's Note, dated 11/13/24 at 4:40 p.m., read in part, [CNA#1] transport called this nurse and stated that [they] had left the hospital with resident and was turning the corner when resident fell out of wheel chair. The document also read, [they] stated [Resident #1] had a knot on [their] head and c/o of upper back pain. The document also read, [name withheld] explained that [they] couldn't latch [them].</p> <p>An Investigative Witness Statement, dated and signed by CNA #1 on 11/13/24, read in part, I didn't have the residents wheelchair secured, the back of the wheel chair was locked and [their] tires. I didn't lock the front because I thought I did lock them. When I went to step on the gas [they] went flying backwards and [they] hit the metal ramp.</p> <p>An intital Incident Report Form, dated 11/13/24 at 9:59 p.m., documented Resident #1 was being transported back to the facility from the hospital when the driver turned a corner, the resident fell out of their wheelchair. It documented the resident was transported to the ER then transported to [name of hospital withheld] for further evaluation.</p> <p>Resident #1's Emergency Department Note, dated 11/13/24 at 4:39 p.m., read in part, was in a transport van that apparently accelerated too quickly when [their] wheel chair tipped over backwards c/o head neck and upper spine pain. The note also read, there is a nondisplaced vertical linear fracture through the mid C6 vertebrae. The note documented Resident #1 was placed in a neck brace, given Tylenol and morphine for pain, and transferred to an acute care hospital.</p> <p>Resident #1's After Visit Summary, dated 11/13/24, documented Resident #1 was diagnosed with a closed nondisplaced fracture of the sixth cervical vertebrae and a closed head injury from a ground level fall.</p> <p>On 11/18/24 at 3:30 p.m., Resident #1 stated CNA #1 did not buckle their wheelchair in the front in the transport van correctly. They stated when CNA #1 accelerated from the traffic light they fell backwards hitting their head and neck on the ramp in the transport van. Resident #1 stated their family was called and told CNA #1 to take them to the ER. Resident #1 was observed wearing a cervical neck collar and stated they had pain in their neck and shoulders as a result of the accident.</p> <p>On 11/18/24 at 4:25 p.m., the ADON stated CNA #1 reported to the hospital they did not secure the resident in the van, but then they changed their story. The ADON stated CNA #1 reported a passerby and unidentified police helped sit the resident back into the chair and CNA #1 contacted the family which directed them to take the resident to the ER.</p> <p>On 11/18/24 at 4:30 pm., the administrator stated CNA #1 changed their story frequently. They stated the CNA admitted to not securing the residents wheelchair in the transport van correctly and should not have picked up the resident after the incident. The administrator stated CNA #1 was suspended immediately then terminated for the incident.</p>		