Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375477	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anadarko Nursing & Rehab	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41873 Based on record review and interview, the facility failed to ensure a resident's power of attorney was notified of doctor appointments for one (#28) of two sampled residents reviewed for notifications. The administrator identified 79 residents resided in the facility. Findings: Resident #28 had diagnoses which included cardiac arrhythmia and hypertension. A comprehensive assessment, dated 08/27/24, documented Resident #28 had moderately impaired cognition. A progress note, dated 10/23/24, documented the resident was out of the facility for a doctor's appointment via the transport team. The progress note documented at 1:10 p.m., the resident returned to the facility and a follow up appointment had been made for December 5th at 8:30 a.m. The note documented social services was made aware. On 11/07/24 at 9:58 a.m., Resident #28's POA reported they were still having an issue with not being notified of all the resident's scheduled doctors appointments. On 11/12/24 at 12:22 p.m., Social Services reported residents family members were notified of their doctors appointments when the facility scheduled the appointments. Social Services reported Resident #28's POA was aware of scheduled doctor appointments. The social services staff reported notifications to the resident's POA had not been documented. On 11/12/24 at 12:30 p.m., LPN #1 reported residents family members were to be notified of doctors appointments, new orders, and changes in condition. The LPN reported Resident #28's POA was made aware of changes and doctors appointments. The LPN reported the POA was probably contacted on 10/23/24 with notification of a doctor's appointment scheduled for 12/05/24, but the LPN had failed to document the notification.

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34333 Based on record review and interview, the facility failed to ensure a resident was free from sexual abuse for one (#47) of five residents sampled for abuse. The administrator reported two allegations of sexual abuse. An Abuse Policy and Procedure policy, dated 07/23/21, read in part, We will endeavor to protect our occupants from maltreatment, which means adult abuse, exploitation, neglect, physical abuse, sexual abuse, neglect .Sexual abuse includes sexual harassment, sexual coercion, or sexual assault. Resident #47 was admitted to the facility on [DATE] and had diagnoses which included schizophrenia, bipolar disorder, depression, rheumatoid arthritis, lupus, anxiety, and history of traumatic brain injury. An annual assessment for Resident #47, dated 08/13/24, documented the resident was cognitively intact. An OSDH incident report form, dated 11/01/24, documented Resident #47 reported to a dietary employee CNA #1 came to their room at approximately midnight on 11/01/24 during the 6:00 p.m. to 6:00 a.m. shift. The incident report documented the CNA exposed their genitals to the resident and made sexually explicit comments to the resident while requesting sexual favors. The report documented the CNA was immediately suspended and an investigation was conducted. A care plan for Resident #47, updated 11/04/24, documented the resident had behaviors which included attention seeking. The care plan documented the resident often fabricated stories against others. The care plan documented two staff members would provide care at all times and no employee would assist the resident without a female employee present. On 11/06/24 at 1:22 p.m., the administrator reported an allegation of sexual abuse involving Resident #47 and CNA #1 had been substantiated. The administrator reported the facility would be submitting their 5-day final report to the SA in the next day or two. The administrator reported they had interviewed other residents and staff members to ensure there were no other allegations against CNA #1. On 11/06/24 at 2:24 p.m., Resident #47 was interviewed in their room. The resident spoke freely about the incident and stated nothing like this had ever happened before. The resident reported CNA #1 had worked at the facility off and on for a couple of years and had never done anything to make the resident uncomfortable. The resident stated they felt safe and was not fearful of anything happening again and had no fear of being abused in any way. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/08/24 at 1:14 p.m., LPN #2 reported there had been recent staff in-services following the incident with Resident #47 and CNA #1. The LPN reported staff had been informed no male staff member should go into a female residents' room without a female staff member being present. The LPN reported they were attempting to have male CNAs care for male residents and female CNAs care for female residents. On 11/08/24 at 1:34 p.m., LPN #3 reported Resident #47's care plan had been updated to reflect changes in how care would be provided for this resident. The LPN reported they had implemented a two-person assist with all of Resident #47's care. On 11/12/24 at 11:26 a.m., the administrator reported Resident #47 initially reported the incident with CNA #1 to dietary aide #1. The administrator stated the resident waited until the dietary aide came on duty the following day to say anything. The administrator reported they were not sure why the resident reported the incident to the dietary aide and the dietary aide was not available for interview with the SA. The administrator reported CNA #1 was suspended as soon as the incident was reported and ultimately terminated.

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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** 41873 Based on record review and interview, the facility failed to refer residents with newly diagnosed mental illnesses to the OHCA and or LOCEU for a level II PASARR evaluation for one (#28) of three sampled residents reviewed for PASARR. The administrator identified 79 residents resided in the facility. Findings: A PASARR policy and procedure, dated 09/01/17, read in part, a new condition of intellectual disability or mental illness must be referred to the LOCEU by the nursing facility for determination of the need for the Level II assessment. Resident #28 was admitted to the facility on [DATE]. The resident was diagnosed with anxiety disorder on 06/27/17 and schizoaffective disorder on 08/04/21. A comprehensive assessment, dated 08/27/24, documented moderately impaired cognition. The assessment also documented the use of antianxiety medication. The level I PASARR screen completed on admission was unavailable in the resident's medical record. The Order Summary report, dated 11/07/24, documented the following medication: divalproex sodium (anticonvulsant medication) 125 mg for schizoaffective disorder and hydroxyzine pamoate (antihistamine medication) 25 mg for anxiety. On 11/12/24 at 10:41 a.m., the ADON reported not being able to locate the resident's PASARR completed on admission. The ADON reported being unaware if the anxiety disorder diagnosis given to the resident had been reported to the OHCA. The ADON reported the diagnosis of schizoaffective disorder was not reported to the OHCA. The ADON reported they had recently been made aware a new diagnosis of mental illness, not on the level I PASARR, needed to be reported to the OHCA.

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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** 41873 Based on record review and interview, the facility failed to ensure a level I PASARR assessment was completed before or on admission for one (#9) of three sampled residents reviewed for PASARR. The administrator reported 79 residents resided in the facility. Findings: A PASARR policy and procedure, dated 09/01/17, read in part, the nursing facility must independently evaluate the Level I PASARR screen regardless of who completes the form and determine whether or not to admit an individual to the facility .nursing facilities which inappropriately admit a person without a PASARR screen are subject to recoupment of funds. Resident #9 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder and mood disorder. A comprehensive assessment, dated 10/08/24, documented the resident's cognition was intact. The assessment also documented antipsychotic and antidepressant medication use. An Order Summary report, dated 11/07/24, documented the following medication: donepezil hcl (cholinesterase medication) 5 mg for mood disorder, lamotrigine (phenyltriazine medication) 25 mg for mood disorder, riluzole (benzothiazole medication) 50 mg major depressive disorder, risperidone (antipsychotic medication) 1 mg for mood disorder, sertraline (antidepressant medication) hcl for major depressive disorder, and Vraylar (antipsychotic medication) 3 mg for mood disorder. On 11/07/24 at 3:43 p.m., the ADON reported a level I PASARR was not completed for Resident #9. They reported it was missed.