STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375478	A. Building B. Wing	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summers Healthcare, LLC	119 North 6th Street Okeene, OK 73763

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 45462 Based on record review and interview, the facility failed to develop and implement interventions for reducing or discontinuing the use of bed rails and provide ongoing monitoring and evaluation for three (#1, 3, and #4) of three sampled residents with bed rails in use. The administrator identified 19 residents resided in the facility. There were six residents with bed rails in use. 1. Resident #1 had diagnoses that included gastrostomy, tracheostomy, and ventilator dependent. On 01/17/24 at 12:10 p.m., Resident #1 was observed in bed with two upper bed rails raised. 2. Resident #3 had diagnoses that included gastrostomy, tracheostomy, and ventilator dependent. On 01/17/24 at 1:08 p.m., Resident #3 was observed in bed with four bed rails raised. 3. Resident #4 had diagnoses that included gastrostomy and tracheostomy. On 01/17/24 at 12:05 p.m., Resident #4 was observed in bed with two upper bed rails raised. There were no interventions documented on the care plan or implemented for resident #1, #3, nor #4, to reduce or discontinue the use of bed rails. There was no documentation in resident #1, #3, or #4's clinical records showing ongoing monitoring and evaluation of bed rail use was being conducted. On 01/18/24 at 1:10 p.m., the DON was asked if interventions had been put in place to reduce the use or discontinue the use of bed rails for the above-named residents. They stated the residents had been using the bedrails since they have been here. The DON was asked to provide documentation of ongoing monitoring and evaluations for residents with bed rails in use and stated no monitoring or evaluations had been documented.

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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 45462 Based on interview and record review, the facility failed to have a qualified activity director for 19 of 19 residents who resided at the facility. Findings: On 01/18/24 at 1:10 p.m., the DON was asked if the facility had a certified activity director. She stated not at this time, CMA #1 does activities when they are here and comes in on their days off, the rest of the staff pitches in too. The DON was asked if CMA #1 or any other staff were certified activity directors. They stated no. On 01/18/24 at 3:56 p.m., the Administrator reported the last day the facility had a certified activity person was on 07/31/23.

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 On 01/18/24, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide Resident #1 with an environment that was free from accident hazards. A nurses' note, written 01/03/24 at 5:40pm, documented resident was found with left arm caught in bed rail and the bed rail had fallen on it. A nurses' note, written 01/04/24 at 3:28pm, documented the resident was transferred to the ER following xray of left arm. An ER report, dated 01/04/24, documented resident had a closed fracture of the left distal humerus. On 01/17/24 at 12:10pm, the resident was observed in bed with two upper bed rails raised. On 01/18/24 at 1:10pm, the DON acknowledged no physician's orders and no bed rail risk assessment had been completed. There was no documentation that the risk and benefits of using bed rails had been discussed with the resident's representative and no signed consent had been obtained before bed rails were put in use nor upon her return from the hospital. On 01/18/24 at 5:09 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 01/18/24 at 5:15 p.m., the administrator and the DON were notified of the IJ situation. On 01/23/24 at 4:16 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented: 1/18/2024 All residents have the potential to be affected. 1/18/2024 at approximately 1600 all bedrails in the facility were lowered pending Pre-restraining assessment, restraint: side rail utilization assessment, consent from resident/family member for physical restraint and physicians order for the use of bedrails. [Resident #1's] bedrails were lowered, her bed was lowered to the lowest position and pillows were placed to maintain position for her protection. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1/18/2024 at approximately 1800 all residents or their families were educated on the pros and cons of bedrail restraints. Pre-restraining assessments were completed on all residents. Side rail utilization assessments were completed on [five] residents requesting bedrails, which included [Resident #3], [Resident #4], [unnamed resident #1], [unnamed resident #2], [unnamed resident #]. Consents were obtained verbally from [Resident #1's] guardian, [unnamed resident #2's] poa, and [Resident #3] and consent form mailed to them on 1/19/2024. [unnamed resident #1] and [unnamed resident #3] signed their own consents. Physician's orders were obtained for the five residents that requested bedrails be utilized while in bed. Care plans have been updated for [Resident #3], [Resident #4], [unnamed resident #1], [unnamed resident #2], and [unnamed resident #3] to indicate their request for bedrails. The five residents that have requested bedrails will be reassessed quarterly and consents will be updated annually. Residents that have requested some type of bedrail will be visualized for safety and positioning every two hours and as needed while in bed when bedrail is being utilized. All bedrails in the facility that are not being used have been zip tied to prevent use when not authorized by staff and visitors without proper assessments, consents and orders. 1/18/2024 Staff have been educated on the facility policy for restraints: pre-restraining assessment, side rail utilization assessment, consent for side rail and physicians order for side rails. Staff were educated on making sure residents are safe and moved from faulty bed then reporting to maintenance log. Staff were also in-serviced on procedure for reporting faulty bed to maintenance using identifying bed number along with room number and problem that has been identified to maintenance in the maintenance logbook. All beds were reassessed for proper working order. All beds will be assessed monthly for proper working order utilizing a tracking log. The maintenance supervisor or designee will monitor the maintenance log daily or as needed for any beds that are not working properly. The Director of nurses or designee will assess all residents upon admission and quarterly for restraints and consents will be obtained upon admission and annually per facility restraint policy. The QAPI committee will review all new assessments and quarterly assessments monthly and consents for new admissions and annual consents will be reviewed monthly. Care plans will be updated quarterly and on admission. The QAPI committee will review all care plans for residents that have requested bedrails. The Maintenance Supervisor will address any bed or equipment issues quarterly and as needed with the QAPI committee. The Maintenance Supervisor will present bed tracking log to the QAPI committee quarterly or as needed. The immediacy was lifted, effective 01/23/24 at 12 p.m., when all components of the plan of removal had been completed. The deficient practice remained as isolated with the potential for harm to Resident #1. Based on record review, observation, and interview, the facility failed to identify and eliminate a known and foreseeable accident hazard for one (#1) of three sampled residents reviewed for the use of bed rails. The administrator identified 19 residents resided in the facility. Findings: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Restraints (Physical) policy, undated, read in parts, .General Guidelines for Assessments may include . Potential to injure self . Resident #1 had diagnoses that included gastrostomy, tracheostomy, and ventilator dependent. A quarterly MDS, dated [DATE], documented Resident #1 had severely impaired cognition, limited movement with impaired ROM to upper extremities, and was dependent for all ADL's. A nurses' Note, written 01/03/24 at 5:40 p.m., documented resident was found with left arm caught in bedrail and the bedrail had fallen on it. A nurses' note, written 01/04/24 at 3:28 p.m., documented the resident was transferred to the ER following xray of left arm. An ER report, dated 01/04/24, documented resident had a closed fracture of the left distal humerus. On 01/17/24 at 12:10 p.m., the resident was observed in bed with left arm in a sling and two upper bed rails raised. On 01/18/24 at 9:17 a.m., the DON was asked if a bed rail risk assessment had been completed for Resident #1 and if any new interventions had been put in place to prevent further injury when Resident #1 returned from the hospital. The DON stated no.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 45462 Based on record review and interview, the facility failed to a. assess the resident for need and safety of bed rail use, b. discuss the risks and benefits of bed rails and obtain informed consent from the resident or the resident's representative, and c. obtain a physician's order for the use of bed rails for three (#1, 3, and #4) of three sampled residents reviewed for restraints. The administrator identified 19 residents resided in the facility. There were six residents with bed rails in use. Findings: A Restraints (Physical) policy, undated, read in parts, .Procedure .1. Assess resident's need for restraint use . Obtain informed consen .Obtain physician's order .Develop or review resident care plan . 1. Resident #1 had diagnoses that included gastrostomy, tracheostomy, and ventilator dependent. On 01/17/24 at 12:10 p.m., Resident #1 was observed in bed with two upper bed rails raised. 2. Resident #3 had diagnoses that included gastrostomy, tracheostomy, and ventilator dependent. On 01/17/24 at 1:08 p.m., Resident #3 was observed in bed with four bed rails raised. 3. Resident #4 had diagnoses that included gastrostomy and tracheostomy. On 01/17/24 at 12:05 p.m., Resident #4 was observed in bed with two upper bed rails raised. There was no documentation in the clinical records of Resident #1, #3, nor #4 of the reason bed rails were being used, risks or benefits of use, informed consent for use, nor a physician's order for the use of bed rails. On 01/18/24 at 1:10 p.m., the DON was asked the facility policy regarding the use of bed rails. They stated bed rails could only be used with a physician's order and resident or family consent. The DON was asked if there was documentation of the reason bed rails were being used, the risks or benefits of use, an informed consent for use, or a physician's order for the use of the bed rails in the clinical records of Resident #1, #3, or #4. They stated no and acknowledged the facility policy had not been followed.