STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375479	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk City Nursing and Rehabilitation Center	301 North Garrett Elk City, OK 73644

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure:a. proper labeling/dating of stored bread, b. both the large and small ice machines were cleaned and free from debris, andc. hand hygiene was maintained during meal service to prevent cross contamination during kitchen observations. The DON identified 46 residents received food from the kitchen. Findings: A policy titled Receiving and Open Date Policy, undated, read in part, It is the policy of the nursing home to date food products received from delivery trucks upon arrival to facility and upon use. A policy titled Dietary Personnel Hand hygiene Policy, undated, read in part, The goal is to prevent the spread of foodborne illness and ensure the safety of residents, staff, and visitors.Gloves will be worn when handling ready-to-eat foods or other situations where bare hand contact is prohibited or poses a risk of contamination.Staff will be trained on the importance of hand hygiene, proper procedures, and the consequences of non-compliance.After touching any unclean surface or object that could potentially contaminate hands. A policy titled Ice Machine cleaning policy and procedure, undated, read in part, Maintaining a clean and sanitary ice machine in a nursing home is crucial for resident safety and infection control, as ice is considered a food product by the FDA.All ice machines will be cleaned and sanitized regularly according to the manufacturer's policy recommendations and facility policy. Staff responsible for cleaning and maintenance will receive proper training and adhere to safety precautions.Records of cleaning and maintenance activities will be maintained.Daily: Wipe and disinfect external components. Weekly: Thoroughly clean internal surfaces and accessible ice-making components. On 07/29/25 at 11:07 a.m., during the initial kitchen observation with the dietary manager, there were multiple bags of halfway full undated items:a. 2 bags of hamburger buns,b. 2 bags of hot dog buns,c. 1/2 bag of chips,d. 1 and 1/2 loaves of white bread, ande. 1/2 bag of English muffins. On 07/29/25 at 11:13 a.m., the dietary manager stated the policy and procedure was to label when open or when comes in. They stated none of the identified bread was dated. On 07/29/25 at 11:38 a.m., the large ice machine was observed to have brown/black debris on the white plastic piece inside the ice machine. There was no signage of when last cleaned. On 07/29/25 at 11:39 a.m., the dietary manager observed the white plastic piece and stated there was black stuff and was dirty. They stated they were not aware of who was responsible to clean it. On 07/30/25 at 11:02 a.m., observed the small ice machine to have floating gray debris and a dead moth in the water at the bottom of the drip tray. The DM was present and stated that machine was cleaned by dietary on Mondays. The DM stated it did not look cleaned and was partially clogged. There was no cleaning log located near the ice machine. The DM was observed to take a wire to try to unclog. The DM stated maintenance is called to unclog when there is a problem. On 07/30/25 at 11:34 a.m., the meal service started with cook #1 plating from the steam table wearing gloves. The menu was soft shell taco, Spanish rice, and refried beans. On 07/30/25 at 11:48 a.m., cook #1 was observed still wearing the same gloves, open bag of tortillas, remove the tortilla, touch the ladles and plates, all while wearing the same pair of gloves. The Dietary Manager was present during the entire observation of meal service. On 07/30/25 at 11:52 a.m., while meal service continued, the DM stated the policy and procedure was for hand hygiene during meal service from the steam table was to wash hands at start (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and if something was on hands, then to wash hands and start over. The DM was asked if cook #1 touched the tortillas with the gloved hands. The DM stated they should have had tongs to pull the tortillas with. The DM went to get a pair of tongs and handed to cook #1.The DM stated they did not even notice they did not change gloves after touching the tortillas or before touching the ladles again. On 07/30/25 at 12:13 p.m., the maintenance director stated the big ice machine was serviced and thoroughly cleaned 3 weeks ago. They stated they could not tell when it was last cleaned since then. The maintenance director stated they needed a schedule. They further stated the small ice machine was clean and wiped down and they will unclog it when dietary lets them know and was not notified about it yesterday or today until the DM told him about it after was observed by surveyor.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure:a. a nebulizer mouthpiece was stored in a manner that promoted infection control practice for 1 (#3) of 2 sampled residents reviewed for respiratory care, andb. clean linens were stored appropriately for 1 of 1 laundry room observation.The DON identified 47 residents resided in the facility and 16 residents received nebulizer treatments.Findings:1. On 07/29/25 at 11:50 a.m., a nebulizer machine with a mouthpiece was observed on top of Resident #3's drawer. The mouthpiece was set on top of the drawer.An undated facility Use of Hand-Held Nebulizers policy read in part, All staff involved in the administration must follow infection control procedures and adhere to the treatment protocol to prevent cross-contamination and ensure efficacy.An undated facility Linen Storage Policy and Procedure policy read in part, All linen used in the facility must be stored, handled, and distributed in a manner that maintains cleanliness, prevents contamination, and complies with infection control standards.A physician's order, dated 04/09/25, showed ipratropium/albuterol inhalation solution (duoneb) 3 ml one vial. Administer nebulizer four times a day for chronic obstructive pulmonary disease.Resident #3's significant change in status resident assessment, dated 04/16/25, showed the resident had diagnosis which included chronic obstructive pulmonary disease and their cognition was intact with a BIMS of 14.On 07/29/25 at 11:51 a.m., Resident #3 stated they used the nebulizer daily.On 07/30/25 at 12:36 p.m., CMA #1 stated they administer nebulizer treatments. They stated nebulizer mouthpiece should be stored in a bag or resident drawer when not in use.On 07/30/25 at 12:37 p.m., CMA #1 stated Resident #3's nebulizer mouthpiece was not in a bag.On 07/30/25 at 12:41 p.m., the director of nursing stated the nebulizer mouthpiece was to be set on the nebulizer machine. They stated they were putting them in bags but was told putting them in bags lead to harboring bacteria.On 07/30/25 at 12:46 p.m., CMA #1 stated the nebulizer mouthpiece was set on the resident's beside table.2. On 07/31/25 at 2:15 p.m., two grey barrels lined with plastic bags and had lids was observed next to a clean clothing rack with pants by the entrance of the laundry room. The clothing rack next to the rack with pants had two clothing items touching the floor.On 07/31/25 at 2:24 p.m., a short clothing rack was observed with clothes touching the floor in the clean storage area.On 07/31/25 at 2:30 p.m., There were five bags sitting on the floor in the clean storage area.On 07/31/25 at 2:16 p.m., the laundry supervisor stated the clothes on the clothing racks by the entrance were clean.On 07/31/25 at 2:19 p.m., the laundry supervisor stated the barrels were used for collecting dirty linens. They stated they sprayed them with Lysol after use.On 07/31/25 at 2:21 p.m., the laundry supervisor stated the barrels were not 100% clean. They stated the barrels were not stored in manner that prevent cross contamination.On 07/31/25 at 2:25 p.m., the laundry supervisor stated the clothes on the short rack were clean and not stored appropriately.On 07/31/25 at 2:33 p.m., the laundry supervisor stated the bags had pads to be taken to the dog shelter. They stated the water under the bags was due to the condensation from the air conditioning unit.On 07/31/25 at 2:34 p.m., the laundry supervisor stated the bags were not stored appropriately.