STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375485	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hennessey Nursing & Rehab	705 East 3rd Street Hennessey, OK 73742

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 On 04/11/24 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to assess, monitor, and intervene for a resident experiencing a significant change in condition and ensure a resident received prescribed antibiotic therapy to treat pneumonia. 03/08/24 Resident #1 had acute change of condition, very weak, unable to stand/sit, 3-4 person assist to transfer, irregular HR, O2 sats 80%, incontinent B&B, and decline in mental status. MD notified. Not sent to ER. 03/19/24 Resident #1's condition deteriorates and they requested to be sent to ER. Returned from ER same day with DX: pneumonia and orders for Augmentin 875mg-125mg tab- 1 tab oral q12hrs x7days. Their physician was not notified of new order, the medication order was not submitted to the pharmacy, and the medication was not placed on the MAR. There was no documentation that Augmentin was ever ordered, received from the pharmacy, or given to the resident between 03/19/24 and 04/08/24. 03/26/24 Nursing staff documented further decline in residents condition including cannot sit or stand without support, cannot bear weight, requires full body lift, brown urine, poor food/fluid intake, and decreased mental status. 04/08/24 Resident #1 was sent to ER with low B/P, labored breathing, erratic pulse, and altered mental status. Resident was admitted and is currently in the hospital. On 04/11/24 at 10:40 a.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 04/11/24 at 4:15 p.m., the administrator was notified of the IJ situation. On 04/15/24 at 2:38 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented: Plan of Removal On 04/11/2024, All Licensed RN/LPN staff educated on how to recognize acute changes in resident baseline condition\ orientation and\or change in vital signs with documentation of notification to the physician and family. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. All newly hired Licensed RN/LPN staff will be educated on how to recognize change in resident baseline condition\ orientation and\or change in vital signs with documentation of notification to the physician and family. 2. All direct care nursing staff educated on how to recognize acute changes in resident baseline condition/orientation and/or change in vital signs and report to charge nurse immediately. 3. DON/Designee will review all new hire packets to ensure all training is completed. 4. DON/Designee will report any negative findings monthly to the QAPI team. Completed by 8:00 p.m. 04/11/2024. On 04/11/2024, all licensed RN/LPN In-serviced on Facility Policy and Procedure properly assessing, monitoring, and intervening effectively and timely in the event of change in resident condition, and following physician orders for antibiotics/medications as prescribed. 1. All licensed new hires will be educated on Facility Policy and Procedure on properly assessing, monitoring, intervening effectively and timely in the event of change in resident condition, and following physician orders for antibiotics/medications as prescribed. 2. DON/designee will review all new hire packets to ensure all training is completed. 3. DON/designee will report any negative findings quarterly to QAPI Completed by 8 p.m. 04/11/2024. 1. DON/Designee will compare physician orders on all new admissions to MAR and verify all medications are on hand. 2. Any staff that are on leave will be educated prior to being placed on the schedule. 3. DON/ADON in-serviced on reviewing all physicians' orders to include hospital discharges/doctor's appointment daily during clinical meeting to ensure orders are not missed. 4. DON/ADON will review all physicians' orders to include hospital discharges/doctor's appointment daily during clinical meeting to ensure orders are not missed. Any negative findings will be corrected immediately. Completed by 1030 a.m. 04/12/2024. 1. All Licensed nurses educated on comparing new orders/hospital discharge orders with the MAR and updating MAR to reflect any new orders. Completed by 3:00 p.m. 04/15/2024. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediacy was lifted, effective 04/15/24 at 3:30 p.m., when all components of the plan of removal had been completed. The deficient practice remained as isolated with potential for harm to the residents. Based on record review and interview, the facility failed to: a. assess, monitor, and intervene for a resident experiencing a significant change in condition for one (#1) of two sampled residents reviewed for change in condition, and b. ensure a resident received prescribed antibiotic therapy to treat pneumonia for one (#1) of two sampled residents reviewed for receiving medications as ordered. The Administrator identified 31 residents resided in the facility. Findings: a. Resident #1 had diagnoses that included s/p amputation of left toes and PICC line in upper right arm. A 'Skilled Daily Nurses Note', written 03/8/24 at 7:50 p.m., documented Resident #1 experienced episode of being very weak, unable to stand or sit up, unable to follow direction, irregular pulse, and low O2 saturation. MD was notified and advised staff to monitor resident. A 'Skilled Daily Nurses Note', written 03/8/24 at 9:00 p.m., documented Resident #1 required the assistance of three staff to transfer them from bed to wheelchair and the assistance of four staff to transfer them back to bed. 'Skilled Daily Nurses Notes', written 03/9/24 through 03/15/24, document Resident #1's persistent weakness, inability to stand/sit, need for assistance to transfer, incontinence of B&B, and decline in mental status. No MD notification was documented throughout this time period. A 'Skilled Daily Nurses Note', written 03/19/24 at 6:30 p.m., documented Resident #1 was transported to the emergency room per their request. On 04/10/24 at 10:05 a.m., CNA #1 reported, on admission, Resident #1 was able to get out of bed and use the walker with minimal assistance to go to the bathroom. When asked if they had noticed a change in Resident #1's condition, CNA #1 stated, Yes, [they] were a lot weaker. After a while, we had to use a full body lift to get [them] up. [They] were still verbal but not all there. On 04/10/24 at 4:50 p.m., the DON was asked to review the 'Skilled Daily Nurse Notes' for Resident #1 from 03/8/24 through 03/19/24. When asked if Resident #1 had experienced an acute change of condition, the DON stated yes. The DON acknowledged Resident #1 had not been assessed, monitored, nor received necessary interventions according to facility policy, after they experienced a significant change of condition. b. Resident #1 returned to facility from the emergency roiagnom on [DATE]. emergency room diagnoses included pleural effusion with evidence of possible pneumonia. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An 'ED Physician Record' for Resident #1, dated 03/20/24, read in parts, .Impression and Plan .we will plan to treat for possible early pneumonia including use of antibiotics .Augmentin 875 mg-125 mg oral tablet (Prescribe): 1 Tabs, Oral, q12H, for 7 Days . A 'Skilled Daily Nurses Note', written 03/20/24 at 1:30 a.m., documented Resident #1 had returned from the emergency room with no new orders. There was no documentation in Resident #1's clinical record their physician was notified of the ER diagnoses nor the order for Augmentin stated in the 'ED Physician Record'. Resident #1's March 2024 and April 2024 MAR's did not include documentation that Augmentin had been given to the resident between 03/19/24 and 04/08/24. On 04/10/24 at 4:45 p.m., the DON was asked to review the above records. After reviewing the records, the DON acknowledged Resident #1 had not received the prescribed antibiotic therapy to treat pneumonia.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45462 Based on record review and interview, the facility failed to accurately assess residents' risk for and initiate dietary measures to aide in the prevention of avoidable pressure ulcers for one (#1) of two sampled residents reviewed for pressure ulcers. The Administrator identified 31 residents resided in the facility. Findings: Resident #1 had diagnoses that included s/p amputation of left toes and PICC line in upper right arm. Resident #1's Care Plan documents, on 03/15/24, resident was at risk of nutritional decline and had lost 12 lbs. in a month. The RD completed a 'Nutrition Risk Assessment' for Resident #1, dated 03/18/24, with a risk score of NO/LOW RISK, and no interventions for prevention of pressure ulcers were put into place. Discrepancies in the RD assessment included: 1. RD documented no weight loss/gain- weight record documented a weight loss of <5% since admission. Resident #1's documented weights include 176 lbs. on 02/28/24, 172 lbs. on 03/11/24, 168 lbs. on 03/22/24, 164 lbs. on 03/27/24, and 160.5 lbs. on 04/05/24. 2. RD documented oral/nutrition intake meets 76-100% of estimated needs- 'Skilled Daily Nurses Notes' documented appetite poor-to-very poor with significant change in condition after 03/08/24 3. RD documented resident was ambulatory and able to feed self- 'Skilled Daily Nurses Notes' document decreased activity and need for extensive assistance with mobility and transfers and some assist with eating after significant change in condition on 03/08/24 4. RD documented lab values were WNL- Chem Profile done 03/13/24 documented Albumin less than 3.0 g/dL (2.5g/dL) and 3 other nutrition-related labs were abnormal (Potassium 3.4 mEq/L, Calcium 8.0 mg/dL, Protein 5.7 g/dL) 5. RD documented skin was intact- resident had become incontinent of bowel after change in condition on 03/08/24. Physicians' orders on Resident #1's April 2024 MAR, read in parts, .04/03/24 .Clean coccyx open areas with NS, pat dry apply Triad cream and cover with foam drg q3 days . A 'Skilled Daily Nurse Note', written 04/04/24, read in parts, .Skin (cont'd.) .Pressure Injury(ies) .Coccyx . No date of development, measurements, nor description of the pressure injury to the coccyx was documented anywhere in Resident #1's clinical record. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	There were no assessments for risks of skin breakdown documented in Resident #1's clinical record following their change in mobility and continence status that occurred on 03/08/24 through 04/08/24. No updates were made to Resident #1's Care Plan addressing interventions to prevent skin breakdown following their change of condition on 03/08/24. On 04/10/24 at 4:20 p.m., the DON was asked to review the RD's 'Nutrition Risk Assessment', the Care Plan, the Physician's Orders, and the Skilled Daily Nurse Notes for Resident #1 referenced above. After reviewing the documents, the DON acknowledged the RD's assessment was not accurate, dietary measures should have been initiated, and interventions should have been care planned to aid in preventing Resident #1's development of pressure ulcers.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 45462 Based on record review and interview, the facility failed to ensure care of a peripheral intravenous central catheter in accordance with professional standards of practice for one (#1) of one sampled resident reviewed for treatment of an intravenous catheter. The Administrator identified 31 residents resided in the facility. Findings: A 'Peripheral and Midline IV Dressing Changes' policy, revised March 2022, read in parts, 4. Change the dressing if it becomes damp, loosened or visibly soiled and: a. at least every 7 days for TSM dressing; b. at least every 2 days for sterile gauze dressing .unless site is not obscured; or c. immediately if the dressing or site appears compromised .The following should be documented in the resident's medical record: a. Date, time, type of dressing, and reason for dressing change . Resident #1 had diagnoses that included s/p amputation of toes on left foot and PICC line in upper right arm. A 'Physician's Order', dated March 2024, read in parts, .Daptomycin 500 mg vial 500 mg via IV every 24 hours *Stop date: 03/11/24* .Cefepime 2 GM injection 2 g via IVPB twice daily *Stop date: 03/11/24* .Flush PICC line with 10cc N.S. before and after medication administration . The March and April 2024 TAR's documented Resident #1 completed their IV ABT on 03/11/24 and continued to receive PICC line flushes twice a day from 03/12/24 through 04/06/24 without a physician's order. A 'Skilled Daily Nurse Note', written 03/11/24 2 p.m.-10 p.m., documented dressing to Resident #1's PICC line site was coming loose and was reinforced with gauze. There was no documentation between 03/11/24 and 04/08/24 Resident #1's PICC line dressing was changed. There was no documentation in Resident #1's clinical record their physician had been contacted to obtain orders for PICC line flushes, IV site dressing changes, nor removal of IV access after Resident #1's IV antibiotic therapy was completed on 03/11/24 and through 04/08/24. On 04/10/24 at 8:45 a.m., LPN #1 was asked if the physician was notified for an order to continue PICC line flushes or to remove Resident #1's PICC line when their ABT was completed. They stated no. LPN #1 was asked if Resident #1's PICC line dressing had been changed between 03/11/24 through 04/08/24. They stated, Not by me. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 4:06 p.m., the DON was asked the facility policy regarding care of intravenous access sites. They stated site dressing changes were done every 3-7 days and as needed if soiled or dislodged and flushes were done according to the physicians' order. The DON was asked if Resident #1's PICC line dressing had been changed or if they had an order for flushes between 03/11/24 and 04/08/24 and they stated no. The DON was asked to review the physicians' orders, TAR's, and the clinical record for Resident #1 referenced above. After reviewing the documents, the DON acknowledged facility policy nor professional standards of practice had been followed.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45462 Based on record review and interview, the facility failed to ensure medication was administered as ordered for one (#3) of one resident reviewed for medications being given as ordered. The administrator identified 31 residents resided in the facility. Findings: An 'Administering Medications' policy, revised December 2022, read in parts, .3. Medications must be administered in accordance with orders . Resident #3 had diagnoses that included multiple sclerosis, insomnia, and abnormal weight loss. A 'Hospital Discharge Summary', dated 04/07/24 - 04/12/24, read in parts, .temazepam 15 MG capsule .take 1 capsule (15 mg) by mouth nightly as needed for sleep . An April 2024 MAR, read in part, temazepam 15 mg capsule give 1 capsule by mouth every hs ., and documented medication was given at 12 a.m. on 04/12/24, 04/13/24, 04/14/24, and 04/15/24. On 04/15/24 at 12:00 p.m., LPN #1 was asked to review the order for temazepam on Resident #3's hospital discharge paperwork and on their April 2024 MAR. After reviewing the documents LPN #1 stated they had transcribed the order incorrectly. On 04/15/24 at 12:12 p.m., the ADON reviewed the documents for Resident #3 referenced above and acknowledged the medication had not been given according to the physicians' order.