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	08/07/2024

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

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review and interview, the facility failed to ensure residents were not involuntarily discharged for one (#30) of three sampled discharged residents. The DON identified 33 residents resided in the facility. Findings: Resident #30 was admitted on [DATE] with diagnoses that included anxiety disorder, bipolar disorder, psychotic disorder, schizophrenia, and PTSD. A physician's order, dated 06/25/24 at 7:48 p.m., read in parts, .Transfer to VA hosp ER D/T behaviors . There was no documentation in the clinical record that the facility followed-up on Resident #30's status after he was transferred to the VA hospital ER and no documentation stating the resident had been discharged . On 08/06/24 at 9:33 a.m., the DON stated Resident #30 did not return to the facility because they were a danger to self and others due to their behaviors. They stated they could not meet Resident #30's needs at the facility. On 08/06/24 at 11:50 a.m., Nurse Consult. #1, who completed the transfer MDS for Resident #30, was asked how they determined Resident #30's return was not anticipated. Nurse Consult. #1 stated, Probably by the time I put the MDS in on 06/28/24 we must have known we weren't taking him back. There was no documentation in Resident #30's clinical record indicating the facility would not be able to meet the needs of the resident upon their return from the VA hospital and there was no physician's order in the clinical record to discharge resident #30.

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review and interview, the facility failed to provide notice of a facility initiated discharged for one (#30) of three sampled discharged residents. The DON identified 33 residents resided in the facility. Findings: Resident #30 was admitted on [DATE] with diagnoses that included anxiety disorder, bipolar disorder, psychotic disorder, schizophrenia, and PTSD. A nurse's note, dated 06/25/24 at 8:10 p.m., documented Resident #30 was transferred to the VA hosp ER D/T behaviors. A Discharge Summary, dated 06/26/24, documented Resident #30 had been discharged from the facility on 06/25/24. There was no documentation in the clinical record that the facility notified, or attempted to notify, Resident #30 or their family of their discharge from the facility. On 08/06/24 at 9:33 a.m., the DON acknowledged neither Resident #30 nor their family had been notified of their discharge from the facility.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review and interview, the facility failed to ensure a discharge MDS assessment was completed within the required timeframe for one (#11) of three sampled residents whose discharge assessments were reviewed. The DON identified 33 residents resided in the facility. Findings: Resident #11 was admitted to the facility on [DATE] and discharged at the end of their skilled days on 04/12/24. The EHR did not document a discharge MDS assessment had been completed. On 08/06/24 at 11:40 a.m., Nurse Consult. #1 acknowledged the discharge MDS assessment for Resident #11 had not been completed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on record review and interview, the facility failed to ensure a baseline care plan was completed in a timely manner for one (#131) of 12 sampled residents reviewed for baseline care plans. The DON identified 33 residents resided in the facility. Findings: Resident #131 was admitted on [DATE]. Resident #131's baseline care plan documented a completion date of 07/27/24. On 08/06/24 at 8:16 a.m., Nurse Consult. #1 stated Resident #131's baseline care plan was not completed in a timely manner. They stated a baseline care plan was to be completed within 48 hours of admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on observation, record review, and interview, the facility failed to implement a comprehensive care plan for one (#132) of one sampled resident reviewed for the use of a urinary catheter. The DON identified 33 residents resided in the facility. Three residents had urinary catheters in the facility. Findings: Resident #132 was admitted on [DATE] with diagnoses which included neuromuscular dysfunction of bladder and hydronephrosis. A physician order, dated 07/05/24, documented to change foley catheter every 30 days on the 1st of the month on night shift. Resident #132's admission resident assessment, dated 07/11/24, documented the Resident had an indwelling catheter. On 08/04/24 at 10:31 a.m., Resident #132 was observed to have an indwelling urinary catheter. Review of Resident #132's baseline care plan did not document the use of an indwelling urinary catheter. There was no record of the completion of a comprehensive care plan for Resident #132. On 08/07/24 at 9:18 a.m., Nurse Consult. #1 stated Resident #132 did not have a comprehensive care plan. They stated they were working on completing one.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review and interview, the facility failed to ensure a discharge summary and discharge instructions were completed upon discharge for one (#11) of three sampled residents whose discharge paperwork was reviewed. The DON identified 33 residents resided in the facility. Findings: Resident #11 was admitted to the facility on [DATE] and discharged at the end of their skilled days on 04/12/24. A 'Discharge Summary' form for Resident #11, dated 02/28/24, was located in their clinical record, but it had not been completed. A Discharge Instructions form for Resident #11, was located in their clinical record undated and not completed. On 08/06/24 at 9:27 a.m., the DON acknowledged the discharge summary and discharge instructions for Resident #11 had not been completed.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on record review and interview, the facility failed to have a process in place to identify a resident's code status for one (#131) of three sampled residents reviewed for advanced directives. Findings: Resident #131 was admitted on [DATE]. A physician's order, dated 07/23/24, documented DNR. A care plan, dated 07/27/24, documented Resident #131 preferred to be a DNR. There was no documentation of a completed Oklahoma DNR consent form in Resident #131's record. On 08/05/24 at 10:47 a.m., the DON stated Resident #131 did not have a DNR consent form in their health record. They stated residents should have a physician's order and a DNR form in their chart upon admission or remain a full code until a DNR consent form was obtained. On 08/05/24 at 11:36 a.m., LPN #1 stated residents code status were found in their health record and resident roster at the nurse's station.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48344 Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered by the physician and oxygen tubing was changed for one (#27) of one sampled resident reviewed for respiratory care. The DON identified two residents who received continuous oxygen therapy in the facility. Findings: The Oxygen Administration policy, revised 10/10, read in part, Review the physician's orders or facility protocol for oxygen administration. Resident #27 had diagnoses which included COPD and acute and chronic respiratory failure with hypoxia. A physician's order, dated 02/05/24, documented oxygen at 3 liters per nasal cannula to keep oxygen saturation at 90% or above. On 08/04/24 at 1:29 p.m., Resident #27 was observed receiving oxygen. The concentrator was set at 3.5 LPM. The oxygen tubing was dated 07/22. On 08/04/24 at 1:42 p.m., RN #1 stated Resident #27's oxygen order was 3 liters via nasal cannula. On 08/04/24 at 1:43 p.m., RN #1 stated oxygen tubing were to be changed weekly on Sundays. On 08/04/24 at 1:46 p.m., RN #1 observed the Resident's concentrator. They stated the oxygen delivery was set at 3.5 LPM. RN #1 stated the physician's order was not followed. On 08/04/24 at 1:47 p.m., RN #1 stated the date on the Resident's oxygen tubing was 07/22. They stated the oxygen tubing should have been changed per facility policy.

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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 observation, record review, and interview, the facility failed to complete bed rail safety assessments, review the risks and benefits of bed rails with the resident or resident representative, and obtain informed consent prior to installation of bed rails for three (#13, #15, and #82) of three sampled residents with bed rails in use. The DON identified 33 residents resided in the facility. Findings: A Bed Safety and Bed Rails' policy, revised August 2022, read in parts, .3. The use of bed rails or side rails . is prohibited unless the criteria for use of bed rails have been met, including .interdisciplinary evaluation, resident assessment, and informed consent . 1. On 08/04/24 at 12:25 p.m., Resident #13 was observed in bed with two upper bed rails raised. 2. On 08/04/24 at 2:05 p.m., Resident #15 was observed in bed with two upper bed rails raised. 3. On 08/05/24 at 12:58 p.m., Resident #82 was observed in bed with two upper bed rails raised. There was no documentation in the clinical records of Resident #13, #15, nor #82 that bed rail safety assessments had been completed, risks and benefits of bed rails had been reviewed with the resident or resident representative, nor that informed consent had been obtained. On 08/06/24 at 10:10 a.m., the DON acknowledged the necessary paperwork that needed to be completed before bed rails were used had not been completed according to facility policy for the Residents listed above.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 48344 Based on record review and interview, the facility failed to complete a nurse aide performance review once every 12 months for two (CNA #1 and CNA #2) of five employee files reviewed. The DON identified 33 residents resided in the facility. Findings: The Competency of Nursing Staff policy, revised 10/17, read in part, All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law. CNA #2 had a hire date of 04/28/22. There was no CNA annual competency review located in the employee's file. CNA #1 had a hire date of 05/12/23. There was no CNA annual competency review located in the employee's file. On 08/06/24 at 7:59 a.m., the BOM stated there was no CNA annual competency review for CNA #1 and CNA #2.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48344 Based on record review and interview, the facility failed to: a. implement a physician order for a gradual dose reduction for one (#26); b. have a physician response to a gradual dose reduction recommendation for one (#6) of five sampled residents reviewed for unnecessary medications. The DON identified 33 residents resided in the facility. 18 residents received psychotropic's in the facility. Findings: 1. Resident #26 had diagnoses which included insomnia and anxiety. An MRR, dated 05/28/24, documented a GDR recommendation for 150 mg trazodone (an antidepressant) reduction to 100 mg at bedtime. A physician's response, dated 06/11/24, documented agreement to the trazodone reduction. A nurse's acknowledgement, dated 06/14/24, was documented on the MRR. There was no physician's order corresponding to the nurse's acknowledgement on 06/14/24 for Resident #26. A nurse's acknowledgement, dated 06/21/24, was documented on the MRR. A physician's telephone order, dated 06/21/24, documented 100 mg trazodone one tablet by mouth at bedtime per pharmacy recommendation. The June 2024 MAR documented 150 mg trazodone was given till 06/21/24. The June 2024 MAR documented 100 mg trazodone was first given on 06/22/24. On 08/06/24 at 1:54 p.m., the DON reviewed Resident #27's June 2024 MAR, MRR, and physician orders. They stated the physician's response to the GDR was implemented on 06/21/24. They stated the Resident received the first dose of the 100 mg trazodone on 06/22/24. 2. Resident #26 had diagnoses which included schizophrenia, anxiety, insomnia, and depression. A physician's order, dated 05/30/23, documented 10 mg Abilify (an antipsychotic) give one tablet by mouth once daily at bedtime for schizophrenia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 07/13/23, documented 5 mg buspirone (an antianxiety) give one tablet by mouth twice daily for anxiety. A physician's order, dated 07/27/23, documented HCL 60 mg duloxetine (an antidepressant) give one capsule by mouth twice daily for depressive disorder. A physician's order, dated 04/02/24, documented 50 mg trazodone (an antidepressant) give two tablets by mouth every evening for insomnia. An MRR, dated 02/13/24, documented a GDR recommendation for buspirone 5mg to half tablet twice daily. An MRR dated 03/19/24, documented a GDR recommendation for Abilify from 10 mg to 7.5 mg at bedtime. An MRR, dated 04/15/24, documented a GDR recommendation for duloxetine from 60 mg twice daily to 30 mg in the morning and 60 mg at bedtime. There was no documentation of a physician's response to the above three GDRs. On 08/07/24 at 9:27 a.m., the DON reviewed the above MRRs with the GDR recommendations. They stated there was no physician response to the above GDRs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45462 Based on observation, record review, and interview, the facility failed to ensure proper infection control practices were followed during the administration of medication for one (#13) of seven sampled residents observed during medication administration. The DON identified 33 residents resided in the facility. Findings: An 'Administration Set/Tubing Changes' policy, revised February 2023, read in parts, General Guidelines .4. Label tubing with date, time, and initials .5. Any tubing that is found not labeled must be changed and then labeled accordingly .6. Any tubing that is suspected to have been contaminated or compromised is changed immediately . Resident #13 was receiving intravenous antibiotic therapy via a PICC line in place to left upper arm. On 08/05/24 at 8:45 a.m., this surveyor observed LPN #1 during IV medication administration for Resident #13. Upon entering the resident's room, I observed there was no date on the tubing that was hanging in the previously used IV bag. LPN #1 used the hanging IV tubing to spike the new IV bag, primed the line and laid the end of the IV tubing on the resident's pillow. During the process of flushing the 3 PICC line lumens, the end of the IV tubing that you connect to the lumen slid to the floor. After flushing the lumens, LPN #1 picked the tubing up from the floor, removed the cap, connected it to the PICC line lumen, and started the IV. LPN #1 was asked if a new IV tubing should have been used. They stated the night nurse probably changed it. When asked if the IV tubing should have been placed on the resident's pillow or used after it had fallen to the floor, LPN #1 stated it had a cap on it. On 08/06/24 at 10:49 a.m., the DON reported facility policy dictated IV tubing should be changed every 24 hours and labeled with the date, time, and initials. The DON was informed of the above observations and acknowledged that proper infection control practices were not observed and facility policy had not been followed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 45462 Based on record review and interview, the facility failed to ensure influenza and pneumococcal vaccinations were offered for four (#15, 18, 22, and #82) of five residents reviewed for immunizations. The DON identified 33 residents resided in the facility. Findings: Immunization records for Residents #15, #18, #22, and #82 were reviewed. There was no documentation in their record the residents, nor their representatives had been offered or received an influenza or pneumonia immunization. On 08/07/24 at 9:41 a.m., the DON was asked if residents were offered influenza and pneumonia vaccines. They stated immunizations should be offered during admission process and annually. The DON acknowledged neither Resident #15, #18, #22, nor #82 or their representative had documentation in their clinical record showing they were offered nor received the influenza or pneumococcal vaccines.