STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375486	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Health Care	1307 R D Miller Drive Okmulgee, OK 74447

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 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. 45913 Based on record review and interview the facility failed to notify the physician for out of parameters blood sugars for one (#41) of two sampled residents reviewed for insulin. The DON identified 31 residents who received insulin. Findings: The Bedside Blood Glucose Monitoring policy, revised on 02/12/20, read in part, If the glucose level is out of the established ranges ordered by the physician .The physician is contacted. Res #41 had diagnoses which included diabetes. The June physician's orders documented the physician was to be called for a blood sugar greater than 350. On the following dates in June, Res #41's blood sugar was above 350 with no documentation the physician was notified. 06/02/24 at 11:00 a.m., the blood sugar was 420. 06/10/24 at 11:00 a.m., the blood sugar was 368. 06/20/24 at 4:00 p.m., the blood sugar was 379. 06/24/24 at 11:00 a.m., the blood sugar was 484. 06/26/24 at 11:00 a.m. the blood sugar was 361. 06/28/24 at 4:00 p.m., the blood sugar was 544. The July physician's orders documented the physician was to be called for a blood sugar greater than 350 between 07/01/24 through 07/22/24. Between 07/22/24 and 07/31/24, the physician was to be called for a blood sugar greater than 501. (continued on next page)

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the following dates in July, Res #41's blood sugar was above 350 or 501 with no documentation the physician was notified. 07/02/24 at 4:00 p.m., the blood sugar was 415. 07/03/24 at 11:00 a.m., the blood sugar was 380. On 07/08/24 11:00 a.m., the blood sugar was 507. On 07/11/24 at 8:00 p.m., the blood sugar was 368. On 07/12/24 at 8:00 p.m., the blood sugar was 362. On 07/17/24 at 8:00 p.m., the blood sugar was 387. On 07/19/24 at 4:00 p.m., the blood sugar was 381. On 07/19/24 at 8:00 p.m., the blood sugar was 363. The August physician's orders documented the physician was to be called for a blood sugar greater than 501. On the following dates in August, Res #41's blood sugar was above 501 with no documentation the physician was notified. 08/16/24 at 8:00 p.m., the blood sugar was 522. 08/18/24 at 4:00 p.m., the blood sugar was 518. 08/18/24 at 8:00 p.m., the blood sugar was 590. There was no documentaion the facility called the physician when the blood sugars were out of parameter in June, July August 2024. On 08/23/24 at 12:50 p.m., the DON reported when a blood sugar is out of parameter, the nurses should follow the physician's orders and call the physician for guidance.

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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 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. 33097 Based on record review and interview, the facility failed to ensure a psychotropic medication was used for a specific diagnosis for one (#71) of five residents who were reviewed for unnecessary medication. The DON identified 15 residents who received psychotropic medication. Findings: Resident #71 had diagnoses which included dementia without psychotic disturbance, cerebrovascular disease, and major depressive disorder. A physician order, dated 02/08/24, documented the resident received olanzapine 10 mg tablet one time a day at bedtime for major depressive disorder without psychotic features. A quarterly assessment, dated 05/22/24, documented the resident was receiving an antipsychotic medication. The assessment documented no potential indicators of psychosis or behaviors. On 08/20/24 at 9:33 a.m., the resident was in bed eating breakfast. The resident was calm and pleasant. The care plan, dated 03/01/24, documented psychotropic drug use. The care plan documented the staff was to monitor for resident behaviors and side effects of the medication every shift and document. On 08/22/24 at 11:24 a.m., the DON reviewed the resident's clinical record and stated the resident was receiving an antipsychotic medication (olanzapine) for the diagnosis of major depression without psychotic features. The DON reviewed the resident's diagnoses list and stated there was no diagnosis for the use of an antipsychotic medication.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46702 Based on observation, record review, and interview, the facility failed to: a. store clean dishware inverted and on sanitary surfaces, b. maintain a clean and sanitary kitchen, and c. label, date, and cover food items in the refrigerators during one of two kitchen observations. The DON identified 77 residents received nutrition from the kitchen. Findings: The facility's Employee Infection Control policy, dated 08/01/18, read in part, All local, state, and federal standards and regulations are followed to ensure a safe and sanitary Nutrition Services Department. The policy also read, Store clean dishes inverted or in enclosed or covered storage units. The facility's Food Storage policy, dated 08/01/18, read in part, All foods are covered, labeled and dated. Defrosting meat, eggs, and milk shakes are labeled with date pulled for thawing. The facility's Use of Left Overs policy, dated 08/01/18, read in part, Leftovers should be covered, labeled, dated and stored appropriately. On 08/20/24 at 7:00 a.m., the Initial tour of the kitchen was conducted. The following observations were made in the walk-in refrigerator: a. cooked pork loin in a metal pan uncovered with foil torn and no date label indicating when it was pulled or cooked, b. raw uncooked pork loin not in a pan was on the bottom shelf of the walk-in refrigerator thawing out setting on top of a box of breakfast sausage with no date idicating when it was pulled top thaw out, and c. raw chicken in a plastic pan thawing out in the walk-in on the bottom shelf with no date indicating when it was pulled to thaw out. On 8/20/24 @ 7:15 a.m., [NAME] #1 number one was asked about the items above items. They stated that the cooked pork loin in the walk-in needed to be thrown away and she was not sure when it was cooked. [NAME] #1 was asked what the policy was regarding these items. They stated the raw meat should of been in a pan and dated the date, it was pulled and the chicken should have had a pulled date labeled on it and they were unsure when it was pulled to thaw. On 08/20/24 at 7:20 a.m., the following observations were made: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. next to the griddle on a wood dresser in a brown plastic bin and unknown substance was spilled with spices stored in the bin that had sticky and unsanitary lids, b. the wall behind the food preparation area next to the grill had three dead flies, food debris, a half a cup of unidentified, white powder, not covered, and plastic utensils in a cup with food debris in the bottom of the cup, c. a serving wheeled cart for condiments had food debris on the surface and the bottom shelf had plasticware and crackers with visible food debris and a wet and sticky unknown substance where the crackers and plasticware were stored, d. clean pans under the food prep table were stored and not inverted, e. dishware was stored on a wire rack upright and not inverted or covered, f. a 10 gallon plastic bucket with food debris inside, plastic bags, and aprons were stored on the top shelf above clean dishes, g. the trays used to stack clean glasses had food debris and an unknown sticky substance with clean glasses stacked on them, h. the cereal station had clean bowls stored underneath that were not inverted and had visible food debris in the clean bowls, i. the top of the cereal station had a sticky and white powdery residue on the lids, and j. the floors under the hand sink and three compartment sink had food debris, a black unknown substance, other unknown contaminants, and soiled dirty towels on the floor. On 8/20/24 at 7:36 a.m., dietary aid #2 was showed the above mention items and ask what the policy was. They stated it looks like they didn ' t clean up after themselves. On 8/20/24 at 7:40 a.m., Cook#1 was shown the above items and asked what was their policy. They stated, you should clean as you go. They don't do their job around here. On 8/20/24 at 8:21 a.m., the CDM was shown above items and asked what the policy was for maintaining a clean kitchen and labeling in the refrigerators. They stated the kitchen staff were supposed to follow a cleaning list and were not following the cleaning schedule. The CDM was asked what they thought about the kitchen. They stated the kitchen was not clean and sanitary. On 8/20/24 at 8:31 a.m., the Administrator walked through the kitchen with the surveyor and was shown the above items. The Administrator was asked what they thought about the kitchen. They stated they were very disappointed. The administrator was asked if they thought the kitchen was clean and sanitary. The Administrator stated they did not think the kitchen was clean and sanitary based upon the observations, all items should of been labeled in the refrigerator the date they were opened, and the kitchen should be cleaned after each meal.