STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375487	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAlester Nursing & Rehab	615 E Morris Ave McAlester, OK 74501

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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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. 35389 Based on observation, record review, and interview, the facility failed to ensure information on how to file a formal complaint with the State agency was visible to the residents. The Administrator identified 43 residents resided in the facility. Findings: On 07/30/24 at 10:05 a.m., a meeting with the Resident Council Group was held. They stated they had not been informed of their right and given information on how to formally complain to the State about the care they were receiving. On 07/30/24 at 10:39 a.m., the Long Term Care Facility Complaint Procedure form was observed on a brown board next to the dining room. Only the top part of the form was visible. A plastic sleeve that contained survey results was observed covering the bottom half of the form. There was no contact information, mailing address, e-mail address, or telephone number for filing a formal complaint to the State viewable. On 07/30/24 at 11:02 a.m., Social Services stated they went over resident rights and how to file a grievance during Resident Council meetings. They stated as far as with the State agency, they didn't have a certain form. They stated, if they had a problem, they could speak with Social Services. They stated they had never had a resident who wanted to file a report with the State. On 07/30/24 at 11:05 a.m., the Administrator and Social Services walked over to the brown board to observe the Long Term Care Facility Complaint Procedure form. The Administrator stated the forms got moved around. They stated the contact information was not viewable at that time because someone had covered it. They stated staff did not cover it.

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 35389 Based on observation, record review, and interview, the facility failed to ensure residents had access to the most recent survey results conducted by State surveyors. The Administrator identified 43 residents resided in the facility. Findings: A complaint investigation was conducted at the facility on 12/11/23. On 07/30/24 at 10:05 a.m., a meeting with the Resident Council Group was held. They stated they did not know how to access the results of the State inspections. They stated the facility had not informed them. On 07/30/24 at 10:39 a.m., there were State survey results observed in a clear plastic sleeve on a brown board next to the dining room. There was no sign indicating these were the State survey results. The survey results located inside were dated 06/28/23. On 07/30/24 at 10:52 a.m., the survey results for the 12/11/23 complaint survey conducted at the facility were not observed in the clear plastic sleeve. On 07/30/24 at 10:57 a.m., Social Services stated survey results were usually posted up by one of the west doors. Social Services stated they honestly didn't share where to find the survey results with the residents. They stated they had just taken over social services and they did go over resident rights with the Resident Council Group. They stated in April 2024, the right to be fully informed, which included the right to the results of survey, was gone over with the Resident Council Group. On 07/30/24 at 11:05 a.m., Social Services and the Administrator walked over to the brown board to observe the survey results. On 07/30/24 at 11:07 a.m., the Administrator reviewed the contents of the clear plastic sleeve and stated it was the facility's last survey dated 06/28/24. They stated the 12/11/23 complaint survey should have been in there, but it wasn't.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 35389 Based on record review and interview, the facility failed to ensure Resident Assessments were accurately coded for two (#39 and #50) of 13 sampled residents reviewed for accurate assessments. The Administrator identified 43 residents resided in the facility. Findings: 1. Resident #39 had diagnoses which included hepatic encephalopathy, metabolic encephalopathy, and cirrhosis of the liver. Resident #39's physical therapy treatment notes documented they received services on 06/26/24, 06/27/24, and 07/01/24. A Quarterly Resident Assessment, dated 07/01/24, documented Resident #39 did not receive physical therapy services. On 07/30/24 at 3:22 p.m., MDS Coordinator #1 stated they would code a resident received therapy services in section O of the Resident Assessment. They stated therapy brought them a log to identify what residents had received therapy services. They stated no therapy services were coded on Resident #39's assessment. MDS Coordinator #1 reviewed Resident #39's physical therapy records and stated the 06/26, 06/27, and 07/01/24 physical therapy services should have been captured on the Resident Assessment. 2. Resident #50 had diagnoses which included chronic kidney disease stage four. A Physician Order, dated 05/17/24, documented admit to hospice with a diagnosis of renal failure stage four. Resident #50's Significant Change Resident Assessment, dated 05/29/24, documented no for the question Prognosis: life expectancy of less than [six] months. On 07/30/24 at 9:37 a.m., MDS Coordinator #1 stated to ensure Resident Assessments were accurate, they would complete an assessment on the resident, look at the chart, and tried their best to get the right answer. They stated they would mark yes on the question for prognosis life expectancy less than six months if the resident was on hospice and if the physician deemed it that way. MDS Coordinator #1 reviewed Resident #50's record and identified the start date for hospice services was 05/17/24. They stated I put no on the prognosis life expectancy less than six months. They stated it was not accurately coded.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46216 Based on record review and interview, the facility failed to ensure a care plan was updated related to an unstageable pressure ulcer for one (#152) of 12 sampled residents reviewed for care plans. The Administrator identified 43 residents resided in the facility. Findings: Resident #152 had diagnosis which included unstageable pressure ulcer. A nursing note, dated 07/18/24, documented Resident #152 had readmitted to the facility with a 5.0 cm in length by 3.0 cm in width by 0.1 cm in depth moisture associated wound to their right buttock. A Physician's order, dated 07/26/24, documented, clarification order clean unstageable area on buttock with wound wash, pat dry, apply hydrogel and collagen. cover area with foam dressing every day and PRN x 14 days then re-evaluate. There was no documentation of Resident #152's unstageable pressure ulcer in the care plan. On 07/31/24 at 9:39 a.m., MDS Coordinator #1 stated they had not updated the care plan since Resident #152 had returned from the hospital.

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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** 46216 Based on record review and interview, the facility failed to ensure a resident's code status was updated in the care plan for one (#38) of 12 sampled residents reviewed for code status. The Administrator identified 43 residents resided in the facility. Findings: A Care Plans, Comprehensive Person-Centered policy, revised December 2016, documented assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions changed and when a resident had been readmitted to the facility from a hospital stay. Resident #38 admitted on [DATE] with diagnoses which include myocardial infarction and atherosclerotic heart disease of the native coronary artery without angina pectoris. A Care Plan, dated 05/03/24, documented Resident #38 had chosen a full code and staff were to follow full code protocol. A Physician's order, dated 06/27/24, documented Resident #38's code status as DNR. Resident #38's chart had an orange sticker on the front and the side that documented DNR. A DNR form, in Resident #38's clinical record was signed by their guardian. On 07/31/24 at 2:01 p.m., MDS Coordinator #1 stated the resident's code status was DNR. They stated the care plan documented Resident #38 was a full code.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35389 Based on observation, record review, and interview, the facility failed to ensure medications were not left at a resident's bedside for one (#39) of 16 residents observed for bedside medications. The Administrator identified 43 residents resided in the facility. The DON identified no residents with orders to self-administer medications. Findings: A Medication Storage in the Facility policy, revised 08/14, read in part, .Medications and biologicals are stored safely, securely, and properly .Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications .permitted to access medications . Resident #39 had diagnoses which included hepatic encephalopathy, metabolic encephalopathy, and cirrhosis of the liver. Resident #39's July 2024 Physician Order's did not contain an order to self-administer medications. On 07/28/24 at 9:37 a.m., Resident #39 stated they noticed a white pill they hadn't been taking during medication pass. They stated the staff was going to go and see what the medication was. Resident #39 stated the staff reported it was oxxybutynin, but the resident didn't believe that pill was white. They stated staff had brought them the medication maybe 45 minutes ago. There was one white medicine cup with one white pill observed on the resident's bedside table. On 07/28/24 at 10:06 a.m., Resident #39 stated CMA #3 was who passed their medications today. There was also a container of Vicks vapo stick no mess observed next to the resident's bed. They stated they used it when they had Covid-19. They stated they had asked their family member to bring it to them. They stated they knew they were not supposed to do that. On 07/28/24 at 10:08 a.m., CMA #3 stated they would go into a resident's room, introduce themselves, give them their medication, and watch them take it, then give them water. They stated they always took the empty cup. They stated they did not have any residents who self-administered their medications. They stated Resident #39 likes to hold [their] bladder pill. They stated they were not sure the reason the Vicks was in the room. On 07/28/24 at 10:10 a.m., the DON stated there was paperwork to complete if a resident wanted to self-administer medications. They stated they did not believe there were any residents who could self-administer medications in the facility. The Administrator stated staff should be watching the residents take their medications. The DON stated staff should punch, initial, and give the medications.

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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. 35389 Based on observation, record review, and interview, the facility failed to ensure meat products were thawed in a manner to prevent cross-contamination for one of two kitchen observations. The Administrator identified 43 residents resided in the facility. The DON identified one resident who received nothing by mouth. Findings: A Food Receiving and Storage policy, revised 10/17, read in part, Foods shall be received and stored in a manner that complies with safe food handling practices .Uncooked and raw animal products and fish will be stored separately in drip-proof containers . On 07/28/24 at 9:00 a.m., there was a grey container observed on the bottom shelf of the walk in cooler. There was one clear wrapped container of meat labeled ground beef that was dated 07/11/24. In the same container, there were two partially frozen hams with a use by date of 10/29/24. There was a red liquid substance noted at the bottom of the container the meats were stored in. On 07/28/24 at 9:10 a.m., the Dietary Manager stated the meats were supposed to be separated. They stated both items required cooking before eating. They stated the red liquid was blood. On 07/28/24 at 9:22 a.m., the Dietary Manager and [NAME] #2 discarded the above meat products into the outside trash can.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 Based on observation, record review, and interview, the facility failed to ensure accurate documentation of blood pressure for one (#6) of five sampled residents observed for medication pass. The administrator identified 43 residents resided in the facility. Findings: A Nursing Care Policies and Procedures, for blood pressures, revised 05/18/01, documented, A blood pressure measurement is taken to accurately determine the blood pressure to assist in diagnosis and to show progress and change in a resident's condition. Resident #6 admitted on [DATE], with diagnoses which included essential hypertension and tachycardia. A Physician's order, dated 06/08/24, documented metoprolol tartrate give 25 mg twice daily, hold if SBP is less than 110. On 07/31/24 at 10:08 a.m., LPN #1 obtained Resident #6's blood pressure with a wrist cuff. the blood pressure reading was 101/52 with a pulse of 101. On 07/31/24 at 10:09 a.m., LPN #1 stated, I always round up so it is 102/52. On 07/31/24 at 10:10 a.m., LPN #1 documented 102/52 on the MAR. On 07/31/24 at 10:33 a.m., LPN #1 stated the purpose of rounding up a blood pressure number was to have an even number. They stated it could affect the parameters. On 07/31/24 at 10:56 a.m., the DON stated the policy for complete and accurate recording of vitals signs was to record them at the time they were obtained. They stated the vital signs should be documented as read on the machine. They stated it was not okay to round up ever.