

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Forrest Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 North Choctaw Dewey, OK 74029	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure a resident was safe to self-administer medication for one (#204) of one sampled resident reviewed for self-administering medications.</p> <p>The ADON identified one resident that self-administered medications.</p> <p>Findings:</p> <p>An undated policy titled Right to Self-Administer Medications read in part, .Each resident has the right to self-administration of drugs unless the interdisciplinary team has determined that the practice would be a danger to the resident or others .The attached form will be completed and kept in the resident's medical record .the interdisciplinary team must assess the resident's cognitive, physical, and visual ability to carry out the responsibility .</p> <p>Physician orders, dated 08/09/24, documented Resident #204 was to receive albuterol 3 mg/ipratropium 0.5 mg (bronchodilator medication) via nebulizer four times a day and it could be kept at bedside; and tiotropium bromide (anticholinergic medication) 2.5 mcg two inhalations once a day and it could be kept at bedside.</p> <p>On 09/11/24 at 12:34 p.m., the ADON stated an self-administration of medication assessment should have been completed for Resident #204.</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270</p> <p>Based on record review and interview, the facility failed to provide an opportunity for a resident to create an advance directive for two (#9 and #50) of three sampled residents reviewed for advance directives.</p> <p>A facility census list, dated 09/08/24, documented 61 residents resided in the facility.</p> <p>Findings:</p> <p>A facility face sheet, dated 06/13/19, documented Resident #9 had been admitted to the facility on [DATE].</p> <p>There was no documentation the resident was given an opportunity to create an advance directive.</p> <p>On 09/10/24 at 1:51 p.m., the ADON stated they had reviewed Resident #9's records and had not found documentation they had been provided the opportunity to create an advance directive.</p> <p>On 09/10/14 at 1:55 p.m. Resident #9 stated they did not recall talking to anyone about an advance directive.</p> <p>On 09/10/24 at 2:17 p.m., the BOM stated they had searched the resident's records that had been thinned from the chart and did not find documentation regarding an advance directive.</p> <p>On 09/11/24 at 10:15 a.m. the ADON stated a resident has a right to create an advance directive.</p> <p>2. Resident #50 had diagnoses which included chronic pain and pressure ulcers.</p> <p>A review of the clinical record revealed there was no documentation the resident had an opportunity to create an advance directive. There was no documentation of the resident's code status in the physician's orders or chart cover.</p> <p>On 09/11/24 at 2:02 p.m., the resident's clinical record was reviewed with the ADON and BOM. The ADON stated the resident's code status should have been documented on the physician's order and a sticker placed on the front of the chart. The BOM located a blank copy of the facility form to address advance directives in the resident's clinical record. The BOM stated the form was blank and the facility had not addressed advance directives with Resident #50.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to provide a CMS-10123 form to a resident who discharged from part Medicare Part A services for one (#50) of three sampled residents reviewed for required paperwork related to discharging from Medicare Part A services.</p> <p>The BOM stated six resident had discharged from Medicare Part A services in the previous six months to the survey.</p> <p>Findings:</p> <p>An undated CMS-10123 form, documented Resident #50's coverage for Medicare Part A services would end on 06/14/24. The form was not signed.</p> <p>On 09/09/24 at 1:31 p.m., the BOM stated they had forgot to provide Resident #50 a CMS-10123 form for Medicare Part A services which Resident #50 discharged from on 06/14/24.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to transmit MDS assessment data to CMS in the required timeframe for six (#13, 17, 26, 29, 37, and #51) of 20 sampled residents reviewed for MDS assessments.</p> <p>The administrator identified 61 residents resided at the facility.</p> <p>Findings:</p> <p>A facility policy titled MDS Completion and Submission Timeframes, dated 2001, read in part, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.</p> <p>A facility MDS 3.0 Assessment Summary Report, was provided to the survey team on 09/10/24. The report documented quarterly assessments for six residents had been submitted to CMS beyond the required timeframe. The late assessments were:</p> <ol style="list-style-type: none"> 1. Resident #13's quarterly assessment, completion date 07/17/24, had a transmit by date of 07/31/24. The transmitted date was documented as 08/29/24; 2. Resident #17's quarterly assessment, completion date 07/15/24, had a transmit by date of 07/29/29. The transmitted date was documented as 08/22/24; 3. Resident #26's quarterly assessment, completion date 08/04/24, had a transmit by date of 08/18/24. The transmitted date was documented as 09/10/24; 4. Resident #29's quarterly assessment, completion date 08/01/24, had a transmit by date of 08/15/24. The transmitted date was documented as 08/22/24; 5. Resident #37's quarterly assessment, completion date 06/20/24, had a transmit by date of 07/04/24. The transmitted date was documented as 07/23/24; and 6. Resident #51's quarterly assessment, completion date 07/30/24, had a transmit by date of 08/13/24. The transmitted date was documented as 09/10/24. <p>On 09/10/24 at 10:49 a.m., the ADON stated they had just taken over the MDS coordinator duties. They stated they were aware of multiple overdue assessments. They stated they were aware the assessments were not transmitted.</p> <p>At 12:34 p.m., the administrator stated they had been unaware the MDS assessments had not been completed and transmitted. They stated it was their expectation all MDS assessment would be opened, completed, and submitted in a timely manner.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure a baseline care plan was completed for one (#203) of five sampled residents reviewed for care plans.</p> <p>The ADON identified 61 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #203 had diagnoses which included diabetes mellitus and hypertension.</p> <p>There was no documentation a baseline care plan had been completed.</p> <p>On 09/12/24 at 10:21 a.m., RN #1 stated they did not complete Resident #203's admission. They stated they did not know if a baseline care plan was completed.</p> <p>On 09/11/24 at 12:34 pm, the ADON stated a baseline care plan for resident #203 was not located.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan for one (#203) of five sampled residents reviewed for care plans.</p> <p>The ADON identified 61 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #203 had diagnoses which included diabetes mellitus and hypertension.</p> <p>There was no documentation a comprehensive care plan was completed for the resident.</p> <p>On 09/11/24 at 12:34 p.m., the ADON stated a care plan for resident #203 was not completed.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>34270</p> <p>Based on observation, record review, and interview, the facility failed to care plan the use of bedrails for one (#42) of three sampled resident reviewed for accidents.</p> <p>The ADON identified 10 residents had some form of bed rail attached to their beds.</p> <p>Findings:</p> <p>A care plan, dated 05/23/24, did not include a problem, goal, or intervention regarding the safe use of bedrails.</p> <p>On 09/11/24 at 12:38 p.m., Resident #42's assigned bed was observed to have a full side rail attached to each side.</p> <p>On 09/11/24 at 12:46 p.m., CNA #2 stated Resident #42 had used a bed with bedrails for about six months.</p> <p>On 09/11/24 at 1:39 p.m., the ADON stated they had reviewed Resident #42's current care plan. They stated the resident's use of bedrails was not care planned. They stated the bedrails should have been care planned.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>30267</p> <p>Based on observation, interview, and record review, the facility failed to provide showers as scheduled for one (#50) of two sampled residents whose clinical records were reviewed for ADL care for dependent residents.</p> <p>A facility census list, dated 09/08/24, documented 61 residents resided in the facility.</p> <p>Findings:</p> <p>On 09/08/24 at 11:45 a.m., Resident #50 was observed in bed. The resident's hair was long and appeared tangled and greasy.</p> <p>On 09/08/24 at 11:45 a.m., Resident #50 stated they were scheduled for two showers per week, but only received one a week. The resident stated they usually did not receive their shower scheduled for the weekend.</p> <p>The resident's clinical record was reviewed and documented they were scheduled to receive showers on Wednesdays and Saturdays. There was no documentation the resident was offered/received showers on 08/10/24, 08/17/24, 08/24/24, or 08/31/24 (all Saturdays).</p> <p>On 09/11/24 at 9:00 a.m., the ADON stated there should be a shower sheet filled out even if the resident refused. The ADON stated they needed to educate the weekend staff on ADL care and charting.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34270</p> <p>Based on observation, record review, and interview, the facility failed to provide a care plan intervention for contracted hands of one (#6) of 24 sampled residents reviewed for the presence of contractures.</p> <p>The ADON identified five residents had contractures.</p> <p>Findings:</p> <p>A care plan problem for bilateral contracted hands, updated 06/04/24, documented the resident was to have contracture cushions or rolled rags in their hand if possible.</p> <p>On 09/08/24 at 12:32 p.m., Resident #6 was observed sitting in the dining room. Both of their hands appeared to be contracted. Neither hand had a device or material to protect and support their contracted hands.</p> <p>On 09/10/24 at 7:33 a.m., Resident #6 was observed in their room watching television. Both hands of the resident appeared contracted. There was nothing in either hand to protect or support the hands.</p> <p>On 09/10/24 at 1:56 p.m., RN #1 stated Resident #6 did have two contracted hands.</p> <p>On 09/11/24 at 11:12 a.m., CNA #1 stated the staff sometimes put rags in Resident #6's hands. They stated the resident did not have anything in their hand at that time. They stated they did not know if the rags were care planned.</p> <p>On 09/11/24 at 11:16 a.m. RN #1 stated the resident did not currently have rags in their hand. They stated there was no order for the rags and they were unaware if the rags were care planned.</p> <p>On 09/11/24 at 12:14 p.m., RN #1 stated they had got an order for the rolled rags to be place in the resident's hands.</p> <p>On 09/11/24 at 2:12 p.m., the ADON stated the rolled rags should have been placed in the resident's hands as they were care planned. They stated the staff had not been following the resident's care plan.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>30267</p> <p>Based observation, interview, and record review, the facility failed to provide dietary interventions as ordered by the physician and/or documented in the plan of care for two (#19 and #50) of two sampled residents whose clinical records were reviewed for nutrition.</p> <p>A facility census list, dated 09/08/24, documented 61 residents resided in the facility.</p> <p>Findings:</p> <p>1. Resident #19 had diagnoses which included end stage renal disease.</p> <p>The care plan, updated 05/09/24, documented the resident had the potential for alteration in nutrition status related to end stage renal disease. The facility interventions were to encourage the resident to follow the diet as planned and ordered by the physician, monitor weight, educate on diet, monitor appetite, diet consultant to monitor diet monthly, monitor labs and report results to physician, administer medications as ordered, and provide low sodium diet. It was documented the resident was on a regular renal diet with low sodium. The facility interventions were to serve the diet as ordered and offer substitutions if less than 75% was eaten, monitor/discuss food preferences, offer snacks within the resident's dietary limitations, obtain weights as ordered, remind and encourage the resident to follow the prescribed diet, and provide supplement of Nova Source renal [meal supplement] as ordered.</p> <p>A dialysis communication form, dated 06/28/24, documented the resident was to receive a diet with less phosphorus and no calcium.</p> <p>A dietary communication form, dated 06/28/24, documented the resident was to receive less phosphorus foods and no calcium.</p> <p>The monthly physician's orders, dated 08/01/24, documented no diet ordered for Resident #19.</p> <p>On 09/10/24 at 1:25 p.m., the DM stated all residents received the same meal or an alternate of their choosing from a list of soup, salad, grilled cheese, or a peanut butter and jelly sandwich. The DM stated it was the residents responsibility to make appropriate meal choices for their diet. The DM observed the dietary communication form dated 06/28/24. They stated the facility was not meeting the resident's nutritional needs.</p> <p>On 09/11/24 at 12:35 p.m., the ADON stated there were orders to limit the resident's phosphorus and calcium intake back in June and there was a communication form sent to dietary. The ADON stated they were not sure how dietary orders were followed. The ADON stated with the liberal diet and the alternate choices available, Resident #19 did not have the options for meal choices to limit the calcium and phosphorus intake. The ADON stated they were not accommodating the resident's dietary needs.</p> <p>2. Resident #50 had diagnoses which included spina bifida and pressure ulcers.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The August 2024 monthly physician's orders documented the resident was to receive double portions of protein.</p> <p>On 09/08/24 at 11:45 a.m., Resident #50 stated they did not receive double portions of protein on their meal trays or the protein drink with each meal. They stated they now purchase their own protein drinks to supplement their intake. They stated they did not think it was right to have to buy supplements when they were to receive supplements with each meal.</p> <p>On 09/08/24 at 1:20 p.m., the midday meal was observed on the resident's overbed table. There were four small beef tips in brown gravy on the resident's plate. Each were roughly the size of a half dollar. The resident's diet card located on their meal tray documented the resident was to receive double portions of protein.</p> <p>On 09/10/24 at 12:55 p.m., the noon meal was observed on the resident's overbed table. There was one bratwurst link on their plate. The resident's diet card located on their meal tray documented the resident was to receive double portions of protein.</p> <p>On 09/11/24 at 8:50 a.m., the DM stated the serving size for the prior days lunch was one link. The DM was asked about the above observations. The DM stated the resident did not receive double portions of protein as ordered and they thought staff overlooked the order on the diet card.</p> <p>On 09/11/24 at 12:35 p.m., the ADON was asked about the above observations. The ADON stated they did not follow the physician's order for double portions of protein for wound healing.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>30267</p> <p>Based on interview and record review, the facility failed to perform a post dialysis assessment for one (#19) of one sampled resident who was reviewed for dialysis.</p> <p>The ADON identified one resident who required dialysis.</p> <p>Findings:</p> <p>Resident #19 had diagnoses which included end stage renal disease.</p> <p>The August 2024 monthly physician's orders documented the resident was to attend dialysis three times a week.</p> <p>The pre/post dialysis communication reports, dated 08/02/24, 08/05/24, 08/07/24, 08/09/24, 08/19/24, 08/21/24, 08/23/24, 08/26/24, 08/28/24, 08/30/24, 09/02/24, 09/04/24, 09/06/24, and 09/09/24, documented the pre-dialysis assessment and the section for communication from the dialysis unit were completed, but there was no documentation of a post dialysis assessment on the form.</p> <p>On 09/11/24 at 11:19 a.m., RN #1 stated the post dialysis assessment included checking the resident's weight, vital signs, dialysis site, and bruit. They stated the dialysis pre/post assessments were kept in a dialysis log book which traveled with the resident to dialysis and back to aide with communication between the dialysis center and the facility. RN #1 reviewed the documentation in the resident's dialysis log book and stated the nurses' had not performed the post dialysis assessment.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>34270</p> <p>Based on observation, record review, and interview, the facility failed to attempt alternatives to the use of bed rails and obtain informed consent for the use of bed rails prior to their use for one (#42) of three sampled residents reviewed for accident hazards.</p> <p>The ADON identified 10 residents at the facility had some form of bed rail attached to their beds.</p> <p>Findings:</p> <p>A facility Bed Safety policy, dated 12/2007, read in part, If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation of the Attending Physician, and input from the resident and/or legal representative. The policy further reads, The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use.</p> <p>Resident #42 had diagnoses which included Alzheimer's disease and atherosclerosis.</p> <p>A quarterly assessment, dated 05/16/24, documented Resident #42's cognition was severely impaired.</p> <p>On 09/11/24 at 12:38 p.m., Resident #42 was observed to have bedrails attached to both sides of their bed.</p> <p>At 12:46 p.m., CNA #2 stated the resident had the bedrails on their bed for about six months. They stated they had not observed or heard of the resident attempting to get out of their bed unassisted for the past two months.</p> <p>On 09/11/24 at 1:20 p.m., the ADON confirmed Resident #42 had bedrails attached to their bed. They stated they were unable to locate documentation the resident's representative had been educated on the use of bedrails and given the opportunity to give written consent. They stated there was no documentation of less restrictive interventions having been attempted in the resident's medical records. They stated they understood the dangers associated with the use of bedrails.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to employ a full time DON.</p> <p>The administrator identified 61 residents resided in the facility.</p> <p>Findings:</p> <p>An undated facility policy, titled Nursing Services - Staffing , documented the facility would maintain a full time licensed RN or LPN as the director of nursing.</p> <p>On 09/08/24 at 8:51 a.m., the BOM stated the facility did not have a full time DON. They stated the DON had quit their position about three weeks prior to the survey. They stated the organization was actively advertising for a new DON.</p> <p>On 09/08/24 at 9:40 a.m., the administrator provide a letter that stated the former DON had resigned suddenly via text message on 08/26/24. They stated they were advertising for a new DON. They stated they had not assigned the DON's duties to another RN since the former DON had resigned.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure GDR requests were attempted and/or addressed by the physician for two (#37, and #49) of five sampled residents reviewed for unnecessary medications.</p> <p>A Consultant Pharmacist Activity Report dated 09/11/24 documented 48 residents were receiving psychotropic medications.</p> <p>Findings:</p> <p>1. Resident #37 had diagnoses which included PTSD and major depressive disorder.</p> <p>A physician's order, dated 03/16/23, documented Resident #37 was to receive 150 mg of venlafaxine xr (antidepressant medication) by mouth every day.</p> <p>A physician's order, dated 03/16/23, documented Resident #37 was to receive 30 mg of mirtazapine (antidepressant medication) by mouth at bedtime.</p> <p>A physician's order, dated 04/05/23, documented the resident was to receive 10 mg of buspirone (antianxiety medication) by mouth three times a day.</p> <p>A quarterly assessment, dated 6/14/24, documented Resident #37 had routinely received antidepressant medications and an antianxiety medication.</p> <p>A review of Resident #37's medical records did not document any GRD's had been attempted for resident #37.</p> <p>On 09/11/24 at 12:34 pm, the ADON stated no GDR's had been located for Resident #37.</p> <p>2. Resident #49 had diagnoses which included unspecified dementia and anxiety disorder.</p> <p>A physician's order, dated 01/12/24, documented Resident #49 was to receive 0.75 mg of risperidone (antipsychotic medication) by mouth twice a day.</p> <p>A physician's order, dated 01/12/24, documented the resident was to receive 75 mg of sertraline (antidepressant medication) by mouth every day.</p> <p>A quarterly assessment, dated 05/03/24, documented Resident #49 routinely received an antipsychotic medication and an antidepressant medication.</p> <p>A GDR, dated 08/30/24, recommended a dose reduction be attempted for risperidone 0.75mg twice a day. There was no documentation that the physician had addressed the GDR.</p> <p>A review of Resident #49's medical records did not document any other GDR's for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/11/24 at 12:34 pm, the ADON stated no other GDR's had been located for Resident #49.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to culture a urine sample prior to prescribing and administering an antibiotic for one (#9) of 24 sampled residents reviewed for the use of antibiotics.</p> <p>The ADON identified 17 residents who had been prescribed antibiotics in the past 90 days.</p> <p>Findings:</p> <p>A laboratory report documented a sample of Resident #9's urine was collected on 07/10/24. The report documented an abnormal finding including high nitrate and white blood cell levels. The report also documented a note that stated a culture of the urine was indicated, but had not been ordered. On the bottom of the first page of the laboratory report was a hand written note which documented, Macrobid [antibiotic medication] 100 mg BID X 7 days. The hand written entry was noted by RN #1 on 07/16/24.</p> <p>A July 2024 MAR documented the resident had been administered Macrobid 100 mg orally for seven days starting on 07/16/24.</p> <p>On 09/09/24 at 7:36 a.m., Resident #9 stated they were taking an antibiotic medication.</p> <p>On 09/10/24 at 8:27 a.m., the ADON stated the resident was no longer being administered an antibiotic.</p> <p>On 09/10/24 at 1:15 p.m., the ADON confirmed a culture had not been performed to determine the organism causing the infection of what antibiotics would be effective against that organism. They stated it was best practice to make those determinations prior to administering antibiotics, but it looked like it was not done in that case.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to ensure a resident who received an antipsychotic medication had an appropriate diagnosis/indication for the use of the medication for one (#49) and failed to ensure a PRN psychotropic medication was limited to 14 days for one (#42) of five sampled residents reviewed for unnecessary medications.</p> <p>A Consultant Pharmacist Activity Report dated 09/11/24 documented 48 residents received psychotropic medications.</p> <p>Findings:</p> <p>1. Resident #42 had diagnoses which included anxiety.</p> <p>A Consultant Pharmacist Communication to Physician, dated 08/29/24, read in part, PRN Psychotropics: 14 day limitation on all PRN orders. The orders may be extended beyond 14 days if the attending physician or prescribing practitioner: 1.) Believes it is appropriate to extend the order 2.) Documents clinical rationale for the extension 3.) Provides a specific duration. The document provided a section for a practitioner to provide a rationale and signature. The form did not have a rationale or physician's signature.</p> <p>A September 2024 MAR documented an order for Ativan (antianxiety medication) 2 mg tablets to have been administered to Resident #42 every 4 hours as needed. The order had a start date of 02/19/24. The order did not have an end date. The record documented the resident had received three doses of the medication in during the month.</p> <p>2. Resident #49 had diagnoses which included unspecified dementia and anxiety disorder.</p> <p>A quarterly assessment, dated 05/03/24, documented Resident #49 routinely received an antipsychotic medication.</p> <p>A physician's order, dated 01/12/24, documented Resident #49 was to receive risperidone (antipsychotic medication) 0.75 mg by mouth twice a day for unspecified dementia.</p> <p>On 09/11/24 at 12:34 p.m., the ADON stated dementia was not an appropriate diagnosis for an antipsychotic medication.</p> <p>On 09/11/24 at 1:17 p.m., the ADON stated they understood the regulation regarding the use of PRN Ativan and the requirement for a rationale for extended use beyond 14 days.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>30267</p> <p>Based observation, record review, and interview, the facility failed to provide a therapeutic diet as ordered by the physician and/or documented in the plan of care for two (#19 and #50) of two sampled residents whose diets were reviewed.</p> <p>A facility census list, dated 09/08/24, documented 61 residents resided in the facility.</p> <p>Findings:</p> <p>1. Resident #19 had diagnoses which included end stage renal disease.</p> <p>The care plan, updated 05/09/24, documented the resident had the potential for alteration in nutrition status related to end stage renal disease. The facility interventions were to encourage the resident to follow the diet as planned and ordered by the physician, monitor weight, educate on diet, monitor appetite, diet consultant to monitor diet monthly, monitor labs and report results to physician, administer medications as ordered, and provide low sodium diet. It was documented the resident was on a regular renal diet with low sodium. The facility interventions were to serve the diet as ordered and offer substitutions if less than 75% was eaten, monitor/discuss food preferences, offer snacks within the resident's dietary limitations, obtain weights as ordered, remind and encourage the resident to follow the prescribed diet, and provide supplement of Nova Source renal [meal supplement] as ordered.</p> <p>A dialysis communication form, dated 06/28/24, documented the resident was to receive a diet with less phosphorus and no calcium.</p> <p>A dietary communication form, dated 06/28/24, documented the resident was to receive less phosphorus foods and no calcium.</p> <p>The monthly physician's orders, dated 08/01/24, documented no diet ordered for Resident #19.</p> <p>On 09/10/24 at 1:25 p.m., the DM stated all residents received the same meal or an alternate of their choosing from a list of soup, salad, grilled cheese, or a peanut butter and jelly sandwich. The DM stated it was the residents responsibility to make appropriate meal choices for their diet. The DM observed the dietary communication form, dated 06/28/24, and stated the facility was not meeting the resident's nutritional needs.</p> <p>On 09/11/24 at 12:35 p.m., the ADON stated there were orders to limit the resident's phosphorus and calcium intake back in June. They stated there was a communication form sent to dietary. They stated they were not sure how dietary orders were followed. They stated with the liberal diet and the alternate choices available, Resident #19 did not have the options for meal choices to limit the calcium and phosphorus intake. The ADON stated they were not accommodating the resident's dietary needs.</p> <p>2. Resident #50 had diagnoses which included spina bifida and pressure ulcers.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The August 2024 monthly physician's orders documented the resident was to receive double portions of protein.</p> <p>On 09/08/24 at 11:45 a.m., Resident #50 stated they did not receive double portions of protein on their meal trays nor the protein drink with each meal. They stated they now purchase their own protein drinks to supplement their intake. They stated they did not think it was right to have to buy supplements when they were to receive supplements with each meal.</p> <p>On 09/08/24 at 1:20 p.m., the midday meal was observed on the resident's overbed table. There were four small beef tips in brown gravy on the resident's plate. Each roughly the size of a half dollar. The resident's diet card documented the resident was to receive double portions of protein.</p> <p>On 09/10/24 at 12:55 p.m., the noon meal was observed on the resident's overbed table. There was one bratwurst link on the resident's plate. The resident's diet card located on their meal tray documented the resident was to receive double portions of protein.</p> <p>On 09/11/24 at 8:50 a.m., the DM stated the serving size for the prior days lunch was one link. The DM was asked about the above observations. The DM stated the resident did not receive double portions of protein as ordered. They stated they thought staff overlooked the order on the diet card.</p> <p>On 09/11/24 at 12:35 p.m., the ADON was asked about the above observations. The ADON stated they did not follow the physician's order for double portions of protein for wound healing.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>30267</p> <p>Based on record review and interview, the facility failed to:</p> <ul style="list-style-type: none"> a. update the dietary menu, b. offer nutritionally equivalent alternatives to planned meals, and c. have a RD review the menus for nutritional adequacy. <p>The DM identified 61 residents who ate meals from the kitchen.</p> <p>Findings:</p> <p>On 09/10/24 at 11:05 a.m., the extended menus were requested from the DM. The DM stated they were new to the position and did not know where to find the extended menu. They stated they received the week's menu from the BOM.</p> <p>On 09/10/24 at 12:35 p.m., the BOM and DM located the extended menu on a small flat bar above the steam table. The extended menu cover was dated November 2022.</p> <p>On 09/10/24 at 12:35 p.m., the BOM stated the residents complained they were continually receiving the same meals. The BOM stated they requested current menus from the company representatives, but never received the new menus. The BOM stated they started creating the weekly menus and/or substitutions the facility used based on the November 2022 menu and meals the residents requested. The BOM stated the old menus were reviewed and approved by the RD, but the facility created menus/substitutions were not reviewed or approved by the RD.</p> <p>On 09/11/24 at 8:50 a.m., the DM stated if a resident did not want what was served for the meal, they could request soup, salad, grilled cheese, or a peanut butter sandwich from the alternate menu. The DM stated the alternate menu was not nutritionally equivalent to the served meals.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30267</p> <p>Based on observation and interview, the facility failed to:</p> <ul style="list-style-type: none"> a. follow standards of practice in meal service; b. serve meals in a sanitary manner; and c. utilize professional grade equipment in the kitchen. <p>The BOM identified 61 residents who ate meals prepared and served in the kitchen.</p> <p>Findings:</p> <p>1. On 09/08/24 at 8:20 a.m., observations were made in the kitchen. The hand washing sink was located in the corner of the kitchen and was blocked by a mop, bucket, and a covered trash can. Above the hand washing sink was a rack with cooking utensils hanging downward from the edge of a rack, blocking access to the hand washing sink.</p> <p>On 09/08/24 at 8:25 a.m., [NAME] #1 was observed to plate food for multiple residents with their gloved hands including grabbing and splitting biscuits before placing the biscuit on the plate, reaching into the steam table pans and grabbing bacon, fried eggs, toast, and pancakes with their gloved hands. The cook did not change gloves between food items or residents. The cook was observed to touch the pre-printed resident diet cards, the plates, trays, counter tops, steam table, and their clothing while plating meals. The cook was not observed to change gloves or sanitize their hands until after the morning meal was served. The cook did not wear a beard guard.</p> <p>On 09/08/24 at 9:10 a.m., the dish machine was observed. [NAME] #1 repeatedly ran the dish machine without reaching the minimum required wash/rinse water temperature of 120 degrees Fahrenheit. [NAME] #1 checked the disinfectant level multiple times without the litmus paper changing color, signifying no disinfectant was applied to the dishes. [NAME] #1 stated they were unsure of the required water temperatures and concentration of sanitizing agent in a three compartment sink.</p> <p>On 09/08/24 at 9:50 a.m., DA #1 was observed washing dishes through the dish machine. They stated the maintenance supervisor told them they could add sanitizing agent to the dish machine manually by pouring sanitizing agent into the bottom of the dish machine. The DA was observed to take an open cup they identified as the sanitizing agent and poured it into the bottom of the dish machine as the machine continued to run. Once the dish machine completed the cycle, litmus paper was used to check the level of disinfectant. There was no change in color to the litmus paper.</p> <p>On 09/08/24 at 10:00 a.m., the maintenance supervisor stated kitchen staff would need to use the three compartment sink to clean the dishes until the dish machine could be serviced.</p> <p>On 09/10/24 at 11:30 a.m., the DM stated the dish machine was serviced and the pump for the sanitizing agent was replaced.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/10/24 at 11:50 a.m., DA #3 was observed with gloves on to cut a sheet pan of brownies with a knife. They plated each serving of brownies using the side of the knife as a spatula and holding the brownie with their gloved hand as they plated it. The DA was observed to touch the other items with their gloved hand, including the countertop, baking sheet, knife/utensils, small plates, and kitchen towel while plating food.</p> <p>On 09/10/24 at 12:15 p.m., DA #2 was observed to plate food. The DA used their gloved hands to open the lid and grab packaged items from cool storage, and held/touched the individual resident meal tickets, utensils, plates, trays, and steam table. With the same gloved hands the DA was observed to grab bread from the package to serve.</p> <p>On 09/10/24 at 12:45 p.m., DA #2 stated they had helped to serve food from a steam table a few times, but had not been trained how to do so. They stated they felt nervous being watched as they served.</p> <p>On 09/10/24 at 12:50 p.m., the DM stated DA #2 had served from the steam table only a few times and should not have touched the bread with their gloved hands. The DM stated despite baking all morning the brownies were still gooey and difficult to cut and serve. The DM stated DA #3 should have used utensils to serve the brownies.</p> <p>2. On 09/10/24 at 12:00 p.m., the following kitchen appliances were observed to be labeled for household/residential use only:</p> <ul style="list-style-type: none"> a. a small waffle maker, b. a 6-8 quart slow cooker, c. a four slice toaster, and d. a food processor. <p>On 09/10/24 at 12:35 p.m., the BOM stated they would contact administration regarding replacing the appliances.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270</p> <p>Based record review and interview, the facility failed to ensure code status was clearly identified in residents' medical records for two (#9 and #18) of twenty four sampled residents whose medical records were reviewed.</p> <p>A facility census list, dated [DATE], documented 61 residents resided in the facility.</p> <p>Findings:</p> <p>1. Resident #9 had diagnoses which included chronic kidney disease and chest pain.</p> <p>Resident #9's medical record was reviewed. A sticker attached to the outside of the hard chart read, DNR [do not resuscitate]. A second sticker attached to the outside of the hard chart read, Full Code [which means to provide life saving measures].</p> <p>An Oklahoma Do-Not -Rescucitate (DNR) Consent Form, dated [DATE], was found inside the resident's medical record and documented they wanted to a DNR code status.</p> <p>On [DATE] at 8:10 a.m., the ADON stated the sticker which identified the resident as a full code should have been removed once the DNR form had been signed. They stated they did have a policy and procedure that stated in such cases the staff was to look in the chart for the paperwork that stated the code status. They stated the presence of both stickers on the outside of the chart was a problem that should have been caught by staff. The code status policy was not provided.</p> <p>On [DATE] at 8:17 a.m., RN #1 stated the most convenient way they determined code status was to look at the stickers on the outside of each chart. They stated if the sticker was not there they were to look in the chart or in a binder at the nurses station that had each resident's code status.</p> <p>42171</p> <p>2. Resident #18 had diagnoses which included muscular dystrophy and vascular dementia.</p> <p>A face sheet, with an admitted [DATE], documented the resident was a full code.</p> <p>Physician orders, dated ,d+[DATE], documented Resident #18's code status was full code.</p> <p>Stickers on the front cover and the spine of Resident #18's medical record indicated the resident was a full code.</p> <p>A Certification of Physician section of Resident #18's DNR form indicated the physician certified Resident #18 would not have consented to the administration of CPR. This form was signed by the physician on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Forrest Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 North Choctaw Dewey, OK 74029	

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 8:18 a.m., the ADON stated Resident #18's chart and paperwork should document the resident had a DNR in place.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to provide direct care staff information to CMS in the required time frame.</p> <p>The administrator identified 61 residents resided at the facility.</p> <p>Findings:</p> <p>A PBJ report for the third quarter of 2024 documented direct care staffing data had not been received by CMS.</p> <p>On 09/10/24 at 7:40 a.m., the BOM stated the facility administrator was responsible for sending the staffing data to employee #1 who worked at corporate headquarters. They stated employee #1 was the person who sent the data to CMS.</p> <p>On 09/10/24 at 10:55 a.m., the administrator stated employee #1 was responsible for sending the staffing data to CMS.</p> <p>On 09/10/24 at 11:05 a.m., Employee #1 stated they had sent the data to CMS, but did not have the documentation to prove it.</p> <p>On 09/10/24 at 11:17 a.m., the administrator stated they were aware of the time frame for turning in the staffing data to CMS and they believed they had done so timely. They stated the problem may be that their company used standard calendar based quarters while the government did not.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171</p> <p>Based on record review and interview, the facility failed to consistently monitor for trends related to infectious disease.</p> <p>The ADON identified the census was 61.</p> <p>Findings:</p> <p>A policy titled [NAME] Manor Nursing Facility Infection Control Policy and Procedure, updated 05/23/22, read in part, .Facility has established an infection control program under which it .Investigates, controls and prevents infections in the facility .</p> <p>A review of the facilities infection surveillance documentation for 2024 did not document the facility had been tracking infectious disease or looking for trends related to infectious diseases for 01/24, 02/24 or 03/24.</p> <p>On 09/11/24 at 12:34 p.m., the ADON stated there were was no documentation infection surveillance could be located for 01/24, 02/24, or 03/24.</p>

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NAME OF PROVIDER OR SUPPLIER Forrest Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 North Choctaw Dewey, OK 74029	
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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>34270</p> <p>Based on observation, record review, and interview, the facility failed to inspect the bed and bedrails of a resident prior to the use of bedrails for one (#42) of three sampled resident reviewed for accident hazards.</p> <p>The ADON identified 10 residents at the facility had some form of bed rail attached to their beds.</p> <p>Findings:</p> <p>A facility Bed Safety policy, dated 12/2007, read in part, To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories) the facility shall promote the following : a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks.</p> <p>On 09/11/24 at 12:38 p.m., Resident #42's assigned bed was observed to have a full side rail attached to each side.</p> <p>On 09/11/24 at 12:41 p.m., CNA #2 stated Resident #42 did have full bedrails on their bed. They stated the resident was moved to their currently assigned room about six months prior to the survey. They stated the bed had rails attached. They stated the resident did not have bedrails attached to the bed they had been using before the move.</p> <p>On 09/11/24 at 1:40 p.m., the maintenance supervisor stated they had not been performing bed or bedrail safety inspections prior to the use of bedrails by the residents. They stated Resident #42's bed had not been inspected for safety.</p> <p>On 09/11/24 at 1:20 p.m., the ADON stated they were aware of the dangers of using bedrails and they would make improvements.</p>		