STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375504	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North County Center for Nursing and Rehabilitation	2300 West Broadway Collinsville, OK 74021

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42171 Based on observation, record review, and interview, the facility failed to ensure physician orders were followed in relation to wound care for one (# 7) of three residents reviewed for wound care. The administrator reported the census was 41. Findings: An undated facility policy titled Wound Care read in part, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .Verify that there is a physician's order for this procedure .Report other information in accordance with facility policy and professional standards of practice . Resident #7 had diagnoses which included a pressure ulcer of the sacral region and diabetes mellitus. An admission assessment, dated 11/24/23, documented Resident #7 was cognitively intact and was dependent on staff for transfer. A physician order, dated 02/20/24, documented the sacral wound was to be cleaned with normal saline and a wound vac was to be applied. A Wound Evaluation and Management Summary, dated 03/14/24, documented the wound vac on the sacral wound was to be discontinued and the wound was to be covered with an abdominal pad and gauze. On 03/26/24 at 10:11 a.m., Resident #7 was observed in their room, the wound vac was at the bedside but did not appear to be on. On 03/26/24 at 10:11 a.m., Resident #7 stated that the wound vac had been off since Saturday. The resident stated the nurse working Saturday was unfamiliar with wound vacs and the nurse reported to Resident #7 they would get the other nurse to assist, but never returned. On 03/26/24 at 12:45 p.m., LPN #1 stated that sometimes the wound vac comes off or gets soiled and has to be removed and the nurse on duty is not able to put it back on. LPN #1 also stated they were not sure if the wound vac was supposed to have been discontinued on 03/14/24. They further stated they would contact the wound physician for clarification. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/26/24 at 1:30 p.m., the DON stated the nurse that accompanied the wound physician was responsible for putting orders into the resident's medical record. On 03/27/24 at 10:51 a.m., CNA #1 stated that they had provided care for Resident #7 on 03/26/24 and the wound vac had not been in place all day. They also stated that the wound vac came off all the time. On 03/27/24 at 11:35 a.m., the DON stated the charge nurses were responsible for ensuring the wound vac was in place and functioning properly. They also stated that the wound vac had not been discontinued until 03/26/24.