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	08/06/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure an antipsychotic medication was not prescribed for the diagnosis of dementia for 1 (#25) of 5 sampled residents reviewed for unnecessary medications.The DON identified five residents were prescribed antipsychotic medications.Findings:A facility policy titled Antipsychotic Medication Use, dated April 2007, read in part, Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.A medication administration record for Res #25, dated 08/01/25 through 08/31/25, showed the resident had been prescribed Seroquel (an antipsychotic) 25mg tablets once in the morning and once at bedtime for unspecified dementia with unspecified severity, with other behavioral disturbances and anxiety. The record showed the resident had been administered the medication twice each day on 08/01/25, 08/02/25, 08/03/25, 08/04/25, and one dose on 08/05/25.On 08/05/25 at 11:49 a.m., CMA #3 was asked if they knew the reason Res #25 was being administered Seroquel. They stated the only behavior they were aware of was the resident would try to leave the facility and often say they needed to be somewhere.On 08/05/25 at 12:01 p.m., licensed practical nurse #1 was asked the reason Res #25 had been prescribed Seroquel. They stated they were prescribed the medication for dementia, behavioral disturbances, and anxiety. They stated the resident would often try to leave the facility stating they needed to go to work.On 08/05/25 at 12:16 p.m., the DON was asked the reason Res #25 was prescribed Seroquel. They stated the resident had been taking the medicine since admission for dementia with behaviors. The DON stated they were aware CMS did not approve the use of Seroquel as a treatment for dementia. They stated they would contact the physician about assigning an appropriate diagnosis for the medicine or ending its use.

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an MDS discharge assessment record was transmitted in the required timeframe for 1 (#1) of 14 sampled residents reviewed for MDS assessments.The DON identified 44 residents required MDS assessments to be completed at the facility.Findings:A facility policy titled Electronic Transmission of the MDS, dated [DATE], read in part, All MDS assessments (eg. [for example], admission, annual, significant change, quarterly review, etc. [et cetera]) and discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES [Quality Improvement and Evaluation System] Assessment Submission and Processing (ASAP) system in accordance with current OBRA [Omnibus Budget Reconciliation Act] regulations governing the transmission of MDS data.An undated Transfer/Discharge Report, for Res #1 showed the resident had been discharged from the facility on 03/01/25.On 08/05/25 at 10:33 a.m., the MDS section of Res #1's EMR was reviewed and showed an MDS discharge record, dated 03/01/25, had been completed, but not transmitted.On 08/05/25 at 10:36 a.m., MDS coordinator #1 was asked to describe their process regarding MDS assessments and records. They stated they put together the documents from various sources and assessments they perform. They stated the DON then signed them and the assessments were exported. They were asked to review the MDS section of Res #1's EMR and describe what they found. They stated the discharge records for Res #1 had been completed but not exported. They stated they had made an error by not exporting the document. They stated they understood the MDS process very well and that was an error on their part.On 08/05/25 at 10:58 a.m., the DON was asked to describe their part in the MDS process. They stated they reviewed and signed each MDS as they become due. They were shown Res #1's discharge records from 03/01/25 and asked to comment on what they saw. They stated the record had not been exported. They stated they had not been looking at reports regarding if MDS records had been exported or were incomplete. They stated they had minimal training in the MDS process.On 08/05/25 at 11:03 a.m., corporate nurse consultant #1 was asked about their role in the MDS process. They stated they had been on the job only a few days. They stated their plan for their part in the process was to randomly audit two medical records each week but, considering Res #1's discharge record they would reconsider the number and frequency of their audits.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure staff followed infection control practices between residents while administering medications for 3 (#9, 17, and #23) of 8 sampled residents reviewed for medication administration.The DON identified 43 residents were administered medications by facility staff.Findings:On 08/05/25 at 3:53 p.m. CMA #1 was observed going to their medication cart and preparing medications for Res #23. CMA #1 did not sanitize or wash their hands prior to preparing the medications. CMA #1 was then observed taking the plastic cup that contained Res #23's medication, hydrocodone/acetaminophen (pain medication) 7.5 mg / 325 mg tablet and handing it to Res. #23. Res #23 was observed placing the cup to their mouth and taking the medication. The resident was then observed returning the empty medication cup to CMA #1. On 08/05/25 at 3:57 p.m. CMA #1 was observed going to their medication cart and preparing medications for Res #17 directly after returning from administering medications to Res #23. CMA #1 did not sanitize or wash their hands prior to preparing medications. CMA #1 was then observed taking the plastic cup that contained Res #17's medications baclofen (muscle relaxant) 20 mg tablet, cyclobenzaprine (muscle relaxant) 10 gm tablet, and gabapentin (an anticonvulsant) 300 mg capsule and handing Res #17 the cup. CMA #1 assisted Res #17 take the medication into their mouth. On 08/05/25 at 4:05 p.m. ÇMA #1 was observed going to their medication cart and preparing medications for Res #9 directly after administering medications to Res #17. CMA #1 did not sanitize or wash hands prior to preparing the medication. CMA #1 was the observed preparing Res #9's medications guaifenesin (an expectorant) 100 mg / 5 mg syrup and sucralfate (a gastric protective agent) 1000 mg tablet. CMA #1 was then observed assisting the resident from the laying position to an upright position and then assisted the resident to place the medication into their mouth.A facility policy titled Infection Control Guidelines for All Nursing Procedures, dated 01/2008 read in part, Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions.e. After handling items potentially contaminated with blood, body fluids, or secretions;A facility policy titled Medication Administration,' dated 2022, showed staff members that administered medications to residents were to wash their hands prior to administering medications.A medication administration record for Res #9, dated 08/01/25 through 08/31/25, showed the resident had been ordered guaifenesin oral syrup 100 mg/ 5 ml at a dose of 20 ml to be taken by mouth every six hours and sucralfate 1000 mg tablet to be taken by mouth every six hours. A medication administration record for Res #17, dated 08/01/25 through 08/31/25, showed the resident had been ordered baclofen 20 mg tablet to be taken by mouth every six hours, cyclobenzaprine 10 mg tablet to be taken by mouth every six hours, and gabapentin 300 mg capsule to be taken every six hours.A medication administration record for Res #23, dated 08/01/25 through 08/31/25, showed the resident had been ordered hydrocodone/acetaminophen 7.5 mg / 325 mg tablet to be taken by mouth every eight hours.On 08/06/25 at 10:44 a.m., the DON stated that each CMA working at the facility had completed training regarding medication administration and infection control. They stated they were trained on hire and annually and knew to clean their hands between residents.