

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375505	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2024
NAME OF PROVIDER OR SUPPLIER  Magnolia Creek Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE  2610 Cedar Creek Drive Altus, OK 73521	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>48344</p> <p>Based on observation and interview, the facility failed to ensure the call light was in reach for one (#2) of three sampled residents reviewed for timely call lights.</p> <p>The DON identified 82 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #2 had diagnoses which included legal blindness.</p> <p>Resident #2's annual assessment, dated 02/22/24, documented the resident's vision was severely impaired and required moderate assistance with activities of daily living.</p> <p>On 09/05/24 at 7:10 p.m., Resident #2's call light was observed by the side of their drawer. The resident was sitting in a recliner. Resident #2 stated they used their call light when they needed assistance. They tried to locate the call light and could not find it. They stated, now this makes me mad. The call light was out of reach of the Resident.</p> <p>On 09/05/24 at 7:29 p.m., CMA #1 stated resident #2 used their call light and sometimes came to the door and yelled if they needed assistance. They stated the resident is blind and only able to see shadows. They stated the resident is a fall risk.</p> <p>On 09/05/24 at 7:29 p.m., CMA #1 made observation of resident #2's room and reported the resident's call light was out of their reach.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>48344</p> <p>Based on observation and interview, the facility failed to ensure a resident's bed was made and an extra mattress was store appropriately for one (#2) of three residents reviewed for homelike environment.</p> <p>The DON identified 82 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #2 had diagnoses which included legal blindness.</p> <p>On 09/05/24 at 7:00 p.m., Resident #2 stated their bed was not made. They stated it had been like that for days. There were two pillows without pillowcases and two personal pillows. There was a spare mattress in the resident's room by a wall table.</p> <p>On 09/05/24 at 7:33 p.m., CMA #1 made observation of Resident #2's room.</p> <p>On 09/05/24 at 7:38 p.m., CMA #1 stated the resident's bed was not made. They stated beds were supposed to be always made. They stated they were not sure why the extra mattress was in the resident's room and the resident was a fall risk.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873</b></p> <p>Based on record review and interview, the facility failed to ensure wound care was performed, following physician orders, for one (#5) of three residents reviewed for wound care.</p> <p>The DON reported 82 residents resided in the facility.</p> <p>Findings:</p> <p>A policy Skin and Wound Care Guidelines, not dated, documented Medical treatments will be ordered by a physician or their designee and transcribed onto the treatment record. The licensed nurse will document each time the treatment is completed.</p> <p>Resident #5 had diagnoses which included right femur fracture. The resident was admitted to the facility on [DATE].</p> <p>A physician order for resident #5, dated 08/13/24, documented Cleanse surgical wound to right hip with wound cleanser, pat dry with 4 X 4' s', apply silver dressing to site every 5 days/PRN until healed.</p> <p>Resident #5's treatment administration record documented silver dressing was applied to right hip on 08/13/24.</p> <p>Resident #5's medical record was reviewed and documented no new wound care order for 08/15/24. The medical record documented no reason the silver dressing was not used for resident #5's right hip surgical incision on 08/15/24.</p> <p>A comprehensive assessment, dated 08/18/24, documented resident #5's cognition was intact and required substantial/maximal assistance from staff for most activities of daily living.</p> <p>A physician visit note, dated 08/16/24, read in part, .Patient (resident #5) is here for evaluation of right hip drainage for possible post-op infection .Date of surgery was 08/09/24 .Patient presents with saturated bordered gauze dressing over main incision .Drainage is serous in color .Patient states they have only changed the dressing twice since surgery .They are not using the ordered silver dressing due to cost .The bordered gauze dressing are causing severe skin breakdown around the surgical site.,Plan: There are no signs or indications of any active infections .Patient was told they were unable to use Optifoam silver dressings due to cost at their facility .Facility called and spoke with the director of nursing at [name removed]. The DON informed that they do have the Optifoam silver dressings and that moving forward the will only be using the dressings.</p> <p>On 09/10/24 at 9:45 a.m., resident #5 reported the hospital sent her with the silver dressings for wound care to the surgical site. The resident reported the nurses would not use the silver dressing, they told her the dressings were too expensive. The resident reported making the nurses aware the silver dressing had been brought from the hospital for the facility to use. The resident reported the dressing the staff used stuck to the surgical wound and at the first post op visit with the physician, the skin pulled off around the staples.</p> <p>(continued on next page)</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>On 09/10/24 at 12:29 p.m., LPN #1 reported the facility did use the Optifoam silver dressing for residents when ordered by a physician. The LPN reported the hospital usually sent some with residents for use by the facility. The LPN reported if the ordered dressing was not used for a dressing change, it should have been charted why and what was used. The LPN reported wound care should be performed following physician orders.</p> <p>On 09/10/24 at 2:53 p.m., the DON reported the nurse that performed resident #5's wound care on 08/15/24, before the doctors appointment on 08/16/24, was not aware the resident had the Optifoam silver dressings available and applied a telfa dressing until the resident could see the doctor on 08/16/24.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41873</p> <p>Based on record review and interview, the facility failed to accurately dispense medication to a resident discharging from the facility for one (#6) of one resident reviewed for discharge.</p> <p>The DON reported 82 resident resided in the facility.</p> <p>Findings:</p> <p>The Administrator reported no facility policy related to discharge or dispensing medication at discharge.</p> <p>Resident #6 had diagnoses which included right artificial hip replacement. The resident was admitted to the facility on [DATE].</p> <p>A comprehensive assessment, dated 08/09/24, documented resident #6's cognition was intact.</p> <p>A discharge summary, dated 08/22/24, documented the resident's medications were given to the resident and their husband, and education was given on the importance of administration time.</p> <p>A form medications released on leave of absence or dismissal for resident #6, dated 08/22/24, documented the following medication and amounts sent home with the resident:</p> <p>Morphine 15 mg - 34</p> <p>Oxycodone 10 mg - 28</p> <p>Lomotil - 8</p> <p>Venlafaxine 75 mg - 4</p> <p>Multivitamin - 14</p> <p>Pravastatin 20 mg - 13</p> <p>Lisinopril 20-25 mg - 13</p> <p>Folic Acid 1 mg - 14</p> <p>Aspirin Low 81 mg - 13</p> <p>Eliquis 5 mg - 13</p> <p>Tizandine 4 mg - 18</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Vitamin D 1.25 mg - 3</p> <p>Levothyroxine 50 mcg - 10</p> <p>Hydralazine 10 mg - 30</p> <p>Promethazine 25 mg - 9</p> <p>Colace 100 mg - 20</p> <p>Loperamide 2 mg - 10</p> <p>Atarax 10 mg - 30</p> <p>Miralax PEG 3350 - 2.</p> <p>Resident #6's physician orders, dated 08/22/24, documented no order for the following medication:</p> <p>Eliquis 5 mg</p> <p>Levothyroxine 50 mcg</p> <p>Hydralazine 10 mg,</p> <p>Loperamide 2 mg</p> <p>Atarax 10 mg</p> <p>On 09/09/24 at 3:40 p.m., complainant #1 reported the facility sent resident #6 home with another resident's medication on 08/22/24. The complainant reported resident #6 called the facility and reported being given another resident's medication, along with their own medication, at discharge. The complainant reported resident #6 was told the facility would send someone to pick up the medication. The complainant reported resident #6 called back to the facility on [DATE] because the medication had not been picked up.</p> <p>On 09/10/24 at 4:45 p.m., the Administrator and DON reported they were not aware a resident had been sent home with another resident's medication.</p> <p>On 09/10/24 at 4:50 p.m., CMA #2 reported resident #6 was discharged home with their current prescribed medications and accidentally received some medication that belonged to another resident. The CMA reported resident #6 was discharged home with current medications left in stock and another resident's medication was in the same bin. The CMA reported each package of medication should have been checked for the resident's name and compared to the resident's discharge orders.</p> <p>(continued on next page)</p>

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F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 09/10/24 at 5:00 p.m., the DON reported resident #6 called the facility to inform staff of having another resident's medication. The DON stated the charge nurse called transportation and the medication was picked up. The DON reported resident #6 did not take any of the other resident's medication. The DON reported the medication should have been checked by the discharge nurse and reconciled before the resident left the facility with the medication. The DON reported the error should have been reported to the DON and the Administrator as soon as the error was found.		