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 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Creek Skilled Nursing and Therapy	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 20960 Based on observation, record review, and interview, the facility failed to notify the physician of a severe weight gain of 36 pounds (17.24 %) for one (#45) of two sampled residents reviewed for weights. The facility census was 77. Findings: A Dining Services Policies and Procedures Weight List, revised 07/09/08, read in part .Residents' weights are routinely and systematically monitored .Residents with a weight loss or gain of five percent or more, within one month, should be re-weighed and entered into PCC by the 15th of the month. The resident's physician should be notified of any Significant Weight Change in PCC A Resident's Family or Physician Notification of Change Guideline policy, dated 12-01-09, read in part The facility will inform the resident; consult with the resident's physician .of the following events .A significant change in the resident's physical, mental, or psychosocial status. (i.e. a deterioration in health, mental or psychosocial states in either life-threatening conditions or clinical complications . a need to alter treatment significantly . Resident #45 had diagnosis to include congestive heart failure and edema. A review of the weight record for Resident #45 documented the resident weighted 208.8 pounds on 05/23/24 and weighted 244.8 pounds on 06/07/24. Resident #45 had a 36 pound (17.24%) weight gain in 15 days. There was no documentation Resident #45's physician had been notified of the severe weight gain on 06/07/24. A review of the restorative weight record, dated 06/12/24, documented Resident #45 weighed 240.2 pounds. The Resident #45 continued to have a severe weight gain of 31.4 pounds (15.04%) since 05/23/24. (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: 375505	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician visit note, dated 06/13/24, read in part, .The patient presents for a follow-up visit at the nursing home per the request of the nursing staff. [The resident] complaint is persistent bilateral leg pain, which he describes as feeling like there is a fire inside. [The resident] reports having significant peripheral edema. On 06/20/24 at 2:01 p.m., the DON was asked when the physician had been notified of the 36 pound weight gain. They stated, I don't think the restorative aide put that weight in right or didn't report it to the nurse. They were asked if the physician had been notified in a timely manner. They stated depends on what timely meant but they would have notified the physician as soon as they were aware. On 06/21/24 at 10:44 a.m., the DON was asked what was Resident #45's diagnosis. They stated heart failure. They were asked to review the weights on 05/23/24 and 06/07/24 and asked how did the facility respond. They stated they had reweighed Resident #45 by the fifteenth of the month according to policy. The DON was asked if the physician had been notified on 06/15/24 when the nurse progress note documented 4+ pitting edema and edema to forearm. They stated No. They were asked if the physician had been notified when the nurse progress note documented the Resident #45 had 3+ edema to their lower legs and edema to their arms. They stated No. The DON was asked when the physician was notified. They stated the physician had been asked to see the Resident #45 on 06/13/24. 41872

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 06/21/2024
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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 41872 Based on record review and interview, the facility failed to complete a significant change assessment for one (#52) of 15 sampled residents reviewed for assessments. The facility census was 77. Findings: Resident #52 had diagnoses which included, paraplegia, and high blood pressure. An annual assessment, dated 12/25/23, documented the Resident #52 was independent with oral hygiene, needed setup or clean up assistance with shower/bathing, supervision or touching assistance with upper body dressing and partial to moderate assistance with lower body dressing. A quarterly assessment, dated 03/19/24, documented the Resident #52 required setup or clean up assistance with oral hygiene, needed partial/moderate assistance with shower/bathing and upper body dressing and needed substantial maximal assistance with lower body dressing. On 06/19/24 at 3:37 p.m., the ADON was asked to review the last two assessments dated 12/25/23 and 03/19/24 for ADL assistance. They were asked if there should have been a significant change assessment completed with the decline in two or more areas. They stated, a significant change assessment should have been 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 20960 Based on observation record review and interview, the facility failed to provide assistance with care in a timely manner for three (#12, 18 and #36) of three sampled residents reviewed. The director of nursing identified 25 residents who were totally dependent on two staff for care. Findings: 1. Resident #12 had diagnosis to include dementia, anxiety, major depression, hypertension and hyperlipidemia. Resident #12 care plan, last revised 01/24/24, read in part, .I am at risk for pressure ulcer D/T my incontinence .provide incontinent care every 2 hours as needed . A quarterly assessment, dated 04/2024, documented Resident #12 was not able to complete the brief interview for mental status interview to determine cognition, and was always incontinent of bowel and bladder. Resident #12 was dependent on staff for toileting and hygiene and required two or more staff were required to complete the activity. On 06/20/24 at 5:00 a.m., Resident #12, was observed up in their geri-chair in the lobby near the nurses station. On 06/20/24 from 5:00 a.m. through 8:05 a.m. direct observation was made of Resident #12. No staff was observed checking on the residents and/or providing any care to them. On 06/20/24 at 8:05 a.m., CNA #2 was observed transferring Resident #12 from the lobby directly into the dining room without providing any care. On 06/20/24 at 9:03 a.m., Resident #12 was observed being brought out of the dining room by LPN#3. LPN #3 placed Resident #12 near the nurses station in the lobby On 06/20/24 at 9:08 a.m., CNA # 1 and CNA #2 was observed taking Resident #12 to their room. On 06/20/24 at 9:10 a.m., CNA # 1 and CNA #2 was observed transferring Resident #12 to the bed from the geri-chair and provided incontinent care. Resident #12 was observed up in her geri-chair from 5:00 a.m. through 9:10 a.m. (four hours and ten minutes) without any care being provided. 2. Resident #18 had diagnosis to include Alzheimer's, history of falling, osteoarthritis, chronic atrial fibrillation, and dysphagia. Resident #18 care plan, last revised 04/10/2023, read in part, .has an ADL Self Care Performance Deficit and is dependent on staff for care r/t Alzheimer's Disease and Decreased Mobility toileting requires extensive total dependence X 2 staff .uses geri-chair for mobility . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual assessment, dated 06/02/24, documented Resident #18 had short and long term memory problems, and was always incontinent of bowel and bladder. Resident #18 was dependent on staff for toileting, hygiene and required two or more staff were required to complete the activity. On 06/20/24 at 5:00 a.m., Resident #18, was observed up in their geri-chair in the lobby near the nurses station. On 06/20/24 from 5:00 a.m. through 8:05 a.m. direct observation was made of Resident #18. No staff was observed checking on the residents and/or providing any care to them. On 06/20/24 at 8:05 a.m., CNA #1 was observed transferring Resident #18 from the lobby directly into the dining room without providing any care. On 06/20/24 at 8:41 a.m., Resident #18 was observed being brought out of the dining room by LPN#3. LPN #3 placed Resident #18 near the nurses station in the lobby. On 06/20/24 at 9:27 a.m., Resident #18 was observed being taken back to their room for care by CNA #4. CNA #4 was observed providing care to Resident #18. CNA #4 confirmed Resident #18 was incontinent of urine only. CNA #4 stated they did not know how long it had been since care was provided to Resident #18 since they arrived at work around 8:30 a.m. Resident #18 was observed up in her geri-chair from 5:00 a.m. through 9:27 a.m. (four hours and 27 minutes) without any care being provided. 3. Resident #36 had diagnosis to include anemia, congestive heart failure, depression, anxiety and dementia. Resident #36 care plan, last revised 02/21/24, read in part, .has an ADL Self Care Performance Deficit and is dependent on staff r/t dementia and decreased mobility .transfers requires extensive-total dependence x 2 staff assist .toileting requires extensive total dependence X 2 staff . A quarterly assessment, dated 04/19/24, documented Resident #36 had severly impaired cognitive skills, and was always incontinent of bowel and bladder. Resident #36 was dependent on staff for toileting and hygiene and required two or more staff were required to complete the activity. On 06/20/24 at 5:00 a.m., Resident #36 was observed up in their geri-chair in the lobby near the nurses station. On 06/20/24 from 5:00 a.m. through 8:05 a.m. direct observation was made of Resident #36. No staff was observed checking on the residents and/or providing any care to them. On 06/20/24 at 8:10 a.m., CNA #1 was observed transferring Resident #36 from the lobby directly into the dining room without providing any care. On 06/2024 at 8:54 a.m., Resident #36 was observed being brought out of the dining room by LPN#3. LPN #3 placed Resident #36 near the nurses station in the lobby next to Resident #18. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at 9:05 a.m., Resident #36 was observed being taken to her room at 9:05 a.m., and placed next to her bed in the geri-chair. The resident was not provided any care and left up in the geri-chair. On 06/20/24 from 9:05 a.m. through 10:10 a.m., Resident #36 remained up in her geri-chair without any care being provided. On 06/20/24 at 10:10 a.m., CNA #1 and CNA #2 was observed transferring Resident #36 to the bed and provided incontinent care. Resident #36 had been incontinent of bowel and bladder with a ring of dried feces on their buttocks. Resident #36 was observed up in her geri-chair from 5:00 a.m. through 10:10 a.m. (five hours and ten minutes) without any care being provided. On 06/20/24 at 7:45 a.m., CNA #5 stated they and CNA #6 got Resident #36 up at 4:10 a.m., Resident #12 up at 4:20 a.m., and Resident #18 up at 4:00 a.m. CNA #5 stated all the residents were up and out to the lobby after they were provided care. CNA #5 stated that was the last care that they provided the residents for their shift. CNA #5 stated all residents were required to be checked and provided care every two hours. On 06/20/24 at 8:15 a.m., CNA #6 was asked what times Resident #12, Resident #18 and Resident #36 were up out of bed. CNA #6 stated all the residents on the get up list, which included Resident #12, Resident #18 and Resident #36, were up and out of their room between 4:00 a.m. and 4:20 a.m. The certified nurse aide was asked when care was last provided to the residents. CNA #6 stated care was provided to them prior to being brought out by the nurses station. CNA #6 stated all residents were required to be checked and provided care every two hours. On 06/20/24 at 1:04 p.m., CNA # 1 stated residents were required to be checked on and provided care every two hours. CNA #1 stated Resident #12 and Resident #36 required two people to provide care and transfer them to bed. She was asked when care was provided to Resident #12 and Resident #36. CNA #1 stated they did not provide care to Resident #36 until after 10:00 a.m. and Resident #12 was provided at about 9:10 a.m. CNA #1 stated care was to be provided every two hours and no care was provided since starting work at 6:00 a.m On 06/20/24 at 1:29 p.m., CNA #2 confirmed Resident #12 and #36 was in the lobby when they arrived, went to the dining room and back to the lobby after breakfast. CNA #2 stated neither her or CNA #1 provided care prior to the observations being made at 9:10 a.m. and 10:10 a.m. CNA #2 stated all residents should be provided care every two hours and being up since 4:30 a.m., without any care was not good. On 06/21/24 at 8:35 a.m., the DON stated night staff get residents up that require two people assists with a lift. The DON stated the residents should be up at 5:30 a.m., and the day shift will finish getting everyone else up. The DON stated all residents need care every two hours and as needed. The DON stated, That's not good when describing the observations on Resident #12, Resident #18 and Resident #36 being up at 5:00 a.m. and not receiving care for four and five hours.

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41872

Based on observation, record review, and interview, the facility failed to assess and monitor a resident with a severe weight gain of 36 pounds (17.24 %) for one (#45) of two sampled residents reviewed for weights.

The facility census was 77.

Findings:

A Dining Services Policies and Procedures Weight List, revised 07/09/08, read in part .Residents' weights are routinely and systematically monitored .Residents with a weight loss or gain of five percent or more, within one month, should be re-weighed and entered into PCC by the 15th of the month. The resident's physician should be notified of any Significant Weight Change in PCC

A Resident's Family or Physician Notification of Change Guideline policy, dated 12/01/09, read in part The facility will inform the resident; consult with the resident's physician .of the following events .A significant change in the resident's physical, mental, or psychosocial status. (i.e. a deterioration in health, mental or psychosocial states in either life-threatening conditions or clinical complications . a need to alter treatment significantly .

Resident #45 had diagnosis to include congestive heart failure and edema.

A quarterly assessment, dated 03/24/24, documented Resident #45 was cognitively impaired, was dependent on staff for showers, lower body dressing, putting on and taking off footwear and required substantial/maximal assistance with toileting and upper body dressing.

A review of the weight record for Resident #45 documented the resident weighed 208.8 pounds on 05/23/24 and weighed of 244.8 pounds on 06/07/24.

Resident #45 had a 36 pound (17.24%) weight gain in 15 days.

There was no documentation Resident #45's physician had been notified of the severe weight gain on 06/07/24.

A Skin Evaluation, dated 06/07/24 did not identify any new skin issues. There was no vital signs, lung sounds or edema assessment completed.

A review of the restorative weight record, dated 06/12/24, documented Resident #45 weighed 240.2 pounds. Resident #45 continued to have a severe weight gain of 31.4 pounds (15.04%) since 05/23/24.

A physician visit note, dated 06/13/24, read in part, .The patient presents for a follow-up visit at the nursing home per the request of the nursing staff. [The residents] complaint is persistent bilateral leg pain, which he describes as feeling like there is a fire inside. [The resident] reports having significant peripheral edema . Congestive Heart Failure .Continue current heart failure medications and monitor for any signs of worsening symptoms .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 06/13/24 documented to administer Lasix 20 milligrams by mouth two times per day. The nurse's progress notes did not contain documentation Resident #45 had been assessed by a nurse on 06/13/24 and 06/14/24 for worsening of symptoms. A Skin Evaluation dated 06/14/24, did not identify any new skin issues. There was no vital signs, lung sounds or edema assessment completed. A Nurses Progress Note, dated 06/15/24 at 12:46 a.m., read in part Focuses assessment r/t increase lasix 20 mg to twice daily and N.O. Neurontin 100mg TID. No c/c discomfort. No s/sx of adverse effects .vs-140/87 75 18 97.8 98%RA . ANurse Progress Note, dated 06/15/24 at 1:45 p.m., read in part .Focuses assessment r/t resident recent increase in Lasix to 20mg BID d/t increased edema, and n/o of Neurontin 100mg BID for poyneuropathy. Resident has no complaints at this time .vs wnl - 146/92, 73, 97.3, 18, 98% RA, 5 pain in feet . A Nurses Progress Note, dated 06/15/2024 at 9:45 p.m., read in part .vs 153/64-69-20-98.2 resident in bed high [NAME] position. awake and alert. resp even and unlabored. 4+pitting edema to bil lower ext. bil fa noted to have slight edema. no order for Lasix bid and Neurontin 100mg tid for lower leg pain. tolerating well no s/s of adverse reaction voiced. continuing with plan of care . A Nurses Progress Note, dated 06/16/24 at 5:21 p.m., read in part .Focuses assessment r/t resident recent increase in Lasix to 20mg BID and n/o of Neurontin 100mg TID for europathy. Resident c/o discomfort to legs. Resident currently in bed with feet propped on pillow . No v/s or edema observation was noted. A Nurses Progress Note date 06/16/24 at 10:19 p.m., read in part .VS 136/65-84-18-97.9 pox94% RA. Resting in bed. high [NAME] position. Resp even and unlabored. Edema remains to bil lower extremities 3+ pitting. Decreasing in arms bil. Lasix changed to bid. New order for Neurontin 100mg po bid. [resident] tolerating med changes without s/s of adverse reaction. Continuing with plan of care . A Nurses Progress Note, dated 06/17/24 at 1:14 p.m., read in part .Focuses nursing assessment r/t starting Neurontin and increase of Lasix. No s/e or a/r noted. Sitting up in chair eating lunch at this tie. no distress noted .vs stable. 97.9, 96, 150/73, 76, 18 . A Nurses Progress Note, dated 06/18/24 at 4:39 a.m., read in part .focused assessment r/t n/o Neurontin 100mg TID, Increase Lasix from 20 mg qday to 20mg BID. No adverse reaction noted this shift. Resident continues to c/o burning in bilateral feet and BLE. Resident has order for 5mg Roxicodone QID PRN for pain relief. Resident resting in bed, call light within reach. POC ongoing . No v/s or edema assessment was documented. There was no documentation in the progress notes Resident #45 had been assessed on 06/19/24. On 06/19/24 at 1:13 p.m., Resident #45 was sitting in their wheelchair, both feet were observed to have edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at 5:29 a.m., Resident #45 was observed in their bed in the high [NAME] position. On 06/20/24 at 2:01 p.m., the DON was asked when the physician had been notified of the 36 pound weight gain. They stated, I don't think the restorative aide put that weight in right or didn't report it to the nurse. They were asked if the physician had been notified in a timely manner. They stated depends on what timely means but they would have notified the physician as soon as they were aware. On 06/20/24 at 2:01 p.m., LPN #2 was asked what had been done when the resident had been seen by the physician on the 13th. They stated the doctor gave an order to increase the Lasix to twice a day. A Nurses Progress Note dated 06/20/24 at 4:16 p.m., read in part .[Doctor] notified of cont weight gain. Physician reviews recent PO Lasix as intervention for weight gain, ineffective. Received n/o to send res to ER for eval and tx. A Nurses Progress Note, dated 06/20/24 at 4:44 p.m., read in part .Resident assessed VS wnl - 140/62, 71, 20, 97%RA, 97.4, 9 pain. Resident c/o 3+ edema to BLE being painful, +1 edema to BUE also uncomfortable. Resident states [they] had some SHOB last night and some this day. Lungs clear to all lobes. EMS arrived to transfer resident to [name of hospital], report given to nurse at ER. A Nurses Progress Note , dated 06/21/24 at 12:39 a.m., read in part . resident admitted to [name of hospital] for CHF Exacerbation . On 06/21/24 at 8:38 a.m., the DON was asked what the Resident #45s weight was when they had been weighed. They stated it was 249 pounds, the resident was sent to the hospital and admitted for CHF. On 06/21/24 at 10:44 a.m., the DON was asked what was Resident #45's diagnosis. They stated heart failure. They were asked to review the weights on 05/23/24 and 06/07/24 and asked how did the facility respond. They stated they had reweighed the resident by the fifteenth of the month according to policy. The DON was asked if the physician had been notified on 06/15/24 when the nurse progress note documented 4+ pitting edema and edema to forearm. They stated No. They were asked if the physician had been notified when the nurse progress note documented the resident had 3+ edema to their lower legs and edema to their arms. They stated No. The DON was asked when the physician was notified. They stated the physician was asked to see the resident on 06/13/24. The swelling had been noticed during skin observations. The DON was asked did the physician give orders. They stated to increase the resident's Lasix 20 mg from one time a day to two times per day. They were asked what the rationale for increasing the Lasix. They stated for congestive heart failure. The DON was shown the physician note, dated 06/13/24, and asked what did monitoring for any signs of worsening symptoms mean. They stated To complete assessments. On 06/21/24 at 11:40 a.m., the pharmacy consultant was asked for a policy related to monitoring for the use of diuretics. They stated they were unsure if they had one. The facility did not provide a policy related to monitoring a resident with congestive heart failure.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 20960 Based on observation, record review, and interview, the facility failed to ensure they had sufficent staff to provide care to residents. The facility ceneus was 77. Findings: A review of the stafing sheets for 06/07/24 through 06/21/24 documentd the 6:00 p.m. to 6:00 a.m., shift had one nurse and two aides for the long term care side on the following dates: 06/15/24; 06/16/24; 06/18/24, 06/19/24, and 06/20/24. 1. Resident #12 had diagnosis to include dementia, anxiety, major depression, hypertension and hyperlipidemia. Resident #12 care plan, last revised 01/24/24, read in part, .I am at risk for pressure ulcer D/T my incontinence .provide incontinent care every 2 hours as needed . A quarterly assessment, dated 04/2024, documented Resident #12 was always incontinent of bowel and bladder, was dependent on staff for toileting and hygiene, and required two or more staff were required to complete the activity. On 06/20/24 at 5:00 a.m., Resident #12, was observed up in their geri-chair in the lobby near the nurses station. On 06/20/24 from 5:00 a.m. through 9:10 a.m., direct observation was made of Resident #12. No staff was observed checking on the residents and/or providing any care to them. On 06/20/24 at 9:10 a.m., CNA #1 and CNA #2 was observed transferring Resident #12 to the bed from the geri-chair and provided incontinent care. Resident #12 was observed up in her geri-chair from 5:00 a.m. through 9:10 a.m. (four hours and ten minutes) without any care being provided. 2. Resident #18 had diagnosis to include Alzheimer's, history of falling, osteoarthritis, chronic atrial fibrillation, and dysphagia. Resident #18 care plan, last revised 04/10/23, read in part, .has an ADL Self Care Performance Deficit and is dependent on staff for care r/t Alzheimer's Disease and Decreased Mobility toileting requires extensive total dependence X 2 staff .uses geri-chair for mobility . An annual assessment, dated 06/02/24, documented Resident #18 had short and long term memory problems, was always incontinent of bowel and bladder, dependent on staff for toileting and hygiene and required two or more staff were required to complete the activity. (continued on next page)

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 06/21/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Creek Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 2610 Cedar Creek Drive Altus, OK 73521	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at 5:00 a.m., Resident #18, was observed up in their geri-chair in the lobby near the nurses station. On 06/20/24 from 5:00 a.m. through 9:10 a.m., direct observation was made of Resident #18. No staff was observed checking on the residents and/or providing any care to them. On 06/20/24 at 9:27 a.m., Resident #18 was observed being taken back to their room for care by CNA #4. CNA #4 was observed providing care to Resident #18. CNA #4 confirmed Resident #18 was incontinent of urine only. CNA #4 stated they did not know how long it had been since care was provided to Resident #18 since they arrived at work around 8:30 a.m. Resident #18 was observed up in her geri-chair from 5:00 a.m. through 9:27 a.m. (four hours and 27 minutes) without any care being provided. 3. Resident #36 had diagnosis to include anemia, congestive heart failure, depression, anxiety and dementia. Resident #36 care plan, last revised 02/21/24, read in part, .has an ADL Self Care Performance Deficit and is dependent on staff r/t dementia and decreased mobility .transfers requires extensive-total dependence x 2 staff assist .toileting requires extensive total dependence X 2 staff . A quarterly assessment, dated 04/19/24, documented Resident #36 had severly impaired cognitive skills, was always incontinent of bowel and bladder, dependent on staff for toileting and hygiene, and required two or more staff. On 06/20/24 at 5:00 a.m., Resident #36 was observed up in their geri-chair in the lobby near the nurses station. On 06/20/24 from 5:00 a.m. through 10:10 a.m., direct observation was made of Resident #36. No staff was observed checking on the residents and/or providing any care to them. On 06/20/24 at 10:10 a.m., CNA #1 and CNA #2 was observed transferring Resident #36 to the bed and provided incontinent care. Resident #36 had been incontinent of bowel and bladder with a ring of dried feces on their buttocks. Resident #36 was observed up in her geri-chair from 5:00 a.m. through 10:10 a.m. (five hours and ten minutes) without any care being provided. On 06/20/24 at 7:45 a.m., CNA #5 stated they and CNA #6 got Resident #36 up at 4:10 a.m., Resident #12 up at 4:20 a.m., and Resident #18 up at 4:00 a.m. CNA #5 stated all the residents were up and out to the lobby after they were provided care. CNA #5 stated that was the last care that they provided the residents for their shift. CNA #5 stated all residents were required to be checked and provided care every two hours. CNA #5 stated care can not be provided with only two aides working. They stated they had to provide care to other residents and not able to provide the care as needed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at 8:15 a.m., CNA #6 was asked what times Resident #12, Resident #18 and Resident #36 were up out of bed. CNA #6 stated all the residents on the get up list, which included Resident #12, Resident #18 and Resident #36, were up and out of their room between 4:00 a.m. and 4:20 a.m. The certified nurse aide was asked when care was last provided to the residents. CNA #6 stated care was provided to them prior to being brought out by the nurses station. CNA #6 stated all residents were required to be checked and provided care every two hours. CNA #6 stated they with only two aides working care can not be provided every two hours. On 06/20/24 at 1:04 p.m., CNA # 1 stated residents were required to be checked on and provided care every two hours. CNA #1 stated Resident #12 and Resident #36 required two people to provide care and transfer them to bed. She was asked when care was provided to Resident #12 and Resident #36. CNA #1 stated they did not provide care to Resident #36 until after 10:00 a.m. and Resident #12 was provided at about 9:10 a.m. CNA #1 stated care was to be provided every two hours and no care was provided since starting work at 6:00 a.m. CNA #1 stated that there were two aides for hall 200 and 300, and with all the residents that require two person asssits, answering the call lights and providing showers care can not be provided like it should. The CNA stated the priority was to answer call lights and others would have to wait. CNA #1 stated Resident #36 had to wait until 10:00 a.m. for care because CNA #2 was providing showers and call lights were being answered. On 06/20/24 at 1:29 p.m., CNA #2 confirmed Resident #12 and #36 was in the lobby when they arrived, went to the dining room and back to the lobby after breakfast. CNA #2 stated neither her or CNA #1 provided care prior to the observations being made at 9:10 a.m. and 10:10 a.m. CNA #2 stated all residents should be provided care every two hours and being up since 4:30 a.m., without any care was not good. CNA #2 stated with only two aides appropriate care can not be provided. The CNA stated we have to answer call lights and those needing two staff for care have to wait. On 06/21/24 at 9:29 a.m., the DON stated the facility followed state guidelines for staff and that was all they did. The DON stated the facility had no policy for staffing just that it needs to meet the needs of the residents. The DON then stated based on what was observed the standard of quaility of care was not being followed. 4. On 06/18/24 at 10:1 a.m., Resident #52 stated there was not enough staff to assist when needed and call lights can take up to 45 minutes or longer to respond. Resident #52 stated it took two hours to recieve water. 5. On 06/18/24 at 8:22 a.m., Resident #41 stated there were not enough staff and when she dropped their oxygen tubbing on the floor staff never came in to asssit with getting it. Resident #41 then stated staff came to help reposition them and left after turning off the call light. They stated staff said the would be right back and they had to wait over 20 minutes to be positioned up in bed. 6. On 06/18/24 at 10:36 a.m., a confidential family interview was conducted. The family member stated there were only two aides and one nurse for all four wings and that was not enough to provide the care for all the residents. 7. On 06/19/24 at 1:00 p.m., a resident group meeitng was held with eight alert and oriented residents. When asked about staffing seven out of eight residens stated it took a long time for call lgiths to be answered and care provided. The residents stated that it was bad at nights but it happens on the day because there were not enough staff to respond and provide the care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 30875 Based on observation, record review, and interview, the facility failed to maintain infection control measures: a. during provision of wound care and incontinent care for one (#4) of four sampled residents reviewed for infection control; b. to alert staff of enhanced barrier precautions when providing care for one (#9) of four sampled residents reviewed for infection control; and c. during provision of peri care for one (#32) of four sampled residents reviewed for infection control; and d. when emptying a catheter for a resident on enhanced barrier precautions for one (#42) of four sampled residents reviewed for infection control. Facility census: 77 Findings: The facility's Infection Control and Isolation Policy, revised 03/28/24, read in part, Gloves are used to prevent contamination of healthcare personnel hands when . anticipating direct contact with blood, or bodily fluids, mucous membranes, non-intact skin and other potentially infectious materials. The policy also read, infectious organisms can be reduced by adhering to the principles of working from clean to dirty, and confining or limiting contamination to surfaces that are directly needed for patient care. It may be necessary to change gloves during the care of a single patient to prevent cross contamination of body sites. The policy also read, Hand hygiene following glove removal further ensures that the hands will not carry potentially infectious material that might have penetrated through unrecognized tears or that could contaminate the hands during glove removal. The policy also read, Enhanced Barrier Precautions. Examples of high contact resident activities requiring gown and glove use for enhanced barrier precautions include device care or use: central line, urinary catheter. 1. Resident #4 had diagnoses which included an unstageable pressure ulcer to the left buttock, a deep tissue injury to the right buttock and Alzheimer's. Resident #4's care plan for pressure ulcers, dated 01/18/23 through 01/19/24, documented, a. assess/record/monitor wound healing. b. enhanced barrier precautions related to peg tube/foley catheter. May discontinue if peg tube and foley removed. c. ROHO mattress in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. wound consultant to screen, evaluate and treat as indicated. e. turn and reposition resident from side to side only every 2 hours and prn. A physician order, dated 04/02/24, documented enhanced barrier precautions related to peg tube/foley catheter. May discontinue if peg tube and foley removed, every shift gown and gloves for activities of daily living and foley/peg tube care. A quarterly assessment, dated 04/13/24, documented Resident#4 had severe cognitive impairment, and was dependent on staff for activities of daily living. A physician order, dated 06/18/24, documented to cleanse the right buttock, with wound cleanser, pat dry, apply Medi honey, Durafiber Ag and a bordered foam dressing every Monday, Wednesday, and as needed for a deep tissue injury. A physician order, dated 06/18/24, documented to cleanse the left buttock with wound cleanser, pat dry, apply Medi honey, Durafiber Ag and cover with a bordered foam dressing every Monday, Wednesday, Friday and as needed for an unstageable pressure ulcer of the left buttock. On 06/19/24 10:52 a.m., lying in bed on left side with heel protectors in place and an indwelling catheter flowing to gravity with clear yellow urine. No gowns or gloves behind resident's door at this time for enhanced barrier precautions. On 06/19/24 at 1:38 p.m., LPN #2 was observed to prepare wound care supplies to perform wound care for Resident #4. LPN #2 was observed to put multiple clean gloves in their pocket. LPN #2 donned gloves and brought the supplies into the room and placed the supplies on a clean surface then removed the gloves from their pocket and placed on the clean surface. LPN #2 removed their gown and gloves and went out to the cart to get tongue depressors for wound care. Resident #4 was observed to be incontinent of bowel before and during wound care. LPN #2 was observed to cleanse the two wounds on the residents' buttocks, and remove their gloves. They were not observed to sanitize their hands between changing their gloves. They applied the Medi honey and dressings, then covered the areas with dressings and dated the dressings. LPN #2 then provided incontinent care then placed a new bed pad underneath the resident, repositioned the resident then covered the resident up with a sheet and blanket. LPN #2 was not observed to change their gloves after provision of incontinent care and repositioning the resident. On 06/19/24 at 1:53 p.m., LPN #2 was asked if they had sanitized their hands between glove changes during wound care. They stated No. They were asked if they had changed their gloves after they provided incontinent care and repositioned the resident. They stated No. 2. Resident #9 had diagnosis which included urinary tract infection in the last 30 days and diabetes mellitus. An annual assessment, dated 05/13/24, documented Resident #9 had no cognitive impairment and an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at 7:30 a.m., observed LPN #3 perform catheter care for Resident #9. They reported they kept gowns on the medication cart just in case. The door was not marked to alert staff to use enhanced barrier precautions when providing care and no gowns/gloves were supplied on the back of door. On 06/20/24 at 8:05 a.m., IP nurse reported Resident #9 was not on enhanced barrier precautions and upon entering the room they realized the resident had an indwelling catheter in place. On 06/20/24 at 6:50 a.m., CNA #5 was asked how do they know when they need to wear PPE. They stated there would be a sign on the door and PPE outside the door. On 06/20/24 at 8:11 a.m., IP nurse reported they found out what why the door was not marked for enhanced barrier precautions. Resident #9 went to the hospital and they were on enhanced barrier precautions and when they returned from the hospital on 06/05/24, they did not put the enhanced barrier precautions signs back up. The IP nurse reported they were out on vacation from 06/06/24 and returned on 06/13/24. On 06/20/24 at 8:36 a.m., IP nurse posted a sign on Resident #9's door for enhanced barrier precautions and reported that it just slipped by them. On 06/20/24 at 8:27 a.m., IP nurse reported there was a breakdown in the process for enhanced barrier precautions. 3. Resident #32 had diagnosis which included cerebrovascular accident, heart failure, and high blood pressure. A quarterly assessment, dated 04/17/24, documented Resident #32's cognition was intact, always incontinent of urine, and frequently incontinent of bowel. A care plan, documented Resident #32's bladder incontinence: a. will remain free from skin breakdown due to incontinence and use brief through the review date. b. monitor/document for sign and symptoms of urinary tract infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. c. monitor/document/report to physician as needed for possible medical causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at 5:54 a.m., CNA #5 and CNA #6 were observed to provide incontinent care to Resident#32. Both staff were wearing gloves, they uncovered the resident and pulled the brief down from between the resident's legs. CNA #6 cleansed the buttocks area then placed a new brief under the resident they were not observed to change their gloves. CNA #6 then applied ointment to the Resident's buttocks and wiped the remaining ointment from their glove on the clean brief. They removed their right glove and left the other glove on. CNA #6 used their gloved hand to reposition the resident then reached into their pocket and retrieved a glove then donned it on their right hand. CNA #5 provided peri care to the residents' vaginal area, applied ointment to the peri area then used a wipe to clean their gloves. CNA #5 and CNA #6 were then observed to position the resident and pull up the brief between the residents' legs and reposition the resident to their left side, then pulled the resident up in the bed. CNA #6 got a cover from the resident's chair, and covered the resident. CNA #6 was not observed to change their left glove at any time during the provision of care. On 06/20/24 at 6:31 a.m., CNA #6 was asked to describe handwashing and glove usage. They stated before they change, they wash their hands and after they change they wash their hands then sanitize. They were asked if they change their gloves when providing care. They stated they do not change their gloves. They were asked if they should wash their hands and put on clean gloves. CNA #6 stated they did not take off the gloves and wash their hands and put on clean gloves. They were asked if Resident #32 was soiled when they provided incontinent care. They stated the resident was incontinent of urine. CNA #6 stated they kept their gloves in their pocket and when they ran out they went to get more. They stated not all rooms had gloves. They stated they had applied ointment and after cleaning the buttocks they would be considered dirty and should have washed their hands. On 06/20/24 at 6:50 a.m., CNA #5 was asked how do they know when they need to wear PPE. They stated there would be a sign on the door and PPE outside the door. They were asked what PPE should be worn when emptying a catheter. They stated gloves, a gown and eye protection. They were informed of the observation when emptying the catheter and they stated they should have worn a gown and not just gloves. 4. Resident #42 had diagnoses which included neurogenic bladder and multiple sclerosis. A physician order, dated 04/02/24, documented to provide enhanced barrier precautions related to indwelling catheter. Use gown and gloves for activities of daily living and catheter care. Resident #42's, care plan, dated 08/04/20 through 07/09/24, documented, a. has an indwelling catheter related to: Neurogenic bladder. b. enhanced barrier precautions related to indwelling catheter, may discontinue when indwelling catheter removed. On 06/18/24 at 10:21 a.m.,Resident #42 was observed lying in their bed. Enhanced barrier precautions sign was posted on the door outside of the room. Resident #42 has an indwelling catheter and reported the staff put the sign up outside the door recently. On 06/19/24 at 10:55 a.m., lying in bed, enhanced barrier precautions placed on door (magnet) and supplies were located on the back of door to include gowns and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at 5:50 a.m., CNA #5 was observed to enter Resident #42's room. CNA #5 donned gloves and was observed to empty the residents catheter using a urinal, then emptied the urine into the toilet, rinsed the urinal in the sink, and poured it into the toilet, placed the urinal into a trash bag in the bathroom. CNA #5 was not observed to don a gown. PPE was observed in a yellow cloth bin on the back of the resident door. A sign for EBP precautions was observed on the door frame on the outside of the door. On 06/20/24 at 8:37 a.m., the IP nurse was asked what the process was for getting gloves to prepare for providing care. They stated staff should have those things readily available on a clean spot or bedside table. If performing peri care or catheter care all supplies should be readily available. They were asked when should staff change their gloves during provision of peri care. They stated staff should change gloves after they clean the resident. They should remove the dirty gloves, sanitize their hands then put new gloves on. On 06/20/24 at 8:45 a.m., the IP nurse was informed of CNA #5 not donning a gown when emptying Resident #42's catheter. They were asked if they should have worn a gown. They stated, Yes. The IP nurse was informed of the observations made during provision of wound care provided by LPN #2. They stated that was not acceptable. 41872