

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2025
NAME OF PROVIDER OR SUPPLIER  Lawton Post Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1700 Northwest Fort Sill Blvd Lawton, OK 73507	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to ensure proper PPE (personal protective equipment) was used for 1 (#3) of 2 sampled residents reviewed for enhanced barrier precautions. The director of nursing reported that 19 residents required enhanced barrier precautions. Findings: On 07/14/25 at 1:20 p.m., Res #3 was observed in bed with CNA #1 and CNA #2 present at the bedside providing care to the resident and changing the resident's linens. The two CNAs were observed wearing gloves but no gown. PPE supplies for enhanced barrier precautions were observed hanging on the resident's door. On 07/14/25 at 1:25 p.m., LPN #1 was observed to enter Res #3's room to perform feeding tube site care. The LPN performed hand hygiene and applied gloves. The LPN was observed to clean the feeding tube site and apply a clean gauze pad to the site. The LPN was observed not wearing a gown for enhanced barrier precautions. A policy titled Enhanced Barrier Precautions, revised date 05/01/25, showed enhanced barrier precautions refer to the use of a gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with an MDRO, as well as those at increased risk of MDRO acquisition (residents with wounds or indwelling medical devices. The policy showed high-contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, device care or use (urinary catheters, feeding tube, etc), and wound care (any skin opening requiring a dressing). A quarterly assessment, dated 06/30/25, showed severely impaired cognition with no BIMS score obtained. The assessment showed a feeding tube for nutrition. A physician's order, dated 03/18/25, showed clean feeding tube site twice daily with soap and water, pat dry, and cover with split gauze dressing. A physician's order, dated 04/07/25, showed enhanced barrier precautions for wound, colostomy, and indwelling catheter care. On 07/15/25 at 12:28 p.m., LPN #1 reported Res #3 is on enhanced barrier precautions. The LPN reported that only gloves are worn for enhanced barrier precautions when feeding tube care is performed. The LPN reported that a gown and gloves should be worn by CNAs when providing incontinent care and emptying catheter bags. The LPN reported training for enhanced barrier precautions had been received. On 07/15/25 at 12:30 p.m., the IP nurse reported that a gown and gloves should be worn by staff when performing incontinent care, performing wound care, changing linens, and when performing feeding tube site care.</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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