STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375514	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Nursing Home, Inc.	632 Southeast 3rd Street Lexington, OK 73051

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 41318 Based on record review and interview, the facility failed to ensure medications were coded accurately on MDS assessments for two (#1 and #3) of 12 sampled residents MDS were reviewed. The Administrator identified 43 residents who resided in the facility. Findings: 1. Resident #1 had diagnoses which included Alzheimer's disease. A Quarterly assessment, dated 04/22/24, documented Resident #1 received anticoagulant. There was no documentation the resident received an anticoagulant during the look back period. 2. Resident #3 had diagnoses which included acute cystitis. A Quarterly assessment, dated 04/01/24, documented Resident #3 received an antidepressant. There was no documentation the resident received an antidepressant during the look back period. On 06/27/24 at 11:24 a.m., MDS coordinator #2 stated they review the documentation in the EHR to ensure the MDS was coded accurately. They reviewed Resident #1 and #3's assessments and stated they were not coded accurate regarding their medications.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46582 Based on record review and interview, the facility failed to develop a comprehensive care plan for diabetic monitoring for one (#9) of five residents reviewed for unnecessary medications. MDS coordinator #1 identified eight residents with diabetes. Findings: Res #9 was admitted with diagnoses which included type II diabetes mellitus. A physician order, dated 07/30/23, documented obtaining finger stick blood sugar if resident becomes symptomatic. A physician order, dated 07/30/23, documented offering a diabetic protein snack at bedtime. An admission assessment, dated 08/07/23, documented the resident was cognitively intact and received insulin. A physician order, dated 09/06/23, documented to administer Trulicity 0.75 mg/0.5 ml subcutaneously once a day on Thursdays for diabetes mellitus. A physician order, dated 01/11/24, documented obtaining finger stick blood sugar daily on Wednesdays. A care plan, reviewed 06/27/24, did not document Res #9's diabetic monitoring. On 06/27/24 at 11:30 a.m., MDS coordinator #1 stated they did not know diabetic monitoring needed to be included on the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Lexington Nursing Home, Inc.	632 Southeast 3rd Street Lexington, OK 73051

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46582 Based on observation, record review, and interview, the facility failed to revise the care plan related to falls for one (#9) of three residents sampled for falls. The administrator identified 84 falls in the last six months. Findings: A Managing Falls and Fall Risk policy, revised March 2018, read in parts, .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant .If underlying causes cannot be readily identified or corrected, staff will try various interventions based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of falling is identified as unavoidable . Res #9 had diagnoses which included Alzheimer's disease, seizures, and overactive bladder. A care plan, dated 08/08/23, documented the resident had the potential for falls secondary to balance problems during transition and walking, history of falls prior to admission, and routine antidepressant medication. The eight fall prevention interventions documented under this problem were dated 08/08/23. Incident reports, dated 01/08/24, 01/11/24, 02/02/24, 02/05/24, 02/08/24, 02/12/24, 02/13/24, 02/15/24, 02/18/24, and 02/22/24, documented Res #9 had fell . No additional interventions addressing fall prevention were documented on the care plan after the falls. A quarterly MDS assessment, dated 05/06/24, documented the resident was independent with mobility, transfers, and locomotion with use of a walker. The assessment documented the resident had two or more falls without injury, two or more falls with injury, and one fall with major injury. On 06/24/24 at 9:38 a.m., Res #9 was observed lying in bed. Res #9 stated they had fell on several occasions. Res #9 stated they had a lump on the back of their head from two previous falls which required staples to close the wound. On 06/27/24 at 11:35 a.m., MDS coordinator #1 stated they completed the residents' care plan. They stated after a fall occurs, an incident report is completed, the fall is discussed in an interdisciplinary meeting, and a new fall prevention intervention is added to the care plan. MDS coordinator #1 stated Res #9's care plan had not been revised after every fall but should have been. On 06/27/24 at 1:34 p.m., the DON stated a fall prevention intervention is documented on the incident report after a fall occurs. They stated the care plan should have been updated to reflect these interventions.