

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Northwest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 Northwest 61st Street Oklahoma City, OK 73112	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>48344</p> <p>Based on record review and interview, the facility failed to notify the physician in a timely manner regarding abnormal lab results for one (#8) of eight sampled residents reviewed for weight loss.</p> <p>The Administrator identified 47 residents resided in the facility.</p> <p>Findings:</p> <p>The Test Results policy, revised 04/07, read in part, .Should the test results be provided to the facility, the Attending Physician shall be promptly notified of the results .The Director of Nursing Services, or Charge Nurse receiving the test results, shall be responsible for notifying the Physician of such test results .</p> <p>A physician's order, dated 03/22/24, documented to check bmp a week from today.</p> <p>A laboratory report, dated 03/29/24, documented a high lab result for potassium. There was no documentation the physician was notified of the abnormal lab result.</p> <p>On 04/02/24 at 2:13 p.m., the DON stated the physician should be notified on all abnormal lab results. They reviewed Resident #8's electronic health record. They could not locate a physician notification for the lab result reported on 03/29/24.</p> <p>On 04/03/24 at 2:33 p.m., the ADON stated the facility received the lab result on 03/29/24. They stated the nurse on duty should have notified the physician upon receipt of the abnormal lab report.</p> <p>On 04/03/24 at 2:33 p.m., the ADON stated they reviewed the laboratory report on 04/01/24 and notified the physician.</p> <p>On 04/3/24 at 2:33 p.m., the ADON stated the physician was not notified in a timely manner.</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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>48344</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on record review and interview, the facility failed to ensure:</p> <p>a. meal consumption percentages were documented on a resident who experienced weight loss for two (#3 and #7); and</p> <p>b. weights were documented on a resident who experienced weight loss for three (#2, 3, and #5) of three sampled residents reviewed for weight loss.</p> <p>The Administrator identified 47 residents resided in the facility.</p> <p>Findings:</p> <p>The Weight Assessment and Intervention policy, revised 09/08, read in part, .The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter .If no weight concerns are noted at this point, weights will be measured monthly thereafter .</p> <p>The Frequency of Meal policy, revised 07/17, read in part, .Each resident shall receive at least three meals daily .</p> <p>1. Resident #2 had diagnoses which included dysphagia and cerebral infarction.</p> <p>A physician's order, dated 11/06/23, documented weekly weights every day shift, every Monday.</p> <p>The November 2023 TAR documented blanks for Resident #2's weight on the 6th, 13th, and 20th.</p> <p>The December 2023 TAR documented blank for Resident #2's weight on the 25th.</p> <p>The January 2024 TAR documented blank for Resident #2's weight on the 1st.</p> <p>The February 2024 TAR documented blank for Resident #2's weight on the 12th.</p> <p>On 04/02/24 at 1:45 p.m., the ADON reviewed Resident #2's TARs above. They stated the blanks on the TARs meant the weights were not completed as ordered.</p> <p>2. Resident #3 had diagnoses which included protein calorie malnutrition and muscle wasting.</p> <p>A physician's order, dated 03/11/24, documented weekly weights every day shift, every Monday.</p> <p>There was no documentation of Resident #3's meal consumption amount in January 2024 for:</p> <p>a. lunch on the 10th, and</p> <p>b. dinner on the 12th, 24th, and 26th.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documentation of Resident #3's meal consumption amount in February 2024 for:</p> <ul style="list-style-type: none"> a. breakfast on the 24th, b. lunch on the 24th, and b. dinner on the 24th. <p>There was no documentation of Resident #3's meal consumption amount in March 2024 for:</p> <ul style="list-style-type: none"> a. breakfast on the 16th, b. lunch on the 3rd, 16th, and b. dinner on the 17th, 29th, and 30th. <p>The March 2024 TAR documented blanks for Resident #3's weight on the 18th and 25th.</p> <p>The April 2024 TAR documented blank for Resident #3's weight on the 1st.</p> <p>On 04/03/24 at 2:25 p.m., the ADON stated the March and April 2024 TAR did not document a weight for the above dates. They stated Resident #3 had experienced weight loss.</p> <p>On 04/04/24 at 11:12 a.m., CNA #1 stated staff were to document all meal intakes and refusals. CNA #1 stated there was no documentation for meal consumption on the above dates for Resident #3.</p> <p>On 04/04/24 at 11:29 a.m., the DON stated there was no documentation for meal consumption on the above dates for Resident #3.</p> <p>3. Resident #5 had diagnoses which included dementia and heart disease.</p> <p>Resident #5's Weight Summary documented they weighed:</p> <ul style="list-style-type: none"> a. 150.1 pounds on 12/05/23, b. 137.4 pounds on 02/21/24, c. 136.6 pounds on 03/01/24, and d. 138.3 pounds on 03/07/24. <p>There was no documentation for weight in 01/24.</p> <p>On 04/04/24 at 11:49 a.m., the ADON stated if a resident had documented weight loss, they were put on weekly weight monitoring. They stated the Resident was not on weekly weight monitoring.</p> <p>On 04/04/24 at 11:52 a.m., the ADON stated Resident #5's weights were monitored monthly. They stated the Resident had no weight recorded for 01/24.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Resident #7 had diagnoses which included dysphagia and protein calorie malnutrition.</p> <p>There was no documentation of Resident #7's meal consumption amount in January 2024 for:</p> <ul style="list-style-type: none"> a. lunch on the 6th, and b. dinner on the 12th and 24th. <p>There was no documentation of Resident #7's meal consumption amount in February 2024 for dinner on the 4th, 23rd, 25th, and 29th.</p> <p>There was no documentation of Resident #7's meal consumption amount in March 2024 for:</p> <ul style="list-style-type: none"> a. breakfast on the 2nd, b. lunch on the 2nd, 3rd, and b. dinner on the 2nd, 3rd, and 15th. <p>On 04/04/24 at 11:16 a.m., CNA #1 stated there was no documentation for meal consumption on the above dates for Resident #7.</p> <p>On 04/04/24 at 11:33 a.m., the DON stated Resident #7 had documented weight loss. They stated there was no documentation for meal consumption on the above dates for Resident #7.</p>