STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375530	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corn Heritage Village and Rehab of Weatherford	801 North Washington Weatherford, OK 73096

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review and interview, the facility failed to ensure a resident and/or their legal representative were informed in writing of alternative treatments and side effects of the use of a psychotropic medication for one (#47) of five sampled residents who were reviewed for unnecessary medications. The DON identified 68 residents residing in the facility. Findings: A Psychotropic Medication policy, undated, read in part, Consent: Provide the resident/resident representative with information on the medication, indication, dose, side effects, adverse consequences, and goal of treatment. Obtain informed consent from the resident/resident representative. Resident #47 was admitted to the facility on [DATE] with diagnoses which included dementia and unspecified mood [affective] disorder. A physician's order, dated 01/09/25, documented Resident #47 received olanzapine oral tablet (antipsychotic medication) 2.5 mg by mouth two times a day for anxiety and aggressive behaviors related to unspecified mood [affective] disorder. Resident #47's clinical record was reviewed. The clinical record did not contain signed consent for the use of a psychotropic medication, nor documentation that education and alternative treatments were discussed with the resident and/or their legal representative. On 01/22/25 at 2:45 p.m., MDS coordinator #1 was asked if residents/representatives were informed of risk/benefits of antipsychotic medications and signed consent for usage if prescribed. They stated, Yes. After reviewing the clinical record for Resident #47, MDS coordinator #1 acknowledged no consent had been signed.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed to self-administer medication for one (#31) of one sampled resident reviewed for self administering medications. The DON identified nine residents received nebulizer breathing treatments and 68 residents received medications from the facility. Findings: The facility's Self Administration of Medication policy and procedure, dated 04/10/14, read in part , A physician order must be obtained and permission given. The policy also read, The resident will review with the nurse all medications that they are taking identify the accurate dosage, correct time and why they are taking the medication. Resident #31 was admitted on [DATE] with diagnosis which included type 2 diabetes, tremors, adjustment insomnia, depression, other amnesia, and acute kidney failure. Resident #31's quarterly assessment, dated 11/12/24, documented their cognition was intact with minimal impairments. Resident #31's physician's order, dated 11/14/24, documented they were prescribed ipratropium-albuterol solution (bronchodilator) 0.5-2.5 (3) MG/3ML 1 vial inhale orally every 6 hours for shortness of breath, cough and congestion. The physician order did not document Resident #31 had permission to self-administer medication. On 01/22/25 at 11:20 a.m., Resident #31 was observed in their room. Resident #31 had a nebulizer mask and was giving themselves a breathing treatment. No nurse was observed present in the resident's room or in the hall way. On 01/22/25 at 11:22 a.m., LPN #3 came from a room where the door was closed across the hall from Resident #31's room. LPN #3 was asked what was going on in Resident #31's room. LPN #3 stated the resident was getting a routine breathing treatment. LPN #3 was asked who was in the room with Resident #31 supervising the breathing treatment. They stated, Nobody. LPN #3 was asked what the policy was for residents self-administering medications. LPN #3 stated they should have remained with the resident. LPN #3 acknowledged that they stepped out and went into another resident's room and shut the door across the hall. LPN #3 stated Resident #31 did not have an order to self-administer medications. On 01/22/25 at 11:29 a.m., Resident #31 was asked what they were doing. They stated they were giving themselves a breathing treatment. They were asked was a nurse present in the room. Resident #31 stated, No, not today. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/22/25 at 11:37 a.m., the DON was asked what was the policy for residents who self-administer medication. The DON stated there should have been a physician order that gave permission and the resident should review with the nurse the dosage, time, and why they need the medication. The DON was asked if there was an order for Resident #31 to self-administer medication and breathing treatments. The DON stated across the hall was not considered supervision. The DON stated there was no order for Resident #31 to self-administer medications and they were not assessed to self- administer medications. The DON stated the facility's Self Administration of Medication policy was not followed.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on observation, record review, and interview, the facility failed to ensure the accuracy of a MDS assessment for one (#47) of five sampled residents reviewed for MDS accuracy. The administrator identified 68 residents resided in the facility Findings: Resident #47 was admitted to the facility on [DATE] with diagnoses which included dementia and unspecified mood [affective] disorder. A nurse's note, dated 01/06/25 at 3:10 p.m., documented Resident #47 was threatening to leave the facility and a WanderGuard device was placed on their left ankle by the nurse on duty. An admission MDS assessment, dated 01/10/25, documented in section P, item P0100 E, Resident #47 did not use a wander/elopement alarm. On 01/22/25 at 10:40 a.m., Resident #47 was observed sitting on the side of their bed. A WanderGuard device was noted on their left ankle. On 01/22/25 at 2:30 p.m., MDS coordinator #2 was asked if Resident #47 wore a WanderGuard device. They stated, Yes. After reviewing Resident #47's MDS, the MDS coordinator acknowledged MDS item P0100 E had been answered inaccurately.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review and interview, the facility failed to ensure the baseline care plan was completed within 48 hours for two (#47 and #218) of 17 sampled residents reviewed for care plans. The administrator identified 68 residents resided in the facility. Findings: 1. Resident #47 was admitted to the facility on [DATE] at 6:00 p.m. with diagnoses which included dementia and unspecified mood [affective] disorder. The baseline care plan for Resident #47 documented an implementation date of 01/06/25 at 9:40 a.m. A total of 63.75 hours following the resident's admission. 2. Resident #218 was admitted to the facility on [DATE] with diagnoses which included COPD and encounter for orthopedic aftercare (pelvic fracture). The baseline care plan for Resident #218 documented an implementation date of 01/20/25 at 8:10 a.m. A total of 72 hours following the resident's admission. On 01/22/25 at 2:28 p.m., MDS coordinator #1 was asked what was the facility policy on completion of the baseline care plan for newly admitted residents. They stated the baseline care plan was completed within the first 24 hours after admission. After reviewing the baseline care plans for Resident #47 and Resident #218, MDS coordinator #1 acknowledged the care plans had not been completed within 24 hours by the admitting nurse or the nurse taking responsibility for the resident immediately after. 46702

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was labeled and dated for one (#218) of 18 sampled residents reviewed for labeling and dating of oxygen tubing. The DON identified 18 residents had physician orders for supplemental oxygen. Findings: The facilty's Oxygen System Change Out policy, revised 10/11/17, read in part, Each new oxygen set will be labeled with the date of change and the nurses initials. Resident #218 was admitted on [DATE] with diagnoses which included fracture of the pelvis, fracture of the fifth cervical vertebrae, and osteoporosis. Resident #218's physician's order, dated 01/17/25, read in part, 2L via nc to maintain spo2 [greater than] 89% PRN every shift. On 01/21/25 at 12:21 p.m., Resident #218 was observed in their bed wearing oxygen with a nasal cannula attached to an oxygen concentrator There was no date or label on oxygen tubing concentrator indicating when the oxygen tubing was administered. On 01/23/25 at 11:51 a.m., Resident #218 was observed wearing oxygen via a nasal cannula. There was a bag taped to the oxygen saturator and no date was observed indicating when O2 tubing was administered. On 01/23/25 at 11:53 a.m., LPN #4 was asked what the policy and procedure was when a resident had a saturator and O2. LPN #4 stated the tubing needed to be labeled with the day it was administered and who administered it. They were asked to come to Resident #218's room. On 01/23/25 at 11:59 a.m., LPN #4 was asked what they observed in Resident #218's room. LPN #4 stated they did not see a label with the date the oxygen tubing was administered and who administered the tubing. On 01/23/25 at 12:07 p.m., the ADON was asked what the policy was when a resident was prescribed supplemental oxygen equipment. The ADON stated the oxygen tubing and bag should be labeled and dated the day they were administered. The ADON went into Resident #218's room and was asked to discuss what they observed. The ADON stated there was no label or date on the oxygen tubing or bag and their policy was not followed.