STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375535	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Latimer Nursing Home	103 Southwest 9th Street Wilburton, OK 74578

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide an environment free of urine odors for 1 of 2 halls. The Point of Care Rooms/Beds roster showed there were 14 residents residing on the South hall. Findings: On 05/05/25 at 12:30 p.m., there was a strong urine odor present on the South hall. On 05/06/25 at 7:50 a.m., there was a strong urine odor present on the South hall. On 05/07/25 at 7:55 a.m., there was a strong urine odor present on the south hall. On 05/07/25 at 4:07 p.m., LPN #3 stated in the morning the South hall smelled of urine. LPN #3 stated the odor got stronger when they opened the hopper room door. LPN #3 stated the strong urine smelled like the residents on the hall needed to drink more water. LPN #3 stated they provided water to all their residents and encouraged them to drink. On 05/07/25 at 4:29 p.m., CNA #3 stated the odor on the South hall was urine. CNA #3 stated they thought the strong urine odor was coming from one particular room. CNA #3 stated they changed the resident in that room and changed their linen, but even after cleaning the mattress, it still smelled strongly of urine. CNA #3 stated there was another resident whose mattress smelled of urine as well. CNA #3 stated while they waited for help to transfer and change the resident, they cleaned the resident's mattress and made up their bed with clean linen. CNA #3 stated even though they cleaned the mattress, it still smelled of urine. On 05/12/25 at 3:50 p.m., the administrator stated they addressed the facility odors by changing the cleaning and sanitizing chemicals used, added an odor deodorizer, and scheduled routine stripping and buffing of the floors. The administrator stated due to the strong odor of some residents' urine, those residents routinely received new mattresses.

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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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** Based on record review and interview, the facility failed to ensure an admission resident assessment was completed within the required timeframe for 1 (#126) of 12 sampled residents whose resident assessments were reviewed. The administrator identified 27 residents resided in the facility. Findings: An admission assessment, dated 01/20/25, showed Resident #126 admitted on [DATE]. The assessment was signed as completed on 04/14/25. The assessment should have been completed by the resident's fourteenth day in the facility. On 05/07/25 at 2:08 p.m., the MDS coordinator stated the admission resident assessment was not completed timely. They stated the assessment dated [DATE] was not competed until 04/14/25.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure residents were assisted with incontinent care for 1 (#20) of 1 sampled resident reviewed for ADL care. The administrator identified 27 residents resided in the facility. Findings: On 05/05/25 at 1:39 p.m. CNA #1 was observed to assist Resident #20 with incontinent care. Resident #20's brief was observed to be very saturated with dark yellow substance. There was a very strong urine odor in the room. An undated policy titled Behavioral Programs and Toileting Plans for Urinary Incontinence, read in part, A 'check and change' strategy involves check the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort to protect the skin. Resident #20's quarterly assessment, dated 03/24/25, showed the resident was cognitively intact with a BIMS score of 15 and had diagnoses which included multiple sclerosis and urinary incontinence. The assessment showed Resident #20 was totally dependent upon staff for assistance with all of their ADL's. On 05/05/25 at 1:09 p.m., Resident #20 stated bed checks were not done every two hours. They stated on most days they were only changed once a day. On 05/05/25 at 1:45 p.m., CNA #1 stated the last time they had changed Resident #20 was a bit after 10:00 a.m. They stated the resident had not been changed from 6:45 a.m. to 10:00 a.m. CNA #1 stated the policy for providing incontinent care was to change the residents every two hours. CNA #1 stated they had not changed Resident #20 every two hours because they had been too busy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure a resident received their pain medication as ordered by the physician for 1 (#20) of 1 sampled resident reviewed for narcotic pain medication use. The MDS coordinator identified 15 residents received narcotic pain medications. Findings: Resident #20's quarterly assessment, dated 03/24/25, showed Resident #20 was cognitively intact with a BIMS score of 15 and had diagnoses which included multiple sclerosis and chronic pain. Physicians orders, dated 03/26/25, showed Resident #20 was to receive: a. hydrocodone/acetaminophen (narcotic pain reliever) 10/325 mg, Give one tablet every six hours; b. cyclobenzaprine (muscle relaxant) 10 mg. Give one tablet in the morning, afternoon, and at bedtime; c. ibuprofen (nonsteroidal anti-inflammatory drug) 600 mg. Give one tablet every six hours as needed for pain; and d. Voltaren arthritis pain gel 1%. Administer topical every four hours as needed. A May 2025 medication administration record showed Resident #20 did not receive their hydrocodone/acetaminophen on 05/11/25 at 12:00 a.m., 6:00 a.m., 12:00 p.m., or 6:00 p.m. and on 05/12/25 at 12:00 a.m. and 6:00 a.m. A nursing note, dated 05/11/25 at 1:34 p.m., showed Resident #20 was given ibuprofen 600 mg for a pain level of 7. A nursing note, dated 05/11/25 at 2:30 p.m., showed Resident #20 had no complaints of pain. On 05/12/25 at 12:47 p.m., the administrator stated they were waiting on prior authorization on the hydrocodone/acetaminophen. They stated it usually it took about two days. On 05/12/25 at 12:47 p.m., the administrator stated Resident #20 was given their last hydrocodone/acetaminophen 10/325 mg on 05/10/25 at 6:45 p.m. They stated the facility was waiting for prior authorization from Resident #20's insurance. On 05/12/25 at 1:24 p.m., Resident #20 was asked their pain level and they stated they were dying without their pain medication. They stated their pain was bad.

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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. Based on observation, record review, and interview, the facility failed to utilize EBP for 1 (#21) of 1 resident who was observed to receive catheter care. The Matrix for Providers identified three residents with urinary catheters. Findings: On 05/05/25 at 1:13 p.m., Resident #21 was observed in bed with a catheter bag hooked to the side of the bed. There was no sign to utilize enhanced barrier precautions nor was there enhanced barrier precaution equipment visible near the entrance to the resident's room or in the resident's room. On 05/08/25 at 2:50 p.m., CNA #4 was observed to drain the resident's urinary catheter. There was a towel, washcloth, and gloves lying on the floor near the foot of the resident's bed. CNA #4 was observed to remove gloves from their pocket, don gloves, kneel in front of the urinary catheter drainage bag, pull the towel and wash cloth from the foot of the bed and position the towel under the urinary drainage bag. CNA #4 removed the drainage tube and drained the urine from the bag into a used urinal. CNA #4 wiped the drainage tube with the wash cloth lying on the floor and stored the urinary drainage tube. CNA #4 then exited the room, holding the urinal, wash cloth, and towel in their gloved hands. CNA #4 opened the hopper door with the same gloved hands and then asked if it was ok to wear the gloves if they were still carrying the urinal and dirty washcloth/towel. CNA #4 poured the urine out and ran water from the hopper, to rinse the urinal. CNA #4 then disposed of the washcloth/towel in the dirty linen. CNA #4 doffed their gloves and sanitized their hands. CNA #4 did not wear an isolation gown or mask. On 05/08/25 at 3:30 p.m., LPN #1 was observed to perform urinary catheter care for Resident #21. The urinary catheter tubing was not anchored/secured to the resident's leg. LPN #1 donned gloves to perform the urinary catheter care. LPN #1 did not wear a mask or isolation gown. An undated facility policy titled Policy and Procedure for Enhanced Barrier Precautions, read in part, It is the policy of this facility that any resident that has one of the following must fall under the enhanced barrier precaution rule .colostomy, foley cath, suprapubic cath, rectal tube, peg tube [percutaneous endoscopic gastrostomy], any stoma. EBP rule .When doing any care that requires the staff to come into contact with the artifical [sic] opening into the body or any tubing that is entering the body of a resident the staff member must act as if the resident is in isolation .wearing gloves, a gown, a face shield. This practice is to help prevent infections that can be introduced into the body through the stoma or catheters. A quarterly assessment for Resident #21, dated 04/25/25, showed the resident's cognition was intact with a BIMS score of 15. The assessment showed the resident had an indwelling catheter. On 05/05/25 at 1:15 p.m., Resident #21 stated the facility nursing staff wore gloves when performing urinary catheter care and not all the other stuff the hospital nurses wore. Resident #21 stated the urinary catheter was not secured/anchored. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/08/25 at 2:55 p.m., CNA #4 stated they were taught to wear gloves and clean around the drain tube after clamping it, but before securing the drain tube to the drainage bag. CNA #4 denied knowledge of enhanced barrier precautions. After leaving the resident's room with gloves still on from draining the resident's urinary catheter, CNA #4 asked if it was ok to wear gloves into the hall if they were carrying the soiled towel and washcloth and the urinal filled with urine. On 05/08/25 at 3:45 p.m., LPN #1 stated they noticed the resident's urinary catheter was not secured/anchored earlier in their shift and would anchor the catheter after they completed urinary catheter care. LPN #1 stated urinary catheters were to be secured/anchored. LPN #1 stated they wore gloves for infection control when performing urinary catheter care. LPN #1 stated they were not aware of enhanced barrier precautions. On 05/08/25 at 3:52 p.m., the IP stated they expected the nurses to wear gloves when performing urinary catheter care. The IP was asked if the facility staff utilized any other infection control practices when performing urinary catheter care. The IP stated they expected the nurses to wash their hands, wear gloves, and utilize clean technique when performing urinary catheter care. The IP was asked if the nursing staff utilized enhanced barrier precautions when performing urinary catheter care. The IP stated enhanced barrier precautions was where the staff were to wear the isolation masks, gowns, and gloves. The IP stated they had a policy for enhanced barrier precautions somewhere in their binder, but would need time to find it.