STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375536	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuscany Village Nursing Center	2333 Tuscany Blvd Oklahoma City, OK 73120

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35389 The facility failed to ensure a care plan meeting was held and a resident's representative was included for one (#4) of three sampled residents reviewed for representative included in plan of care. The Administrator identified a census of 128. Findings: Resident #4 had diagnoses which included chronic kidney disease and chronic pain. Resident #4 had a Care Plan Conference on 07/31/23. Resident #4's Annual Resident Assessment was completed on 10/10/23. A Nurse's Note, dated 10/17/24, documented an email was sent to Resident #4's representative regarding setting up a care plan meeting. The next documented Care Plan Conference for Resident #4 was on 02/09/24. On 03/27/24 at 9:18 a.m., LPN #1 stated they were responsible for care plan meetings. They stated the meetings were supposed to be every three months. They stated Resident #4 had a care plan meeting that was missed. They stated the meeting was scheduled, but LPN #1 wasn't working, and no one covered them. They stated it was the meeting that fell between the 07/23 and the 02/24 care plan meetings.

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 The facility failed to ensure a resident experiencing pain received treatment for pain for two (#1 and #15) of four sampled residents reviewed for pain. CNA #1 failed to notify the nurse when Resident #15 experienced pain during incontinent care. Resident #15 continued to holler/cry out in pain throughout the incontinent care provided by CNA #1. The Administrator identified a census of 128. Findings: A Pain Management and Basic Comfort Measures policy, revised 08/19/20, read in part, .Staff will evaluate pain and provide basic comfort measures in accordance with standard practice guidelines .Utilize pain level scale to determine acceptable level of pain .Examine the site of patient's pain .Evaluate the resident's medical history for successful pain relief therapies .Provide pain medication as prescribed by an authorized prescriber . 1. Resident #15 had diagnoses which included Parkinson's disease without dyskinesia and cognitive communication deficit. A Pain Care Plan, last reviewed 02/12/24, documented interventions which included assess characteristics of pain including location, severity, type of pain, frequency, precipitating factors, and relief factors using the pain assessment form. A Quarterly Resident Assessment, dated 02/16/24, documented Resident #15 had severe cognitive impairment, they received scheduled pain medication, and had no pain present upon staff pain assessment interview. Resident #15's Incident Report, dated 03/17/24, documented the resident fell on [DATE] at 8:20 p.m. It documented the nurse was called to the resident's room by the nurse aide. It documented the resident was lying on the floor on their left side next to the recliner. Resident #15 was unable to describe what happened. It documented the resident admitted to hitting their head, a head to toe assessment was completed, and the resident was able to move all extremities. It documented the resident was assisted to bed with the help of the nurse aide with no signs of distress/discomfort noted at the time. Staffing schedules documented CNA #1 was working on Resident #15's hall on 03/17/24 on the 3:00 p.m. to 11:00 p.m. shift and 11:00 p.m. to 7:00 a.m. shift. Resident #15's x-ray result, dated 03/18/24 at 8:22 p.m., documented an acute mildly displaced, mildly impacted fracture at the left femoral head neck junction. Hospital records, dated 03/18/24, documented Resident #15 had experienced a ground level fall at the nursing facility. It documented the resident had been complaining of pain, was brought to the hospital, and x-ray showed a valgus impacted femoral neck fracture. It documented Resident #15 had underwent a hip and femur fracture repair. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 03/22/24 at 11:07 a.m., Family Member #1 stated Resident #15 had fallen around 8:03 p.m. on 03/17/24. They stated on 03/18/24 at 3:00 a.m., CNA #1 came in to change Resident #15 and the family member could hear the resident screaming out in pain. Family Member #1 stated CNA #1 was rough with Resident #15, and they identified later the resident had broken their hip. They reported the concern the next morning to the DON and showed them the video surveillance. They stated they told the DON CNA #1's treatment looked like they were rastling with a bear. The Family Member stated the DON did not watch all of the video because they were in a hurry and didn't want to see the rest. Family Member #1 stated they spoke with hospice and had agreed to wait to x-ray until Monday morning. On 03/22/24 at 11:31 a.m., Surveyor #1 observed the video surveillance of Resident #15 for 03/18/24 from 3:14 a.m. through 3:20 a.m. CNA #1 was observed providing incontinent care to Resident #15. CNA #1 lifted Resident #15's left leg, the resident screamed out and the CNA stated You're wet. CNA #1 removed clothing from the resident's lower body, the resident stated, Please quit. The CNA placed a new brief on and began putting the resident's pants back on. Resident #15 stated, Oh that hurts, Quit it, Stop, Get out of here. CNA #1 took Resident #15's left leg and bent it over their straight right leg creating a triangle shape. Resident #15 began screaming out and crying. CNA #1 continued to provide care to the resident. CNA #1 pushed Resident #15 to the right side and the resident screamed out help. The resident was observed hollering out in pain multiple times as care was being provided. CNA #1 failed to stop and go get the nurse, and instead continued to provide incontinent care to the resident and redress the resident. At the very end of care, CNA #1 asked Resident #15 Are you ok. The Resident stated, No, I'm not ok. CNA #1 asked what was not ok, did not receive a response, and covered the resident up. There was no documentation in Resident #15's clinical record that CNA #1 notified the nurse of the resident's pain experienced during care. On 03/22/24 at 2:23 p.m., the DON stated Resident #15's family member had shown them a video of the resident's fall on 03/17/24, and of care being provided during the next shift from CNA #1. They stated Resident #15 was yelling during care. They stated CNA #1 Kept changing [Resident #15]. The DON stated they did a one on one training with CNA #1 informing them if a resident yelled stop, they were to go get the nurse. They stated CNA #1 was aware the resident had fallen on 03/17/24 as they were working on the resident's hall when they fell . On 03/22/24 at 2:30 p.m., the DON stated the resident hollered often and it did not appear CNA #1 was rough. The DON stated it was determined later that day Resident #15 had broken their hip. On 03/25/24 at 10:10 a.m., an attempt to interview Resident #15 was made, the resident had their eyes open but did not respond to the surveyor. On 03/26/24 at 12:00 p.m., CNA #2 stated they would alert the nurse anytime a resident experienced pain/discomfort during care. On 03/26/24 at 12:05 p.m., CNA #3 stated they would let the nurse know if a resident experienced pain/discomfort during care. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 03/26/24 at 12:08 p.m., CNA # 5 stated they would ask a resident what was wrong if they experienced pain/discomfort, and notify the nurse. On 03/26/24 at 12:11 p.m., LPN #2 stated a CNA would need to stop anytime a resident experienced pain or discomfort during care and notify the nurse that moment. They stated they would follow up by completing an assessment of the resident, address the pain, see if there was an as needed pain medication ordered and assist with position changes to help if needed. They stated they would notify the physician if the resident did not have an order to treat pain. On 03/26/24 at 1:35 p.m., LPN #3 stated CNAs should stop and notify the nurse if a resident experienced pain or discomfort during care. LPN #3 stated they would gather as much information as possible, assess the resident, administer medications as ordered, and reposition the resident for comfort. 2. Resident #1 admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy, rhabdomyolysis, and anxiety disorder. A Physician Order, dated 02/22/24, documented acetaminophen 325 mg take two tablets by mouth every four hours as needed for pain. A Physician Order, dated 02/22/24, documented oxycodone 5mg take one tablet by mouth every six hours as needed. A Physician Order, dated 02/29/24, documented oxycodone 5mg take one tablet by mouth two times a day. The Count Sheet for Resident #1's oxycodone 5mg tablet take one tablet by mouth twice daily documented the first dose was administered on 02/29/24. The February 2024 medication administration record documented: a. the first dose of oxycodone 5mg was administered to the resident at 9:00 a.m. on 02/29/24; b. acetaminophen 325 mg was administered once on 02/22/24 for a pain level of 2, once on the 25th for a pain level of three, and once on the 29th for a pain level of two; c. the oxycodone 5mg one tablet by mouth every six hours as needed for pain was not administered for the month; and d. Resident #1's pain scale for the day shift was rated at a five on the 22nd, 23rd, and 29th, rated at a four on the 25th, 26th, and 27th, and rated at a three on the 24th. On 03/21/24 at 11:35 a.m., Resident #1 stated it took the facility 1 1/2 weeks to get their pain pills at the facility. They stated they had pain medications at the facility they came from. Resident #1 stated the staff stated the doctor was called. They stated staff offered them Tylenol. Resident #1 stated their pain radiated from the right leg to the ankle, and they had pain in their back from a previous surgery which burned and at times was generalized. They stated when their pain medication was finally ordered, they received oxycontin 5mg twice a day routinely and never needed the as needed dose. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 03/22/24 at 9:02 a.m., LPN #2 stated they assessed residents for verbal and nonverbal signs of pain. On 03/22/24 at 9:03 a.m., LPN #2 stated they used a one to ten scale for pain. They stated a three to five was considered mild pain and needed a pain intervention. On 03/22/24 at 9:05 a.m., LPN #2 stated if a resident complained of pain, they would review their orders and administer medication as ordered. On 03/22/24 at 9:07 a.m., LPN #2 stated if a resident wanted an alternative pain medication or the medication was not effective, they would notify the physician for an intervention. On 03/22/24 at 9:47 a.m., the DON stated for a pain level of one to five staff would usually give Tylenol. They stated for a pain level higher than five they would give something stronger. They stated if the pain was consistent over a week, they would call the doctor. On 03/22/24 at 9:50 a.m., the DON stated Resident #1's initial pain scale on admission was a four. They stated from 02/22/24 through 02/29/24 the resident's pain level was a five three times, a four three times, a three one time, and a zero one time all on the day shift. They stated the evening and night shifts all had documented a zero for pain. On 03/22/24 at 9:53 a.m., the DON stated they would have expected the nurses' to give Tylenol for the above pain ratings. On 03/22/24 at 10:00 a.m., the DON stated Resident #1 received Tylenol on the 22nd, 25th, and 29th. They stated the resident only received Tylenol from 02/22/24 through 02/28/24. They stated the resident did not receive oxycodone. On 03/22/24 at 10:07 a.m., the DON stated Resident #1 had received oxycodone at the previous facility, but did not have a script at this facility for it. They stated the order was for oxycodone 5 mg every six hours as needed. They stated the doctor had to see the resident before writing a script for the pain medication. They stated the facility received the order for the oxycodone on 02/29/24 and it was received in the building that same day. On 03/22/24 at 10:16 a.m., the DON stated staff should offer the resident oxycodone if they requested it. On 03/22/24 at 11:07 a.m., LPN #2 stated there was no documentation in the nurse notes of what Resident #1's pain effectiveness was for 02/22/24 and 02/29/24 after the Tylenol administration.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35389 Based on record review and interview, the facility failed to ensure resident records were accurate for one (#3) of three sampled residents reviewed for accurate records. The Administrator identified a census of 128. Findings: A Records Management policy, revised 06/01/17, read in part, .The Organization requires that its records be maintained in a consistent and logical manner and be managed so that the Organization .Meets legal standards for protection, storage, and retrieval .Protects the privacy of healthcare facility residents and patients . Resident #3 had diagnoses which included cerebral infarction and aphasia. Resident #14's hospital records, dated 08/05/23, were observed in Resident #3's clinical record. Resident #13's hospital records, dated 08/07/23, were observed in Resident #3's clinical record. Resident #11's hospital records, dated 09/08/23, were observed in Resident #3's clinical record. Resident #12's hospital records, dated 09/25/23, were observed in Resident #3's clinical record. On 03/21/24 at 2:42 p.m., Medical Records stated they received any resident information in a basket located by the scanner. They stated the ADON reviewed them to ensure the orders were put in correctly, then Medical Records would scan them in. They stated everything had a resident's name, dates of service, and who created the document. They stated they would email Corporate and have the above documents removed from Resident #3's record.