STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montevista Rehabilitation and Skilled Care	7604 Quanah Parker Trailway Lawton, OK 73505

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 30875 Based on record review and interview, the facility failed to ensure the resident's representative was notified of changes in skin condition for 1 (#1) of 3 sampled residents reviewed for notifications. The administrator identified 88 residents resided in the facility. Findings: A Change of Condition policy, dated 02/13/23, read in part, Examples of circumstances of when it is appropriate to communicate information to these parties may include, but are not limited to .unexpected deterioration in condition or status. Resident #1's had diagnoses which included Type 2 diabetes mellitus without complications, intrahepatic bile duct carcinoma, and perforation of gallbladder in cholecystitis. An admission assessment, dated 01/29/25, read in part, Does resident wish to have a representative involved in care decision-yes (enter name in text box)- [Family member name withheld]. A skin assessment, dated 01/29/25, showed Rash/Redness/Denuded (Includes MASD/IAD)- Yes. Location of Rash/Redness- Buttocks blanchable redness. Surgical wound - Yes. Location of surgical wound-abdomen upper right side of abdomen. A skin assessment, dated 02/05/25, showed Rash/Redness/Denuded (Includes MASD/IAD) - No. Surgical wound - No. A physician order, dated 02/07/25, showed to cleanse the wound to the buttocks/ coccyx area with cleanser, pat dry, apply xeroform and cover with bordered gauze daily. Dx: pressure ulcer of specified site, unspecified stage. Entered by LPN #8. D/C by RN #2 on 02/09/25. A baseline care plan, dated 02/07/25, showed resident wanted to be involved in care decisions - Yes, wishes to have a representative involved. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/25 at 8:40 a.m., LPN #8 reviewed the eMAR record. They reported the resident admitted with red buttocks and was starting to get an open area. They stated they notified the physician and received a new order on 02/07/25. They were asked if they contacted the representative listed on the admission assessment. They stated no. They reported a family member was in the room at this time of the treatment and was listed on the contact list in the eMAR. They were asked if they charted the name of the person contacted related to the new wound order. They stated they did not. They were asked if that was the facility policy to chart the person contacted. They stated that was the facility policy to chart the name of person contacted. 03/04/25 at 10:19 a.m., the DON was asked who the staff would notify with a new order for Resident #1. They reported whoever performed the admission assessment should make sure it matched the face sheet in the eMAR. They were asked who the contact person for Resident #1 would be. They stated the name listed on the admission assessment.

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. 30875 Based on record review and interview, the facility failed to: a. verify and obtain clarification from the physician to determine how often to flush the cholecystostomy drain and to measure and record the drain output for 1 (#1) of one sampled resident with a cholecystostomy drain; and b. administer medications as physician ordered for 1 (#1) of 1 sampled resident reviewed for new admissions to the facility. The administrator reported 88 residents resided in the facility and had 47 new admits to the facility in the last 30 days. The administrator reported they currently had no cholecystostomy drains in the facility. Findings: 1. A performance checklist skill Managing Wound Drainage Evacuation policy, dated 2018, read in part, Recording and Reporting, 1. Recorded all pertinent information in the appropriate log. 2. Recorded amount of drainage on I&O record. 3. Documented evaluation of patient learning. 4. Reported sudden change in amount of drainage, pungent odor of drainage or new signs of purulence, severe pain, or dislodgement of tube to health care provider immediately. A H&P for Resident #1, dated 01/20/25, showed per IR patient's cholescystostomy tube needed to be flushed and drained twice daily with 5-10ml normal saline flushes. Per GS, patient will need to follow up outpatient with GS and IR in 4-6 weeks for drain removal. The physician order packet (physicians order), dated 01/29/25, read part, Septic shock 12/31/24 - 01/29/25, return visit 02/04/25 with gastrointestinal cancer clinic .Other instructions an IR appointment has been made for you to remove the cholecystostomy tube. If you do not hear from them in 1 week regarding your appointment, would recommend calling [number removed] to schedule appointment. Cholecystostomy drain .Keep a daily record of output for your provider .Flush your drain daily. The physician packet order consisted of 30 pages and contained the flush procedure for a cholecystostomy drain. On 02/25/25 at 10:48 a.m., the ADON provided the physician order packet (admitting physician orders) they received for Resident #1's admission intake. Inside the packet were instructions to flush a cholecystostomy drain. They stated they did not actually see the resident's drain. They stated the order documented it was a cholecystostomy drain. They were asked if these instructions included how many times a day to flush Resident #1's drain. They stated the flushing instructions related to how many times a day the drain was to be flushed were not included in the physician order packet [admitting physician orders], but were located on the H&P dated 01/20/25. The ADON was asked who received the instructions on how to flush the cholecystostomy drain. They stated they passed the cholecystostomy drain procedure to the staff member who was admitting the resident and they passed it on to the next nurse in report. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/25 at 11:37 a.m., the ADON stated they received the flush orders for Resident #1's drain from the H&P dated 01/20/25, not from the physician order packet (admitting physicians orders). They were asked if the H&P was a physicians order. They stated that it was the plan to take care of them. The ADON was asked if they obtained clarification from the physician. They stated typically they did, but they had cleared everything out of their phone. They were asked if they contacted the physician. The ADON stated it was not charted that anybody was contacted. They were asked if they documented communication with the physician's case manager. They stated there was no clarification from anyone related to the flushes. The ADON determined LPN #6 admitted Resident #1. They stated they made a copy of the instructions and gave that to the nurse that received the resident and then hoped it would become part of their care and passed on in report. On 02/25/25 at 3:12 p.m., the administrator was asked for a policy specifically for drains (cholecystostomy drain/IR drain). The administrator submitted a performance checklist skill document titled, Managing Wound Drainage Evaluation. They stated that was the guide they followed. They were asked if they had a standard facility policy. They stated they have nothing that looked like the other policies submitted. The policy did not mention a cholecystostomy drain. On 02/25/25 at 3:49 p.m., the drain policy and procedure was presented to RN #1. They stated it looked like a checklist. They were asked if they followed the policy. They stated obviously not. RN #1 was asked if drain output should be recorded. They stated the output from drains should be recorded. They stated they would have included the specific instructions for the drain into the actual physician's orders. On 02/26/25 at 6:43 a.m., LPN #6 was asked about the way they flushed the cholecystostomy drain. They stated they would flush it with 10 ml's and go back and see if it drained into the bag and if it did not they would go back and flush it again. They were asked if the physician order stated to record the drain output. They stated it did not, just to flush it with 10 ml's of normal saline. They stated this was the first cholecystostomy tube they had seen. They were asked to review the physician order packet and was asked what the order documented related to measuring output. They stated to keep a daily record of output for your provider. They were asked about the facility policy to record output from a drain. They stated for JP drains it would have been included on the physicians order to measure and record the output from the drain. On 03/04/25 at 12:13 p.m., ADON was asked to review the physician order packet for Resident #1's admission. They stated they transcribed the drain to be flushed twice daily, but the physician order did state to flush it daily. They were asked if it would be acceptable to take physician orders from the H&P dated 01/20/25 dated prior to the residents admission. They stated they agreed it would not be. 2. A Physician Orders Admission policy, dated 03/19/22, read in part, It is the policy of our facility that all treatments and medications be ordered by the resident's physician, advanced practice nurse, physician assistant, or Dentist. The physician order packet, printed on 01/29/25, for Resident #1's admission to the facility showed the following medication list: a. continue loratadine (an antihistamine) 10 mg tablet take 1 tablet by mouth in the morning, (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. continue magnesium glycinate (a supplement) 100 mg capsule take 100 mg by mouth at bed time, last time this was given: ask your nurse or doctor, c. continue vitamin C (an antioxidant) take by mouth, d. continue garlic (a supplement) take by mouth, and e. continue zinc (a supplement) take by mouth, last time this was given: ask your nurse or doctor. On 02/25/25 at 8:40 a.m., the physician orders were reviewed with the ADON. They identified the following medications were not transcribed upon admission. The ADON reported it was the facility policy for another nurse to verify the physician orders and they would both initial the physician order, and if they needed to they would notify the physician. a. loratadine 10 mg in the morning, b. magnesium glycinate 100 mg capsule at bedtime, and c. vitamin C, garlic, and zinc. On 02/25/25 at 4:30 p.m., RN #1 reviewed admission orders and verified the following medications were not transcribed. a. loratadine 10 mg in the morning, b. magnesium glycinate 100 mg capsule at bedtime, and c. vitamin C, garlic, and zinc. On 03/04/25 at 12:20 p.m., the physician orders were reviewed with LPN #1. They stated they had entered the physician orders into the eMAR. They stated if they had any questions they would reach out to the liaison. They stated the following medications were not transcribed and should have been. They reported they did not have another nurse verify the physician order. a. loratadine 10 mg in the morning, b. magnesium glycinate 100 mg capsule at bedtime, and c. vitamin C, garlic, and zinc.

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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 30875 Based on record review and interview, the facility failed to implement a baseline care plan to include a IR drain/cholecystostomy drain within 48 hours of admission to the facility for 1 (#1) of 1 sampled resident reviewed for an IR drain. The administrator reported 47 new admissions in the past 30 days. Findings: A Care Plan - Process policy, dated 03/27/23, read in part, Initiate a Baseline Care Plan and complete within forty-eight (48) hours of admission based on the physician's orders and nursing evaluation. Resident #1's diagnoses included intrahepatic bile duct carcinoma, perforation of gallbladder in cholecystitis, and acute kidney failure. Resident #1's admission assessment, dated 01/29/25, showed renal/urinary history-other (describe below)-IR drain. Current bladder/urine status-urinal at bedside. A Baseline Care Plan, dated 02/07/25, showed Physician Orders/Medications/Treatments. The IR drain was not listed under physician orders/treatment or listed under the nursing evaluation on the baseline care plan. On 02/24/25 at 5:52 p.m., the DON was asked about specific information on the baseline care plan related to the IR drain. They stated they did not see it on the baseline care plan. On 02/25/25 at 3:12 p.m., the administrator was asked when the baseline care plan had been completed. They stated it was completed on 02/07/25. They were asked if they followed the facility policy. They stated they did not follow the policy. The baseline care plan was completed by LPN #3, nine days after Resident #1's admission.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 30875 Based on record review and interview, the facility failed to document a a skin assessment for 1 (#1) of 2 sampled residents reviewed for physician ordered wound treatments. The administrator identified 88 residents resided in the facility and the facility matrix showed seven residents had wounds in the facility. Findings: A policy titled An Overview of Wound Care, dated July 2018, read in part, It is important that existing PU/PI be identified, whether present on admission or developed after admission, and that factors that influenced its development, the potential of additional PU/PIs or the deterioration of the PU/PIs be recognized, assessed and addressed. Any new PU/PI suggests a need to reevaluate the adequacy of prevention measures in the resident's care plan. A policy titled Documentation and Measurement of Wounds, revised July 2018, read in part, Wounds are measured and documented within professional practice guidelines. Resident #1's diagnoses included, type 2 diabetes mellitus without complications, intrahepatic bile duct carcinoma, and perforation of gallbladder in cholecystitis. An admission assessment, dated 01/29/25, showed skin intact, fair turgor, pressure redistribution mattress, other describe below surgical incision right upper abdomen IR drainage bag placed. A skin assessment, dated 01/29/25, showed Rash/Redness/Denuded (Includes MASD/IAD)- Yes. Location of Rash/Redness- Buttocks blanchable redness. Surgical wound - Yes. Location of surgical wound-abdomen upper right side of abdomen. A skin assessment, dated 02/05/25, showed Rash/Redness/Denuded (Includes MASD/IAD) - No. Surgical wound - No. A pressure ulcer risk assessment, dated 02/05/25, showed a pressure ulcer risk, mild risk (21): total score 15-24. A care plan, dated 02/05/25, showed skin breakdown: at risk for/actual. Measures will be taken to prevent skin breakdown over the next 90 days, inspect skin complete body head to toe every week and document results, off load heels, treatment and dressings as ordered per physician, dietitian referral 02/07/25, position resident properly; use pressure-reducing or pressure-relieving devices (For example: pillows, positioning wedges, and alternating pressure mattress) if indicated 02/07/25. A physician order, dated 02/07/25, showed to cleanse the wound to the buttocks/ coccyx area with cleanser, pat dry, apply xeroform and cover with bordered gauze daily. Dx: pressure ulcer of specified site, unspecified stage. Entered by LPN #8. D/C by RN #2 on 02/09/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A baseline care plan, dated 02/07/25, showed pressure ulcer risk, moderate risk: total score 13/14, preventive measures, and education will be provided. Interventions include pressure reducing mattress. On 02/25/25 at 8:40 a.m., LPN #8 reviewed eMAR record. They reported the resident admitted with red buttocks and was starting to get an open area. They stated they notified the physician and received a new order on 02/07/25 and they did not perform a skin assessment, or make a nurse's note related to the description of the wound in the eMAR. They reported the resident was added to the list to be seen by wound care doctor the following Monday on 02/10/25, but the resident left the facility against medical advise on 02/09/25. They reported the left side of the resident's buttocks was redder and it was not blanchable, they believed it was the left side that was worse with purple reddish color, and the skin was starting to flake off and they were concerned about that.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 30875 Based on record review and interview, the facility failed to develop and implement a policy for cholecystostomy drain care for 1 (#1) of 1 sampled resident with a cholecystostomy drain and ensure the nursing staff were properly trained and determined competent for 3 (LPN #3, 5 and #6) of 4 sampled LPNs interviewed for drain care. The administrator reported 88 residents resided in the facility and had no cholecystostomy drains in the facility. Findings: A performance checklist skill Managing Wound Drainage Evacuation policy, dated 2018, read in part, Recording and Reporting 1. Recorded all pertinent information in the appropriate log. 2. Recorded amount of drainage on I&O record. 3. Documented evaluation of patient learning. 4. Reported sudden change in amount of drainage, pungent odor of drainage or new signs of purulence, severe pain, or dislodgement of tube to health care provider immediately. The physician order packet (physicians order), dated 01/29/25, read in part, Septic shock 12/31/24 - 01/29/25, return visit 02/04/25 with gastrointestinal cancer clinic .Other instructions an IR appointment has been made for you to remove the cholecystostomy tube. If you do not hear from them in 1 week regarding your appointment, would recommend calling [number removed] to schedule appointment. Cholecystostomy drain .Keep a daily record of output for your provider .Flush your drain daily. The physician packet order consisted of 30 pages and contained the flush procedure for a cholecystostomy drain. Resident #1's eTAR, dated 02/02/25-02/24/24, showed treatment every 12 hours flush cholecysystomy tube twie a day with 10 ml normal saline. LPN #3 documented flushes on 02/01/25, 02/02/25, and 02/03/25. LPN #5 documented flushes on 02/07/24 and 02/08/25. LPN #6 documented flushes on 02/01/25, 02/06/25, and 02/07/25. The eTAR did not document to measure the output. On 02/24/25 at 4:02 p.m., LPN #5 was asked about Resident #1's cholecystostomy drain. They stated they just came back to work on February 7, 2025, and they did not remember the resident. On 02/24/25 at 5:14 p.m., LPN #5 was asked about flushing Resident #1's drain on 02/07/25 and 02/08/25. They were asked to review the eTAR related to the flushing of the drain. They stated it was documented, so they guessed they did. They were asked if they had received training related to a cholecystostomy drain. They stated, No, ma'am, they were a new admit. They were asked if they disconnected it or just flushed it with normal saline. They stated honestly, they could not remember. They were asked if they remembered if it had an opened/closed position. They stated they did not remember. They stated they only worked over on the skilled side for three hours. They were asked if they emptied the drain, would they chart the drain output. They stated they believed you were supposed to. They reported they were informed it was a bile drain. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/25/25 at 6:43 a.m., LPN #6 was asked about the way they flushed the cholecystostomy drain. They reported they would flush it with 10 ml's and go back and see if it drained into the bag and if it did not, they would go back and flush it again. They stated the treatment order stated to just flush it. They were asked if the treatment order stated to record the drain output. They stated it did not, just to flush it with 10 ml's of normal saline. They reported this was the first cholecystostomy tube they had seen. They were asked about the facility policy to record output from a drain. They stated for JP drains it would have been included on the physicians order to measure and record the output from the drain. On 02/25/25 at 9:48 a.m., LPN #3 reported they did not flush the drain (which they thought was a nephrostomy tube), and reported they did not flush the drain they only emptied the drain bag. They did not document the output in the nurse's notes or in the output record. Reported they were only familiar with JP drains, indwelling catheter, and a nephrostomy tube. They were asked if that was the facility policy to chart drain output. They stated it was the facility policy. On 02/25/25 at 3:12 p.m., the administrator was asked for a policy specifically for drains (cholecystostomy drain/IR drain). The administrator submitted a document titled, performance checklist skill, managing wound drainage evaluation and stated, this was the guide they followed. They were asked if they had a standard facility policy. They stated they have nothing that looked like the other policies submitted. The policy did not mention a cholecystostomy drain. On 03/04/25 at 10:20 a.m., the DON was asked if the staff received training for a cholecystostomy drain. They reported they had no documentation related to training for the drain and were not aware the staff did not understand it. The DON reported if the staff required training the ADON would provide it.