

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Chickasha Nursing Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 South 9th Street Chickasha, OK 73018	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33148</p> <p>Based on record review and interview, the facility failed to ensure a baseline care plan was developed within 48 hours of admission for one (#7) of 14 sampled residents reviewed for care plans.</p> <p>The DON identified 29 residents resided in the facility.</p> <p>Findings:</p> <p>Res #7 was admitted to the facility on [DATE] with diagnoses which included COPD, Alzheimer's disease, unspecified dementia, anxiety, depression, chronic pain syndrome, and hypotension.</p> <p>There was no documentation a baseline care plan was developed.</p> <p>On 09/06/24 at 9:41 a.m., the DON was asked if a baseline care plan was developed for the resident when they were admitted on [DATE].</p> <p>On 09/06/24 at 9:43 a.m., the DON stated a baseline care plan was not completed when the resident was admitted to the facility on [DATE]. They stated it should have been developed within 48 hours.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>33148</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident had a physician order for O2 therapy for one (#8) of one sampled resident reviewed for respiratory care.</p> <p>The DON identified 16 residents who had orders for O2.</p> <p>Findings:</p> <p>Res #8 had diagnosis which included COPD.</p> <p>On 09/03/24 at 12:55 p.m., the resident was observed with O2 in place. The setting on the O2 concentrator was 2 1/2 LPM.</p> <p>There was no documentation the resident had a physician order for O2 therapy.</p> <p>On 09/03/24 at 1:04 p.m., LPN #1 was asked if the resident had an order to receive O2 therapy. They stated they only had orders to monitor O2 saturation. They were made aware of the observation.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to:</p> <ul style="list-style-type: none"> a. have a current contract with a dialysis provider, b. ensure ongoing communication with the dialysis provider, and c. conduct routine assessments before and after dialysis treatments for one (#14) of one sampled resident reviewed for dialysis. <p>The DON identified one resident who received dialysis services.</p> <p>Findings:</p> <p>A facility policy titled End-Stage Renal Disease, Care of a Resident with, dated September 2010, documented the agreement between the facility and the contracted ESRD facility included all aspects of how the resident's care would be managed including how the care plan will be developed and implemented and how information will be exchanged between the facilities.</p> <p>Res #14 had diagnoses which included dependence on renal dialysis, end stage renal disease, and chronic kidney disease.</p> <p>A care plan, dated 11/09/23, documented the resident needed dialysis treatment related to a diagnosis of renal failure. It was documented staff were to encourage the resident to attend scheduled dialysis appointments. It was document staff were to monitor, document, and report signs and symptoms of infection to the access site and signs and symptoms of renal insufficiency.</p> <p>The quarterly assessment, dated 08/08/24, documented the resident received dialysis while a resident.</p> <p>A physician order, dated 08/14/24, documented staff were to monitor thrill and bruit every shift and remove the pressure dressing two hours after returning from dialysis.</p> <p>There was no documentation the facility had a contract with a dialysis provider.</p> <p>There was no documentation the resident had a physician's order to receive dialysis services.</p> <p>There was no documentation routine assessments were conducted before and after dialysis.</p> <p>On 09/06/24 at 12:36 p.m., the administrator stated the dialysis contract with the dialysis provider was out dated.</p> <p>On 09/06/24 at 12:38 p.m., LPN #2 stated there was no routine form of communication with the dialysis provider or assessments completed before and after dialysis treatment.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>33097</p> <p>Based on observation, record review, and interview, the facility failed to assess and monitor a resident for the use of bed rails for one (#4) of one sampled resident reviewed for bed rails.</p> <p>The DON identified 11 residents who had bed rails.</p> <p>Findings:</p> <p>An undated facility policy titled Bed Safety and Bed Rails documented the use of bed rails was prohibited unless the criteria for use of bed rails had been met. It was documented maintenance staff were to routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks.</p> <p>Res #4 had diagnoses which included bipolar disorder, chronic pain, and acquired absence of right leg above the knee.</p> <p>The quarterly assessment, dated 06/04/24, documented the resident was severely impaired for daily decision making and was dependent for most ADLs. It was documented the resident did not use bed rails.</p> <p>On 09/03/24 at 12:33 p.m., staff was observed transferring the resident to bed. The resident was positioned for comfort and staff raised the bed rails on both sides of the bed before exiting the room.</p> <p>On 09/04/24 1:45 p.m., the resident was observed being transferred to bed by staff. The bed rails on both sides of the resident's bed were raised during the transfer. CNA #1 stated the resident was able to assist with turning in bed and sometimes used the bed rails.</p> <p>On 09/05/24 at 8:00 a.m., the resident was observed in bed sleeping with the bed rails raised on both sides of the bed. CMA #2 entered the resident's to administer medication. The CMA stated the bed rails were used due to the resident being sometimes confused. They stated the resident tried to get out of bed without assistance.</p> <p>There was no documentation the resident was assessed and monitored for the use of bed rails.</p> <p>On 09/05/24 at 12:04 p.m., the DON stated if bed rails were used an assessment should be completed. The DON as not able to provide an assessment for the resident.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to perform annual nurse aide competency reviews for two (CNA #3 and CNA #4) of two sampled employee files reviewed for annual competencies.</p> <p>The DON identified 29 residents resided in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. An undated employee roster documented CNA #3 was hired on 09/20/18. There was no documentation an annual competency review was completed in 2023. 2. An undated employee roster documented CNA #4 was hired on 03/05/16. There was no documentation an annual competency review was completed in 2024. <p>On 09/05/24 at 11:50 a.m., the DON was asked to provide documentation annual competencies were completed for CNA #3 and CNA #4. They stated they had no documentation an annual competency review was completed for CNA #3 in 2023. They stated an annual competency review had not been completed for CNA #4 in 2024.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>33148</p> <p>Based on observation and interview, the facility failed to ensure the kitchen and dining room were kept clean and maintained in good repair.</p> <p>The DON identified 29 residents received services from the kitchen.</p> <p>Findings:</p> <p>On 09/03/24 at 11:03 a.m., a tour of the kitchen and the dining area was conducted. The following observations were made.</p> <ul style="list-style-type: none"> a. there was brown water marks on the ceiling tiles, b. there was an accumulation of black and brown residue on the floor and the wall in the dish wash area, c. there was brown residue and/or rust on equipment in the dish wash area, d. the FRP board was not secure to the wall below the three compartment sink, e. the base board was missing off of the wall behind the cook line, f. there was an accumulation of food and grease on the floor and the wall behind the cook line, g. three of three gaskets were torn on the True three door reach in cooler, h. water was leaking from the pipe below the two compartment sink. There was standing water in the container below the sink, i. there was masking tape on the Formica counter near the two compartment sink, The Formica was coming off of the counter, j. there was an accumulation of black and brown residue on the floor under the equipment in the dry storage area, k. there was an accumulation of brown residue and trash on the floor behind the ice machine, l. material was peeling off of the outside area of the ice machine. The catch drain was missing. There was an accumulation of black residue and trash inside of the ice machine, and m. the black material on the floor at the entry way into the dining room was not secure to the floor. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/05/24 at 9:32 a.m., the DM manager was asked how staff ensured the kitchen and the dining area was kept clean and maintained in good repair. They stated they cleaned daily and had a deep cleaning schedule. They stated they recorded maintenance issues in the maintenance log. The DM was made aware of the above observations.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to submit PBJ data to CMS for the second quarter of the fiscal year for 2024.</p> <p>The DON identified 29 residents resided in the facility.</p> <p>Findings</p> <p>The PBJ Staffing Data Report documented the facility failed to submit data for the second quarter of 2024 (January 1 - March 31).</p> <p>On 09/05/24 at 2:13 p.m., the DOO stated they were unable to submit staffing data to CMS due to technical issues.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>33097</p> <p>Based on observation, record review, and interview, the facility failed to clean the mechanical lift before or after each resident use and have a water management program to prevent Legionella.</p> <p>The DON identified 29 residents who resided in the facility.</p> <p>Findings:</p> <p>An undated facility policy titled Lifting Machine, Using a Mechanical documented to disinfect lift surfaces.</p> <p>On 09/03/24 at 12:33 p.m., CNA #1 was observed transferring Resident #4 to their bed with the use of a mechanical lift. The CNA did not clean the lift prior to transferring the resident or after the resident transfer.</p> <p>On 09/04/24 at 1:53 p.m., CNA #1 stated lifts were cleaned weekly by maintenance. They stated the CNAs did not clean the lifts.</p> <p>On 09/05/24 at 8:41 a.m., the DON stated lifts should be cleaned after each resident use.</p> <p>On 09/05/24 at 3:02 p.m., the administrator and the DON stated there was no policy or plan for Legionella.</p>