

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Zarrow Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 2025 East 71st Street Tulsa, OK 74136	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>35389</p> <p>Based on observation, record review, and interview, the facility failed to:</p> <p>a. speak to a resident in a respectful manner for one (#28); and</p> <p>b. ensure resident clothing labels were not visible for one (#39) of three sampled residents reviewed for dignity.</p> <p>The DON identified a census of 58.</p> <p>Findings:</p> <p>A Quality of Life-Dignity policy, revised 08/09, read in part, .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .Residents shall be treated with dignity and respect at all times .Treated with dignity .means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .Staff shall speak respectfully to residents at all times . Demeaning practices and standards of care that compromise dignity are prohibited .</p> <p>1. Resident #28 had diagnosis which included Parkinson's and Dementia.</p> <p>On 04/02/24 at 9:10 a.m., CNA #6 was observed asking Resident #28 if they wanted to be fed like a baby, after the resident was observed sitting in wheel chair moving their fork around aimlessly in the air beneath the bedside table.</p> <p>On 04/02/24 at 9:23 a.m., Resident #28 was observed to be eating easily when the spoon was offered.</p> <p>On 04/02/25 at 10:02 AM, CNA #6 stated resident #28 usually went to the dining room and fed themselves. CNA #1 stated Resident #28 had commented they were not a baby when CNA #6 previously offered to assist them.</p> <p>On 04/02/24 at 10:19 a.m., Resident #28 was asked how it made them feel to be asked if they wanted to be fed like a baby. Resident #28's answer was not understood.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/03/24 at 2:51 p.m., LPN #2 stated Resident #28 had mentioned statements like I don't want you to feed me, but it had been a long time ago since they had stated that. They sated comments like do you want me to feed you like a baby would not be an appropriate statement at all.</p> <p>On 04/03/24 at 3:02 p.m., the DON stated it depended on the relationship between residents on how they would take the comment of Do you want me to feed you like a baby?</p> <p>2. Resident #39 had diagnoses which included Alzheimer's disease and anxiety disorder.</p> <p>A Significant Change Resident Assessment, dated 02/29/24, documented the resident's cognition for daily decision making was severely impaired.</p> <p>On 04/01/24 at 10:16 a.m., Resident #39 was observed seated in their wheelchair. The resident's right sock they were wearing had her name label clearly visible.</p> <p>On 04/02/24 at 9:07 a.m., Resident #39 was observed seated in their wheelchair. The resident's right and left sock they were wearing had a label with their name on each one clearly visible.</p> <p>On 04/03/24 at 10:45 a.m., CNA #3 stated they treated resident's with dignity and respect by making sure the door was shut and the curtain was pulled every time they went in to change them. They stated if a resident was wearing a dress, they would place a blanket over them. They stated they would always go in with respect and ask them if they needed anything, make sure they had a drink in reach, and offer drinks to those who could not get one themselves.</p> <p>On 04/03/24 at 10:46 a.m., CNA #3 stated staff would take resident's personal items over to the laundry who would use a label press on the back side of the shirts and pants to label items.</p> <p>On 04/03/24 at 10:46 a.m., CNA #3 stated they would make sure all clothing residents came with were labeled and placed in their closets.</p> <p>On 04/03/24 at 10:47 a.m., CNA #3 stated they were unsure of the reason the top of the resident's socks were labeled unless they were skid free and they didn't want to label the skid free section.</p> <p>On 04/03/24 at 10:50 a.m., Laundry #1 stated when they pick up resident items to be laundered, they made sure clothes had resident names on them. They stated they had a label machine to print out labels. They stated they placed labels on the inside, back section by the brand name. They stated they tried to place it where it didn't look like a label was there when they were wearing it. Laundry #1 stated they didn't use the inside of the socks because it might bother them, They stated they placed labels on the outside so they could read it and they were not bothered by the label.</p> <p>49701</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35389</p> <p>Based on record review and interview, the facility failed to insure an injury of unknown origin was reported to OSDH for one (#52) of three sampled residents reviewed for abuse.</p> <p>The DON identified a census of 58.</p> <p>Findings:</p> <p>An Abuse Prevention policy, updated 01/01/23, read in part, "[facility name] will make every attempt to protect our Resident's from abuse of any sort by striving to recognize signs and symptoms and potential for abuse or neglect. The facility has policies and procedures in place to identify events, such as suspicious bruising. Once a complaint or situation is identified involving injuries of unknown source, the incident will be immediately reported. A full report will be prepared and forwarded to officials as required by state and federal regulations."</p> <p>Resident #52 had diagnoses which included hemiplegia and hemiparesis following cerebral infarction and dysphagia.</p> <p>A Significant Change Resident Assessment, dated 01/11/24, documented Resident #58's cognition was moderately impaired.</p> <p>An Incident Report, dated 02/05/24 at 10:56 a.m., documented at approximately 9:30 a.m., CNA staff reported to the nurse to come to Resident #52's room. It documented upon entering the room, the nurse observed the resident in bed receiving incontinent care. It documented the nurse noted dark purple bruising with significant swelling to the resident's left labia majora and minora. It documented the area measured 15 cm in length and eight cm in width which was painful to touch. It documented the physician, DON, Care Coordinator, and POA were all notified. The report was prepared by LPN #1.</p> <p>A Skin/Wound Note, dated 02/06/24 at 5:35 a.m., documented Resident #52's groin area was checked. It documented ecchymosis seen to right side of groin and labia which was purple in color. It documented ecchymosis to the right thigh which was healing and pink in color.</p> <p>An Incident Note, dated 02/06/24 at 10:34 a.m., documented at approximately 9:30 a.m., CNA staff reported to the nurse to come to Resident #52's room. It documented upon entering the room, the nurse observed the resident in bed receiving incontinent care. It documented the nurse noted dark purple bruising with significant swelling to the resident's left labia majora and minora. It documented the area measured 15 cm in length and eight cm in width which was painful to touch. It documented the physician, DON, Care Coordinator, and POA were all notified. The note was created by LPN #1.</p> <p>A Nurses Note, dated 02/06/24 at 6:48 p.m., documented the resident had a right groin bruise and right inner thigh bruise.</p> <p>There was no State Reportable incident located for the above injury of unknown origin for Resident #52.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/03/24 at 2:11 p.m., CNA #3 stated if they saw any bruising on a resident that wasn't there the day before, they would immediately notify the charge nurse so they could assess the area. They stated the nurse would complete an incident report. They stated each staff member would also give a statement.</p> <p>On 04/03/24 at 2:15 p.m., CNA #2 stated they would notify their nurse anytime they identified bruising of unknown origin on a resident.</p> <p>On 04/03/24 at 2:17 p.m., LPN #1 stated if bruising of unknown origin was reported to them, they would assess the resident first to see the size and color. They stated they would complete an incident report and determine if the area was raised or painful. They stated they would ensure to inform the oncoming shift, the DON, Care Coordinator, family, POA, and physician. They stated the incident would automatically go in the pink book for Physician #1 to review.</p> <p>On 04/03/24 at 2:20 p.m., LPN #1 stated they remembered the incident involving Resident #52. They stated the CNA had removed the resident's brief during care, and the resident was noted to have a bruise in the pubis. They stated it was good size, and was the first time LPN #1 had seen it. They stated they completed an incident report on it and were never able to determine the cause of it.</p> <p>On 04/03/24 at 2:26 p.m., the DON stated if a resident was noted to have bruising of unknown origin, they would look to see how large the bruise was. They stated they would visit with the resident to see how they got the bruise. They stated if the resident was unable to report, the facility would do an additional investigation. The DON stated they would complete a State Reportable.</p> <p>On 04/03/24 at 2:28 p.m., the DON stated the facility would complete a State Reportable incident on any resident who had a bruise of unknown origin.</p> <p>On 04/03/24 at 2:29 p.m., the DON stated they were the person responsible for completing State Reportable incidents.</p> <p>On 04/03/24 at 2:31 p.m., the DON clarified the nurse note dated 02/06/24 was linked to the incident on 02/05/24. They stated the incident occurred on 02/05/24.</p> <p>On 04/03/24 at 2:36 p.m., the DON was asked what investigation was completed for the bruising of unknown origin.</p> <p>On 04/03/23 at 2:37 p.m., the DON reviewed the State Reportable incidents and did not locate one for the incident involving Resident #52 on 02/05/24.</p> <p>On 04/03/24 at 2:59 p.m., the DON stated they went to Care Coordinator #1 and obtained the facility investigation. The DON provided copied of an inservice related to reporting bruises held on 02/06/24. The DON also provided nine interviews conducted in conjunction with there investigation. The DON was unable to provide documentation OSDH was informed of Resident #52's injury of unknown origin.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>35389</p> <p>Based on record review and interview, the facility failed to revise care plans for two (#22 and #37) of 18 sampled residents reviewed for accuracy of care plans.</p> <p>The DON identified a census of 58.</p> <p>Findings:</p> <p>A Care Plans, Comprehensive Person-Centered policy, dated 12/16, read in part, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .</p> <p>1. Resident #37 had diagnoses which included aftercare following surgical amputation.</p> <p>A progress note, dated 01/15/24, documented Resident #37 was readmitted to skilled care after a left above knee amputation had been performed on 01/11/24. It documented a wound vac was to be in place for seven days.</p> <p>A Care Plan, revised 05/18/23, documented the resident has a venous ulcer of the left lower calf related to peripheral vascular disease. There was no care plan for wound care related to left above knee amputation.</p> <p>On 04/02/24 at 3:33 p.m., MDS Coordinator #1 stated they had started a Performance Improvement Project for care plans. MDS Coordinator #1 stated they care planned relevant new orders every day.</p> <p>2. Resident #22 had diagnoses which included corticobasal degeneration and hypertension.</p> <p>A Quarterly Resident Assessment, dated 01/11/24, did not document the resident received hospice services.</p> <p>There was no physician order for hospice care in Resident #22's current order summary.</p> <p>A Care Plan, last reviewed 01/30/24, documented the resident had a terminal prognosis which was initiated on 06/12/21 with a goal for comfort to be maintained through the review date with a target date of 04/26/24.</p> <p>On 04/03/24 at 10:01 a.m., LPN #3 stated Resident #22 was on hospice services when they first came to the facility. They stated they were unsure of the exact discharge from hospice date, but they thought it was longer than a year ago.</p> <p>On 04/03/24 at 10:20 a.m., MDS Coordinator #1 stated they printed out orders every morning and used them to update care plans. They stated they had a morning meeting where the Care Coordinators printed a list of everything which needed to be updated related to residents on the hall.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/03/24 at 10:21 a.m., MDS Coordinator #1 stated they would complete a care plan for terminal prognosis when the resident received a terminal prognosis.</p> <p>On 04/03/24 at 10:22 a.m., MDS Coordinator #1 stated Resident #22 was not on hospice services. They stated they did not complete the resident's care plan, and the care plan was not updated. They stated they guessed when Resident #22 came off of hospice services, they did not remove it from the resident's care plan. MDS Coordinator #1 stated they had been at the facility approximately one month and had not been able to update every resident's care plan.</p> <p>49701</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>49701</p> <p>Based on record review and interview, the facility failed to ensure a discharge summary was developed for one (#61) of three sampled residents reviewed for discharge.</p> <p>The DON identified a census of 58.</p> <p>Findings:</p> <p>Resident #61 had diagnoses which included pneumonia and bronchitis.</p> <p>A Discharge Summary and Plan policy, dated 12/16, read in part, .a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment .will include a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident .</p> <p>A Physician Order dated 01/10/24, documented the resident was to be discharged to an assisted living facility as of 01/16/24 with home health to include PT, OT, ST, skilled nursing and a home health aide.</p> <p>Resident #61 had no discharge summary in their medical record.</p> <p>On 04/04/24 at 2:00 p.m., the DON stated a discharge should include the condition of the resident, discharge rehabilitation potential, medications, orders, follow up directions, and reason for leaving. The DON stated it should have been in the progress notes and a discharge summary. The DON stated there was no documentation of the resident's discharge that could be located.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49701</p> <p>Based on observation and interviews, the facility failed to ensure harmful chemicals were secured.</p> <p>The Administrator identified six residents that required wander guards to be worn for safety. The DON identified a census of 58.</p> <p>Findings:</p> <p>On 04/01/24 at 9:58 a.m., an observation of 1/10 of a gallon container of dish detergent, 1/10 of a 32 oz. bottle of lime and calcium remover, 1/2 full spray bottle labeled with black marker cleaner with bleach, and a full 15 oz. aerosol can of stainless steel cleaner were observed sitting on top of the dishwasher in the room which connected the two dining rooms. A one gallon container of dish detergent and a one gallon container of sanitizer on a rack that was attached to the sink were also observed in the room. Both doors to the room were observed to be open.</p> <p>On 04/01/24 at 9:59 a.m., Dietary Aide #1 stated the residents don't come in the room. They stated the staff did not lock the door.</p> <p>On 04/01/24 at 12:08 p.m., the Dietary Manager stated there was no key, so the door did not get locked. They stated staff were in and out of the room all day. The Dietary Manager stated the door was only closed from around 7:00 p.m. to 7:00 a.m.</p>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>35389</p> <p>Based on record review and interview, the facility failed to obtain physician ordered labs for one (#56) of five sampled residents reviewed for unnecessary medications.</p> <p>The DON identified a census of 58.</p> <p>Findings:</p> <p>A Laboratory policy, undated, read in part, .It is the policy of this facility to ensure that laboratory .services meet the needs of the residents, that results are reported promptly to the ordering provider .</p> <p>Resident #56 had diagnoses which included severe protein-calorie malnutrition, hypertension, and chronic obstructive pulmonary disease.</p> <p>A Physician Order, dated 02/07/24, documented lab check chem eight for delirium one time only.</p> <p>There was no documentation in the resident's clinical record this lab was obtained.</p> <p>On 04/04/24 at 9:57 a.m., the DON stated if the physician wrote an order for a lab, staff would ensure the order was put in, place the order in the requisition book, and place it in the lab book for them to come and draw it. The DON stated lab came to the building Monday through Friday.</p> <p>On 04/04/24 at 10:38 a.m., the DON stated they were unable to find lab results for the chem eight ordered.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49701</p> <p>Based on observation and interview, the facility failed to ensure food items were properly secured, dated, and labeled for one of one kitchen observations.</p> <p>The DON identified a census of 58.</p> <p>Findings:</p> <p>A Food Receiving and Storage policy, dated 07/14, read in part, All foods stored in the refrigerator or freezer will be covered, labeled and dated .Other opened containers must be dated and sealed or covered during storage .</p> <p>On 04/01/24 at 9:55 a.m., bread in the dining room refrigerator was observed to have no label present. Dietary Aide #1 stated it was for the birds.</p> <p>On 04/01/24 at 10:03 a.m., a carton of au gratin potatoes was observed open and unlabeled in the dry storage area. The Food and Beverage Director stated the au gratin potatoes were opened and not labeled.</p> <p>On 04/01/24 at 10:07 a.m., frozen bread bowls and tri color pasta was observed in the walk in freezer. The Food and Beverage Director stated the frozen bread bowls and tri-color pasta had no expiration date or label.</p>