STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375555	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Haven Nursing Home	1301 North 5th Street Tonkawa, OK 74653

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 30267 Based on record review and interview, the facility failed to complete a discharge summary for 1 (#28) of 1 sampled resident reviewed for a discharge summary. The DON identified 12 residents who discharged from the facility in the last 90 days. Findings: Resident #28 discharged from the facility on 12/13/24. The clinical record for Resident #28 was reviewed and there was no documentation of a discharge summary. On 02/26/25 at 12:54 p.m. the DON stated they documented the discharge planning and the charge nurse documented the actual discharge of the resident. On 02/26/25 at 2:57 p.m., the DON stated there was no discharge summary for Resident #28. The DON stated the discharge summary should have been in the progress notes.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 30267 Based on record review and interview, the facility failed to document the meal intake for 1 (#26) of 1 sampled resident reviewed for weight loss. The facility roster matrix showed one resident with excessive weight loss. Findings: Resident #26 had diagnoses which included stroke and dysphagia. A order summary, dated 02/25/25, showed on 01/14/25 the physician changed the resident's dietary order to Glucerna 1.5 (237 milliliters) via gastrostomy tube if the resident ate less than 50% of a meal and to administer 237 milliliters of Glucerna 1.5 (approximately 1 cup) via gastrostomy tube at bedtime regardless of the amount the resident ate through the day. A review of the clinical record for Resident #26 showed: a. on 11/12/24 the resident weighed 172.4 pounds; b. on 12/10/24 the resident weight 164 pounds; c. on 01/15/25 the resident weighed 166 pounds; and d. on 02/18/25 the resident weighed 159 pounds. There was a difference of 13.4 pounds and a 7.8% weight loss from 11/12/24 to 02/18/25 and a 7 pound weight loss from 01/15/25 when the physician ordered the resident's diet to change to oral feedings (by mouth) with supplemental gastrostomy tube feedings when the resident ate less than 50% of their meal. A review of the clinical record showed there was no documentation of meal percentages since the resident resumed ingesting meals by mouth. On 02/26/25 at 2:43 p.m., the DON stated Resident #26 had a gastrostomy tube, but ate meals prepared in the kitchen. The DON stated the resident received supplemental gastrostomy tube feedings if the resident ate less than 50% of a meal. The DON was asked how the nursing staff knew when to administer the supplemental gastrostomy tube feeding. The DON stated the nurses documented when they administered a supplement via gastrostomy tube, but they would have to compare the documentation of the meal percentages the resident ate against the number of administered supplemental feedings for Resident #26. The DON reviewed the clinical record and stated there was no documentation of meal percentages for Resident #26. The DON stated they would need the meal percentage documentation to determine why the resident was losing weight.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41220 Based on record review and interview, the facility failed to obtain documentation of physician rationale for declining pharmacy recommended gradual dose reductions for 3 (#14, 20, and #25) of 5 sampled residents reviewed for unnecessary medications. The administrator identified 26 residents in the facility. Findings: 1. Resident #14 had diagnoses which included Alzheimer's disease and dementia. A medication regimen review form for Resident #14, dated 04/26/24, showed the pharmacist recommended the a dose reduction for the medication quetiaprine (an antipsychotic). The form showed the physician checked the disagree box, but did not offer a clinical rationale as to why they disagreed with the suggested dose reduction. 2. Resident #20 had diagnoses which included dementia and bipolar disorder. Medication regimen review forms showed the pharmacist recommended the following dose reductions on the following dates: a. on 10/31/24 and 01/09/25 for mirtazapine (an antidepressant), and b. on 01/09/25 for sertraline (an antidepressant). The forms showed the physician checked the disagree box, but did not offer a clinical rationale as to why they disagreed with the suggested dose reduction. 3. Resident #25 had diagnoses which included dementia and anxiety. Medication regimen review forms showed the pharmacist recommended the following dose reductions on the following dates: a. on 12/17/24 for morphine and Norco (pain medications), and b. on 01/09/25 for mirtazaprine. The forms showed the physician checked the disagree box, but did not offer a clinical rationale as to why they disagreed with the suggested dose reduction. On 02/25/25 at 1:48 p.m., the DON stated they did not know why the physician had not provided clinical rationales as required on the medication regimen review.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30267 Based on observation and interview, the facility failed to ensure kitchen staff members contained their hair with hair restraints for 2 of 2 kitchen staff members observed for hair restraints. The dietary manager identified 26 residents who ate meals prepared in the kitchen. Findings: On 02/24/25 at 10:50 a.m. an initial tour of the kitchen was conducted. The dietary manager was in the kitchen preparing the noon time meal. The dietary manager was observed to wear a facial guard around their chin, which covered the beard while leaving the mustache hair unsecured. On 02/24/25 at 12:25 p.m., the dietary manager was observed serving the noon time meal while wearing the facial guard around their chin, leaving their mustache hair unsecured. On 02/24/25 at 12:30 p.m., cook #1 was observed entering the kitchen and placed a facial guard around their chin, which secured a small portion of the beard below the lower lip and chin, but left the beard hair on their cheeks, side burns, and neck unsecured as well as their mustache hair. On 02/24/25 at 3:30 p.m., cook #1 was observed without a hair net or a facial guard on, which left all the hair on their head unsecured while they removed a pan from the drying rack and placed it on the food preparation table. The dietary manager wore their facial guard which secured their beard, but left the mustache hair unsecured. On 02/25/25 at 11:35 a.m., the dietary manager was observed in the kitchen wearing the facial guard around their chin, leaving their mustache hair unsecured. On 02/25/25 at 3:30 p.m., the dietary manager was asked what was the facility policy regarding the use of hair restraints. The dietary manager stated the policy was to have all hair on the head and face covered.