STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375561	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Ann's Skilled Nursing and Therapy	9400 St Ann's Drive Oklahoma City, OK 73162

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 41872 Based on record review and interview, the facility failed to accurately complete a resident assessment for one (#50) of 22 sampled residents reviewed for accurate assessments. The Administrator identified 106 residents resided in the facility. The Corp Nurse Consultant identified 28 residents who received anticoagulant medications. Findings: Resident #50 had diagnoses which included, heart disease, chronic obstructive pulmonary disease, and high cholesterol. A physician's order, dated 04/26/24, documented the resident was to be administered Aspirin 81 milligrams one tablet one time a day in the evening. A physician's order, dated 04/27/24, documented the resident was to be administered Plavix 75 milligrams one time a day. An Admission Assessment, dated 05/02/24 documented Resident #50 received anticoagulant medications. On 05/13/24 at 12:26 p.m., Resident #50 was asked what all the bruising was on their arms. They stated My skin was thin and I take Plavix and Aspirin. On 05/16/24 at 11:40 a.m., MDS Coordinator #1 was shown the admission assessment and Resident #50's physician orders. They were asked what medication Resident #50 had been on that was an anticoagulant. They stated they had coded the Plavix as an anticoagulant. They were asked if Plavix was an anticoagulant. They stated, Yes and ASA was an antiplatelet. On 05/16/24 at 11:55 a.m., MDS Coordinator #1 stated, Plavix is not an anticoagulant, I coded it wrong. On 05/16/24 1:59 p.m., the DON was asked if they were aware Plavix had been coded as an anticoagulant been coded as an anticoagulant. They stated Yes.

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46653 Based on record review, observation and interview, the facility failed to ensure a resident experiencing pain received treatment for pain for one sampled resident (#51) of 35 residents who receive pain medications and treatment. The DON stated 106 residents resided in the facility. Findings: A Pain policy revised, 09/10/07, read in part .1. The leadership of the long-term care facility must ensure that a commitment to resident comfort permeates all aspects of the facility's operation .2. Appoint a pain management coordinator with the responsibility for ensuring that all residents are properly assessed for pain and that all residents who have pain receive effective treatment. 4. Proper communication between teams members must be in place to ensure that information about the resident's pain is routinely conveyed and acted upon. Documentation should meet the same standards regardless of the nursing shift involved and communication between shift changes is vital . Resident (#51) had a diagnosis which included Syncope and Collapse. A Pain Care Assessment, last reviewed 05/11/24, documented Resident (#51) had pain now. Resident (#51) had pain in the past few months. How often does it occur? Resident #51 reported daily and sometimes worse. Resident(#51) reported it is continuous. A Nursing/Progress Note, documented on 05/14/24 for Resident (#51) daughter called stating they have been having pain in their foot and they believe it's gout. They stated they are unable to sleep at night. On 05/14/24 at 11:01a.m., there was no further documentation for pain or pain medication administered in Resident(#51) progress notes. A Care-plan, last reviewed 04/02/24, documented resident (#51) Evaluate the effective of pain interventions. Review for compliance , alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. On 05/14/24 at 10:43a.m., LPN#3 stated Resident (#51) does not have PRN pain medication. On 05/14/24 at 10:44a.m., LPN#3 reported On 05/14/24 at 10:45a.m., LPN#3 stated Resident #51 was not reported to the Physician when Resident #51 reported pain. On 05/16/24 at 11:25a.m., the DON reported that Resident #51 was not administered pain medication after Pain Assessment on 05/11/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/16/24 at 11:26a.m., the DON reported that Resident #51 was not administered pain medication after daughter reported pain for Resident #51, documented in Progress Notes on 05/14/24.35 residents recieve pain medications

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41872 Based on observation, record review, and interview, the facility failed to ensure a medication was available to administer for one (#209) of three sampled residents reviewed during medication observation. The administrator identified 106 residents resided in the facility. The Corp nurse consultant identified 106 residents received medications. Findings: A Medication Ordering and Receiving From Pharmacy policy, dated January 2022, read in part, .Medications and related products are received from the dispensing pharmacy on a timely basis . Resident #209's MAR documented 9 on 05/14/24 at 8:00 p.m., and 05/15/24 at 8:00 a.m. An Orders Administration Note, dated 05/15/24 at 8:14 a.m., read in part .Buprenorphine HCL Sublingual Tablet 2 MG .Ordered yesterday still haven't received order . An Orders Administration Note, dated 05/14/24 at 8:18 p.m., read in part .Buprenorphine HCL Sublingual Tablet 2 MG .waiting on pharmacy to deliver medication . On 05/15/24 at 9:18 a.m., the DON was asked why Resident #209's medication was not available to administer. They stated it was not in the facility. They were asked when the last time the medication had been administered. They reviewed the May 2024 MAR and stated yesterday morning. Resident #209 had missed two doses.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41872 Based on observation, record review, and interview, the facility failed to ensure staff implemented infection control measures (sanitized their hands) while passing medications. The Administrator identified 106 residents resided in the facility. The Corp Nurse Consultant identified 106 residents received medications. Findings: A Hand Hygiene policy, dated 10/07/03, read in part, .Hand hygiene the simple and effective method of preventing the spread of pathogens which cause infections .Failure to properly clean hands can result in the spread of these pathogens to residents .The singe most important step in the prevention of infection is hand hygiene . On 05/15/24 at 7:55 a.m., CMA #1 was observed to pop a tablet of Eliquis that fell in the open med cart drawer. CMA #1 then popped another pill that fell on the floor. CMA #1 was observed to pick the pill up off the floor and throw it in the trash on the end of the cart. They were not observed to sanitize their hands then continued to pop the rest of Resident # 210's medications (four meds). Then administered the medications to the resident. On 05/15/24 at 9:01 a.m., CMA #1 was asked where they disposed of the Eliquis medication that fell on the floor. They stated, In the trash. They were asked if they sanitize their hands after they picked the pill up off the floor. They stated, No. They were asked if there was hand sanitizer on the cart. They opened the cart then stated they use the ones on the hall walls. No hand sanitizer was observed in the medication cart. On 05/15/24 at 9:18 a.m., the DON was asked if staff were expected to sanitize their hands while passing medications. They stated yes, before each resident and after each resident. The DON was asked if staff dropped a pill on the floor, should they sanitize their hands. They stated yes, after they discard the pill.