STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375570	A. Building B. Wing	12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Crystal Park	315 SW 80th Street Oklahoma City, OK 73139

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 41318 Based on record review and interview, the facility failed to ensure residents had the right to view or receive copies of their clinical record for one (#1) of three residents reviewed. The DON reported 46 residents resided in the facility. Findings: Resident #1 had diagnoses which included depression. An Oklahoma Standard Authorization To Use Or Share Protected Health Information form, dated 12/11/23, documented Resident #1 requested Entire Medical Record was to be shared. A Social Note, dated 12/13/23, documented Resident #1 wanted their medical records and they weren't going to pay for them. It documented the SSD told the resident, per their policy, the resident had to fill out the paperwork for the request, it would be submitted to corporate to be processed, and then the records would be released. On 12/28/23 at 11:07 a.m., the medical records personnel was asked what was the policy when a resident requested medical records. They stated the resident was to fill out the release form, it was scanned to corporate with the records that were requested, and they would receive direction from corporate to release the records. On 12/28/23 at 11:19 a.m., the HR/medical record personnel was asked when Resident #1 requested their records. They stated the resident signed the release form 12/11/23. They stated they didn't receive approval to release the records until 12/26/23. They stated they hadn't released the records to the resident because Resident #1 was no longer in the building and they weren't sure about the payment for the records. The HR/medical record personnel was asked what the timeframe was for releasing the records. They stated it varied due to the size of the file, how much corporate had to go through, and how many people were off work. They stated three to four days. They were asked what was the timeframe if the resident provided a verbal request. They stated they had everyone fill out a release form.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41318 Based on record review and interview, the facility failed to ensure resolution of grievances for one (#5) of three sampled residents reviewed for grievances. The DON identified 46 residents resided at the facility. Findings: A Grievance policy, dated 01/12/20, read in part, .The resident .will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems within three .working days of the filing of the grievance . A Grievance, dated 12/21/23, documented Resident #5 reported they don't receive pain medication during the night when they request it. It documented Resident #5 reported the nurse said they would be back but they didn't come back. It documented Resident #5 reported the night shift ignored them. There was no documentation the grievance had been resolved. On 12/27/23 at 12:35 p.m., Resident #5 stated they didn't receive pain medication timely. They stated they have told staff about their complaints. On 12/28/23 at 12:32 p.m., the Administrator was asked what the process was when a resident made a grievance. She stated any staff can input a grievance in the EHR. She stated before the grievance was completed, they would sign and lock the grievance. The Administrator was asked what the was timeframe for resolving the grievances. She stated they didn't have an offical timeframe. She stated some things can be resolved quickly and others may take longer.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41318 Based on record review and interview, the facility failed to ensure allegations of abuse were investigated for two (#5 and #6) of three sample residents reviewed for abuse. The DON identified 46 residents resided in the facility. Findings: An Abuse policy, dated 02/12/20, read in part, .Upon receiving an allegation [of] abuse .the Abuse Coordinator will .initiate an investigation into the allegation . 1. Resident #5 had diagnoses which included unspecified displaced fracture of the fifth cervical vertebra. A Progress Note, dated 12/21/23, read in part, .Unfortunately, [Resident #5] has severe [quadriplegia] . limited use of all extremities with some preservation of right hand/wrist . A Safe Survey, dated 12/22/23, documented Resident #5 stated they didn't feel the night nurse or aide treated them with respect. It documented Resident #5 didn't feel comfortable or safe at night. A Grievance Summary, dated 12/27/23, read in part, .Date of Grievance/Concern 12/21/2023 .Family is upset that staff moved the call light away from the patient and told [Resident #5] [they were] pushing it too much . On 12/27/23 at 12:32 p.m., Resident #5 stated only one or two staff cared. They stated the rest of the staff didn't. Resident #5 stated the night staff took away their call light. Resident #5 denied being afraid of any staff but they stated, They can do anything they want to me and I can't do anything. There was no documentation the allegations had been investigated. 2. Resident #6 had diagnoses which included bacterial pneumonia. A Safe Survey, dated 12/22/23, documented Resident #6 stated staff treated them with respect most of the time. It documented Resident #6 was asked if they felt comfortable and safe in the facility. It documented Resident #6 stated Depends on the staff. There was no documentation the allegation had been investigated. On 12/28/23 at 8:52 a.m., the SSD stated they assisted with asking residents the Safe Survey questions. They were shown the Safe Surveys for Resident #5 and #6. They stated they gave them to the Administrator. The SSD stated Resident #5's family had reported the staff taking away the resident's call light. The SSD stated, I said that's not ok. The SSD stated, [Resident #5] can't walk or get up. I think [Resident #5] can only use one hand and not very well. The SSD stated they did a grievance and it went to the Administrator. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/28/23 at 12:35 p.m., the Administrator explained the process for investigating abuse. She stated staff were to report allegations of abuse immediately. She stated they were the Abuse Coordinator. The Administrator was shown the Safe Surveys and was asked if these had been addressed. She stated she addressed them today. She stated she had not caught it sooner. The Administrator was shown Resident #5's grievance regarding staff taking away the call light. She stated, This is a problem. She was asked if it was an allegation of abuse. She shook her head yes. The Administrator was asked if the allegations had been reported and investigated timely. She stated, No.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41318 Based on observation, record review, and interview, the facility failed to ensure care plan fall interventions were in place for one (#3) of three sampled residents reviewed for falls. The DON identified 46 residents resided in the facility. Findings: Resident #3 had diagnoses which included fracture of unspecified part of right femur. A Care Plan, dated 12/21/23, documented Resident #3 was at risk for falls related to joint mobility interferes with balance, orthopedic surgery, generalized weakness, and a fall within the last month. It documented to keep the call light within reach and remind the resident to call for assistance. On 12/27/23 at 7:52 a.m., Resident #3 was observed laying in bed. The call light was observed hanging on the back of the left side of the bed, out of reach of the resident. Resident #3 stated the staff treat them wonderful when they could get staff to come in to their room. Resident #3 stated, Need a better way to call for the nurse other than a little button. Resident #3 was observed to look around for the call light and stated, I don't know where it's at. On 12/27/23 at 8:50 a.m., RN #3 was asked how they ensured residents' call lights were in reach. They stated they clip it to the bedding or on the bed rails. RN #3 was asked to observe Resident #3's call light. RN #3 was observed to go into Resident #3's room and stated, I don't know where it's at. RN #3 was observed to locate the call light, untangle the call light, and placed it within reach of Resident #3. RN #3 was asked if the resident could have reached it. RN #3 stated, No. On 12/28/23 at 10:55 a.m., CMA #1 was asked how staff prevented residents' falls. They stated, Answering call lights. On 12/28/23 at 12:10 p.m., the DON was asked how staff prevented residents' falls. They stated to make sure call lights were in reach.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41318 Based on record review and interview, the facility failed to provide adequate staff to ensure medications were administered timely for two (#2 and #5) of two sampled resident reviewed for staffing. The DON identified 46 residents resided in the facility. Findings: 1. Resident #2 had diagnoses which included chronic pain. A Summary Report, documented Resident #2 was to receive oxycodone-acetaminophen 5 mg every four hours from 12/08/23 to 12/22/23. It documented Resident #2 was to receive oxycodone-acetaminophen 7.5 mg every four hours from 12/14/23 to 12/22/23. Resident #5's MedAid MAR, dated from 12/01/23 to 12/27/23, documented the resident received oxycodone-acetaminophen 5 mg late two times. It documented the resident received oxycodone-acetaminophen 7.5 mg late four times. 2. Resident #5 had diagnoses which included pain. A Resident's Consolidated Order, dated 12/17/23, documented Resident #5 was to receive gabapentin three times a day and a Lidocaine patch was to be placed on in the morning and taken off in the evening. Resident #5's MedAid MAR, dated 12/01/23 to 12/27/23, documented the resident received the gabapentin late four times. It documented the resident received the Lidocaine patch late four times. On 12/27/23 at 12:35 p.m., Resident #5 stated it took hours to receive pain medications. On 12/28/23 at 10:55 a.m., CMA #1 stated they had a two hour window to administer medications. They stated sometimes they weren't able to pass the medications in the window. They stated, Things come up. On 12/28/23 at 11:01 a.m., LPN #2 stated medications/treatments were administered late a lot of the time. They stated the work load was too heavy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41318 Based on record review and interview, the facility failed to ensure medications were administered timely for two (#2 and #5) of three sampled residents reviewed for medications. The DON identified 46 residents resided in the facility. Findings: 1. Resident #2 had diagnoses which included chronic pain. A Summary Report, documented Resident #2 was to receive oxycodone-acetaminophen 5 mg every four hours from 12/08/23 to 12/22/23. It documented Resident #2 was to receive oxycodone-acetaminophen 7.5 mg every four hours from 12/14/23 to 12/22/23. Resident #5's MedAid MAR, dated 12/01/23 to 12/27/23, documented the resident received oxycodone-acetaminophen 5 mg late two times. It documented the resident received oxycodone-acetaminophen 7.5 mg late four times. 2. Resident #5 had diagnoses which included pain. A Resident's Consolidated Order, dated 12/17/23, documented Resident #5 was to receive gabapentin three times a day and a Lidocaine patch was to be placed on in the morning and taken off in the evening. Resident #5's MedAid MAR, dated 12/01/23 to 12/27/23, documented the resident received the gabapentin late four times. It documented the resident received the Lidocaine patch late four times. On 12/27/23 at 12:35 p.m., Resident #5 stated it took hours to receive pain medications. On 12/28/23 at 10:55 a.m., CMA #1 stated they had a two hour window to administer medications. They stated sometimes they weren't able to pass the medications in the window. On 12/28/23 at 11:01 a.m., LPN #2 stated medications/treatments were administered late a lot of the time. On 12/28/23 at 12:10 p.m., the DON reviewed Resident #2 and #5's administration times. She stated the medications were late.