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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375570 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/21/2024 |
| NAME OF PROVIDER OR SUPPLIER Accel at Crystal Park | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>49701</p> <p>Based on record review and interview, the facility failed to provide showers in a timely manner and according to the plan of care for one (#1) of four sampled residents reviewed for assistance provided with showers.</p> <p>The administrator identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #1 had diagnoses which included fracture of lower end of left femur and muscle atrophy.</p> <p>A Bathing policy, revised 01/20/23, documented staff will provide bathing services for residents within standard practice guidelines and that the procedure should be recorded in the record.</p> <p>A Self-Care Deficit care plan, initiated 01/18/24, documented the resident will assist with bathing and hygiene on a daily basis over the next 90 days.</p> <p>A physician order, initiated on 01/30/24, documented the resident was to receive baths on Tuesdays and Fridays.</p> <p>On 05/20/24 at 3:25 p.m., the ADON stated showers should be given twice a week, and they were only able to locate documentation that a bath or shower was offered on two days during the two weeks' stay.</p> <p>On 05/21/24 at 11:24 a.m., the regional nurse stated the orders for baths should be put in at admission and that orders were checked the next business day.</p> <p>On 05/21/24 at 11:25 a.m., the DON stated that shower assignments are listed on daily assignment sheets, but those documents were not able to be located for that time frame.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701</p> <p>Based on observation and interview, the facility failed to ensure a dirty bedside commode was stored in a manner to prevent cross contamination to facility residents.</p> <p>The administrator identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>On 05/20/24 at 2:35 p.m., CNA #1 stated that a bedside commode would never be used for more than one person without being sterilized. Dirty bedside commodes or bedpans would never be stored in the hallway.</p> <p>On 05/20/24 at 2:44 p.m., CNA #2 stated bedpans would never be shared between patients and bedside commodes must be sterilized between patients. Dirty bedside commodes or bedpans would never be stored in the hallway.</p> <p>On 05/21/24 at 10:13 a.m., a dirty bedside commode was observed sitting in the hallway outside room [ROOM NUMBER]. It had a small amount of yellow orange substance in the bottom of it. An IV pole with a blue baseball cap hanging from it, a red cane, and footrest attachments to a wheelchair were also observed sitting in the hallway. There was no staff addressing the situation.</p> <p>On 05/21/24 at 10:17 a.m., the administrator stated it looked like the room was just being cleaned, and that it was everyone's responsibility to appropriately clean and store equipment. The administrator stated the dirty bedside commode should not have been left in the hallway, but should have been taken to dirty utility closet until it could be addressed appropriately.</p> |