

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 09/09/2024
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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified when a resident experienced a change in condition for one (#2) of three sampled residents reviewed for change in condition.</p> <p>LPN #2 identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>A Change in Condition policy, revised 02/13/23, read in part, .Document in the medical record the date, time, and name of each physician notified, actions taken and/or patient's response to treatment .</p> <p>Resident #2 had diagnoses which included acute respiratory failure with hypoxia, cervical disc disorder with myelopathy, and dysphagia oropharyngeal phase.</p> <p>Resident #2's face sheet documented they admitted to the facility on [DATE] and discharged on [DATE].</p> <p>A Physician Order, dated 06/25/24, documented Resident #2 was to receive three LPM inhalation via nasal cannula.</p> <p>A Nurse Note, dated 06/28/24, documented Resident #2 took off their oxygen. It documented the resident's family member requested the resident be sent to the hospital due to difficulty breathing. It documented staff assessed the resident's oxygen to be 76% with labored breath sounds. It documented staff put oxygen back on Resident #2 and hyperventilated the resident at 10 L. It documented the resident's oxygen came up to 98. It documented staff titrated the resident's oxygen back down to 7 L, 5 L, and then 3 L. It documented the resident was stable and sleeping.</p> <p>There was no documentation the physician was notified of the above event.</p> <p>A Daily Skilled Note, dated 07/01/24, documented Resident #2 had an oxygen saturation of 86%. There was no documentation the physician was notified of this reading.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/05/24 at 8:53 .a.m., family member #1 stated Resident #2 had experienced trouble breathing at the facility. They stated the resident had oxygen on, but the machine was not on. They stated they spoke with the nurse who reported the resident would not keep the oxygen on their face.</p> <p>On 09/05/24 at 9:25 a.m., family member #1 stated there was another instance where Resident #2's oxygen went down to 80 % and they turned it up to 10 liters. They stated they did not understand the reason no one was doing anything. They stated the resident's oxygen came back up to 97%.</p> <p>On 09/06/24 at 2:23 p.m., the DON was asked who the most appropriate nurse would be to interview regarding this closed record. They stated the facility had several new nurses and the resident was not at the facility long.</p> <p>On 09/09/24 at 9:50 a.m., the DON stated they would answer questions related to Resident #2. They stated none of the nurses would recall the resident because they were not at the facility long. They stated the resident admitted to the facility for a skilled stay related to orthopedic aftercare for cervical stenosis.</p> <p>On 09/09/24 at 10:00 a.m., the DON stated staff should contact a physician and let them know when a resident experienced a change in condition.</p> <p>On 09/09/24 at 10:01 a.m., the DON stated staff checked oxygen saturation to monitor the effectiveness of oxygen therapy. They stated staff would notify the physician when a residents oxygen saturation dropped when the resident was standing or changing positions. They stated if a resident had COPD there would be different parameters. They stated Resident #2 did not have a diagnosis of COPD. The DON reviewed the 06/28/24 nurse note for Resident #2 and stated they could not explain the charting of hyperventilate. They stated if staff needed to increase a resident's oxygen, they should have contacted the doctor.</p> <p>On 09/09/24 at 10:04 a.m., the DON stated, No, there is not a doctor notification.</p> <p>On 09/09/24 at 10:05 a.m., the DON reviewed Resident #2's skilled note dated 07/01/24 and stated the resident's oxygen saturation was 86 percent. They stated they did not see any documentation of the physician being notified.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>46216</p> <p>Based on record review and interview, the facility failed to ensure controlled medications were not misappropriated for two (#8 and #9) of three sampled residents who were reviewed for misappropriation.</p> <p>The LPN #2 identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>An Abuse, Neglect and Exploitation and Misappropriation of Resident Property policy, reviewed 02/12/20, read in part, . Each resident has the right to be free from . misappropriation of resident's property .</p> <p>1. Resident #8 had diagnoses which included unspecified fracture of shaft of left fibula and low back pain.</p> <p>An admission assessment, dated 08/01/24, documented there cognition was intact.</p> <p>A physician's order, dated 08/08/24, documented to administer hydrocodone 10 mg - acetaminophen 325 mg (pain medication) every four hours as need for pain.</p> <p>2. Resident #9 had diagnoses which included low back pain, unspecified, pain in left hip, and pain in right hip.</p> <p>An admission assessment, dated 08/11/24, documented they had severely impaired cognition.</p> <p>A physician's order, dated 08/08/24, documented to administer acetaminophen 300 mg - codeine 30 mg (pain medication) every six hours as needed for low back pain.</p> <p>Form 283, incident date 08/09/24, read in parts, .DON identified that patient did not have pain medication available. Upon initial investigation medication had been received from pharmacy, but was not located. Medication and narcotic storage searched. Staff question. [Name withheld], LPN #1 was receiving staff member. Investigation ongoing. [Name withheld] suspended pending investigation .Staff interviewed. Upon investigation it was identified that two additional patients were missing medications from the same delivery. Medications replaced by facility. Other medications from the delivery were received by the facility. [Name withheld] no longer employed at the facility. Staff in serviced on handling medications .</p> <p>On 08/09/24 at 11:23 a.m., the DON stated they were waiting on pain medications. They stated LPN #1 signed, but they were unable to find the medications.</p> <p>On 08/09/24 at 11:25 a.m., the DON stated they did not find the medications. They stated they had to be reordered.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/09/24 at 11:34 a.m., the DON stated their determination was that someone could have possibly taken the medications.</p> <p>On 08/09/24 at 11:35 a.m., the DON stated the medications missing were 60 tablets of hydrocodone 10 mg - acetaminophen 325 mg and 60 tablets of acetaminophen 300 mg - codeine 30 mg.</p>

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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>35389</p> <p>Based on record review and interview, the facility failed to ensure physician ordered vital signs were obtained for one (#2) of three sampled residents reviewed for a change in condition.</p> <p>The DON identified all 53 residents in the facility had physician ordered vital signs.</p> <p>Findings:</p> <p>Resident #2 had diagnoses which included acute respiratory failure with hypoxia, cervical disc disorder with myelopathy and dysphagia oropharyngeal phase.</p> <p>A Physician Order, dated 06/24/24, read in part, Vital Signs every 2 shift Systolic BP Check Diastolic BP Check Pulse Check Respirations Check Temperature Check O2 Saturation Check.</p> <p>The medication administration record for June 2024 documented blanks for the night vital signs on the 26th, 28th, and 30th.</p> <p>On 09/06/24 at 2:23 p.m., the DON was asked who the most appropriate nurse would be to interview regarding this closed record. They stated the facility had several new nurses and the resident was not at the facility long.</p> <p>On 09/09/24 at 9:50 a.m., the DON stated they would answer questions related to Resident #2. They stated none of the nurses would recall the resident because they were not at the facility long.</p> <p>On 09/09/24 at 10:06 a.m., the DON stated vital signs every two shift meant to obtain both shifts 7:00 a.m. to 7:00 p.m. and 7:00 p.m. to 7:00 a.m. They stated if the vital signs area was blank, it meant, They were not obtained.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389</p> <p>Based on observation, record review, and interview, the facility failed to ensure pressure ulcer treatment was provided as ordered for one (#6) of one sampled resident observed during wound care.</p> <p>The DON identified eight residents with pressure ulcers resided in the facility.</p> <p>Findings:</p> <p>A Pressure Ulcer policy, revised 07/2018, read in part, .Pressure ulcers/injuries will be identified, evaluated and treated in accordance with generally accepted guidelines .</p> <p>Resident #6 admitted to the facility on [DATE] with diagnoses which included pressure ulcer of the sacral region unspecified stage.</p> <p>A Physician Order, dated 09/04/24, documented cleanse wound as needed, clean sacrum with normal saline, pat dry, pack with mesalt, cover with nonbordered dressing and secure with tape. It documented change daily and prn.</p> <p>On 09/05/24 at 5:25 a.m., CNA #2 and CNA #3 provided incontinent care to Resident #6 and LPN #3 placed a five by nine inch xeroform on Resident #2's coccyx. LPN #3 placed a six by six inch foam bordered dressing over the right half of Resident #6's coccyx.</p> <p>On 09/05/24 at 5:29 a.m., LPN #3 placed a second six by six inch foam bordered dressing over the left half of Resident #6's coccyx.</p> <p>There was no normal saline observed being used to clean the resident's wound, the wound was not packed with mesalt, and a nonbordered dressing was not used to cover the sacral wound.</p> <p>On 09/05/24 at 5:55 a.m., LPN #3 stated Resident #6's dressing had come when staff were changing them earlier in the shift. LPN #3 stated Resident #6 had admitted later than expected. LPN #3 stated they tried to get an order for wound care because they were responsible for completing wound care on the night shift. They stated they knew to put the xeroform and bordered dressing on because, I just graduated nursing school and I'm using my knowledge. LPN #3 reviewed Resident #6's orders and stated the order was to clean the wound with normal saline, pat dry, pack with mesalt, cover with bordered dressing and secure with tape. They stated they had not followed the physician orders.</p> <p>On 09/05/24 at 11:00 a.m., the DON stated when a resident admitted to the facility with a wound, staff would perform an initial skin assessment. They stated if a resident was admitted with wound care orders the staff would put them in. They stated if they did not have orders, staff would have to contact the provider to obtain orders. The DON stated staff were to provide wound care as ordered by the physician.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>35389</p> <p>Based on record review and interview, the facility failed to ensure oxygen therapy was consistent with professional standards of practice for one (#2) of three sampled residents reviewed for oxygen therapy.</p> <p>The DON identified 18 residents with orders for oxygen therapy resided in the facility.</p> <p>Findings:</p> <p>Resident #2 had diagnoses which included acute respiratory failure with hypoxia, cervical disc disorder with myelopathy, and dysphagia oropharyngeal phase.</p> <p>A Physician Order, dated 06/25/24, documented Resident #2 was to receive three LPM inhalation via nasal cannula.</p> <p>A Nurse Note, dated 06/28/24, documented Resident #2 took off their oxygen. It documented the resident's family member requested the resident be sent to the hospital due to difficulty breathing. It documented staff assessed the resident's oxygen to be 76% with labored breath sounds. It documented staff put oxygen back on Resident #2 and hyperventilated the resident at 10 L. It documented the resident's oxygen came up to 98. It documented the staff titrated the resident's oxygen back down to 7 L, 5 L, and then 3 L. It documented the resident was stable and sleeping.</p> <p>There was no documentation staff had obtained a physician order to hyperventilate Resident #2 or to increase their oxygen setting above three liters.</p> <p>On 09/05/24 at 8:53 .a.m., family member #1 stated Resident #2 had experienced trouble breathing at the facility. They stated the resident had oxygen on, but the machine was not on. They stated they spoke with the nurse who reported the resident would not keep the oxygen on their face.</p> <p>On 09/05/24 at 9:25 a.m., family member #1 stated there was another instance where Resident #2's oxygen went down to 80 % and they turned it up to 10 liters. They stated they did not understand the reason no one was doing anything. They stated the resident's oxygen came back up to 97%.</p> <p>On 09/06/24 at 2:23 p.m., the DON was asked who the most appropriate nurse would be to interview regarding this closed record. They stated the facility had several new nurses and the resident was not at the facility long.</p> <p>On 09/09/24 at 9:50 a.m., the DON stated they would answer questions related to Resident #2 because none of the nurses would recall this resident. They stated because they were not at the facility long.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/09/24 at 10:01 a.m., the DON stated staff checked oxygen saturation to monitor the effectiveness of oxygen therapy. They stated staff would notify the physician when a residents oxygen saturation dropped when the resident was standing or changing positions. They stated if a resident had COPD there would be different parameters. They stated Resident #2 did not have a diagnosis of COPD. The DON reviewed the 06/28/24 nurse note for Resident #2 and stated they could not explain the charting of hyperventilate. They stated if staff needed to increase a resident's oxygen, they should have contacted the doctor.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. the enhanced barrier precautions policy was implemented for a resident with a pressure ulcer for one (#6) of one sampled resident observed during wound care;</p> <p>b. wound care was provided in a manner that prevented cross contamination for one (#6) of one sampled resident observed during wound care;</p> <p>c. incontinent care was provided in a manner that prevented cross contamination for three (#1, 5, and #6) of three sampled residents observed during incontinent care; and</p> <p>d. staff members washed/sanitized their hands after providing care to a resident and before assisting another resident for four (#1, 4, 5, and #6) of four residents observed receiving assistance from staff.</p> <p>The DON identified seven residents with enhanced barrier precautions and eight residents with pressure ulcers resided in the facility. MDS Coordinator #1 identified 23 incontinent residents resided in the facility. LPN #2 identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>A Hand Hygiene policy, reviewed 01/2022, read in part, .To reduce the spread of infection with proper hand hygiene .Hand hygiene is the most important component for preventing the spread of infection .Hand hygiene is done .Before .resident contact .After .contact with soiled or contaminated articles .resident contact .</p> <p>An Enhanced Barrier Precautions policy, dated 04/01/24, read in part, .This facility utilizes Enhanced Barrier Precautions (EBP) as a strategy to decrease transmission of CDC-targeted and epidemiologically important MDROs when Contact Precautions do not apply .Indications .Wounds .</p> <p>A Perineal Care policy, reviewed 04/22/24, read in part, .Staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection .Dispose of gloves and used supplies and perform hand hygiene .Apply new gloves and place a new brief .</p> <p>1. Resident #6 admitted to the facility on [DATE] with diagnoses which included pressure ulcer of the sacral region unspecified stage.</p> <p>A Physician Order, dated 09/04/24, documented cleanse wound as needed, clean sacrum with normal saline, pat dry, pack with mesalt, cover with nonbordered dressing and secure with tape. It documented change daily and prn.</p> <p>A Physician Order, dated 09/04/24, documented enhanced barrier precautions every two shift for wounds. It documented staff were to gown and glove with all direct patient care for a diagnosis of pressure ulcer of sacral region.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #1 had diagnoses which included muscle wasting and atrophy.</p> <p>3. Resident #4 had diagnoses which included acute kidney failure, end stage renal disease, and c-diff.</p> <p>4. Resident #5 had diagnoses which included osteomyelitis of vertebrae, cirrhosis of the liver, and chronic kidney disease.</p> <p>On 09/05/24 at 4:55 a.m., CNA #2 and CNA #3 entered Resident #1's room and donned gloves.</p> <p>On 09/05/24 at 4:58 a.m., CNA #2 and CNA #3 removed a soiled disposable from Resident #1, provided incontinent care, and placed a new disposable on the resident. They did not change gloves or wash/sanitize their hands when going from dirty to clean.</p> <p>On 09/05/24 at 5:01 a.m., CNA #2 removed their gloves, held them in their hand, left the Resident #1's room and obtained ice from the ice chest in the hall while holding the gloves in their left hand. They returned to the room, gave the resident the cup with ice and placed their gloves and items used during incontinent care in the grey bucket.</p> <p>On 09/05/24 at 5:03 a.m., without washing or sanitizing their hands, CNA #2 and CNA #3 donned gloves, gowns, and a mask and entered Resident #4's room. CNA #2 reported the resident had c-diff. The resident did not require incontinent care. CNA #2 removed a blanket from the resident, placed it in the yellow bucket, and both CNAs removed their PPE and sanitized their hands.</p> <p>On 09/05/24 at 5:12 a.m., CNA #2 and CNA #3 entered Resident #5's room, donned gloves, removed a soiled brief, and provided incontinent care to the resident. CNA #3 placed a new brief on the resident and secured it closed all while wearing the same pair of gloves. CNA #2 placed the soiled items in a trash bag and tied it shut. CNA #2 adjusted the resident's bed, pulled the resident's bedside table to them, placed the wipes container in the resident's top dresser drawer, and handed the resident a cup of water all while wearing the same gloves used during incontinent care. Both CNAs removed their gloves.</p> <p>On 09/05/24 at 5:20 a.m., CNA #2 and CNA #3 exited the room and CNA #3 washed their hands in the sink at the nurse's station.</p> <p>On 09/05/24 at 5:22 a.m., CNA #2 walked over to LPN #3 in the hall, gave them a report on Resident #4, touched their scrubs with their hands, then walked over to the sink at the nurse's station and washed their hands.</p> <p>On 09/05/24 at 5:25 a.m., CNA #2 and CNA #3 donned gloves, removed a soiled disposable, provided incontinent care to Resident #6 and placed a new disposable under the resident. The CNAs did not change their gloves or sanitize their hands when going from dirty to clean. LPN #3 placed a five by nine inch xeroform on Resident #6's coccyx. With the same gloved hands used during incontinent care, CNA #3 flattened all the edges of the xeroform over the resident's coccyx. LPN #3 placed a six by six inch foam bordered dressing over the right half of Resident #6's coccyx.</p> <p>On 09/05/24 at 5:29 a.m., LPN #3 placed a second six by six inch foam bordered dressing over the left half of Resident #6's coccyx.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/05/24 at 5:31 a.m., CNA #2 and CNA #3 fastened Resident #6's brief with the same gloved hands. CNA #3 moved a package of wipes to the resident's dresser, and both CNAs used a draw sheet to pull the resident up in bed. CNA #3 picked up a pillow and placed it under the resident's right side while CNA #2 placed a pillow under the resident's left side all while wearing the same gloves used during incontinent care. CNA #3 placed soiled items in a trash bag, carried the bag to the door, opened the door with gloved hands, and placed the items in a grey barrel,. CNA #3 removed their gloves and put a new pair of gloves on without washing or sanitizing their hands.</p> <p>CNA #2, CNA #3, and LPN #3 did not put on a gown to provide care to Resident #6 who had a pressure ulcer and an order for enhanced barrier precautions. There was no normal saline observed being used to clean the resident's wound.</p> <p>On 09/05/24 at 5:34 a.m., CNA #3 entered Resident #5's room, placed a blanket on the resident, removed their gloves and threw them in the grey barrel. CNA #3 obtained a clean cup, accessed the ice chest in the hall, and handed Resident #5 a cup and exited the room. CNA #3 had still not washed or sanitized their hands.</p> <p>On 09/05/24 at 5:37 a.m., CNA #2 and CNA #3 walked down the hall and entered the clean work room with the cart containing the ice chest. CNA #3 dumped a yellow bucket of water from under the ice chest while CNA #2 filled the ice chest with new ice.</p> <p>On 09/05/24 at 5:38 a.m., CNA #3 pushed the cart with the ice chest out of the room and down the hall. CNA #3 still had not washed or sanitized their hands.</p> <p>On 09/05/24 at 5:41 a.m., CNA #1 stated staff were to wash their hands before and after providing incontinent care. They stated if staff were unable to wash their hands, they should at least sanitize them, use gloves, and if they touched anything they would need to re-glove and then wash their hands. They stated with c-diff they would suit up. They stated if they touched the resident, they would not want to touch anything else, and would wash their hands.</p> <p>On 09/05/24 at 5:44 a.m., CNA #1 stated staff were to change their gloves after every use before touching anything else in the room. They stated they were to change gloves before and after every procedure.</p> <p>On 09/05/24 at 6:19 a.m., CNA #2 stated staff were to complete rounds every two hours for incontinent care. They stated staff would knock on the door introduce themselves and would ask the resident if they could check them. They stated they would also offer ice. They stated staff were to sanitize in and out after each room, and were to wash their hands after two rooms. They stated staff were to change gloves after every encounter.</p> <p>On 09/05/24 at 10:54 a.m., the DON stated staff were to knock on a resident's door, explain what they were going to do, wash their hands, get supplies, provide incontinent care, and wash their hands again. They stated if the resident was soiled, staff were to change gloves for infection control purposes. They stated after the completion, staff were to ensure all personal items were in reach. They stated staff also had the option to sanitize when they went into a room and when they came out.</p> <p>(continued on next page)</p>

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 09/09/2024
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/05/24 at 11:00 a.m., the DON stated staff were to provide wound care to residents as ordered by the physician. The DON stated staff were to use enhanced barrier precautions for residents with wounds. They stated they were to wear gowns and gloves.		