| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375570 | A. Building<br>B. Wing | 10/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accel at Crystal Park | 315 SW 80th Street<br>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.

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|---|---|
| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure baseline care plans were completed for 2 (#4 and #5) of 9 sampled residents whose baseline care plans were reviewed.The DON identified 52 residents resided in the facility. Findings:1. Resident #5's 5-day PPS scheduled assessment, dated 08/31/25, showed the resident was re-admitted on [DATE]. The assessment showed the resident had a diagnosis of other major orthopedic surgery.There was no documentation a baseline care plan was completed upon re-admission to the facility on [DATE].On 10/13/25 at 2:00 p.m., the traveling DON stated they could not locate a baseline care plan for Resident #5. 2. Resident #4's 5-day PPS scheduled assessment, dated 04/19/25, showed the resident was admitted on [DATE]. The assessment showed the resident had diagnoses which included diabetes, hypertension, and abnormalities of gait and mobility.There was no documentation a baseline care plan was completed upon admission to the facility on [DATE].On 10/15/25 at 8:25 a.m., the traveling DON stated Resident #4 did not have a baseline care plan. They stated nurses were responsible for completing baseline care plans on admit. |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observation, record review, and interview, the facility failed to ensure a resident had a care plan for the use of a PICC line for 1 (#5) of 9 sampled residents whose care plans were reviewed.The DON identified 52 residents resided in the facility. Findings:On 10/07/25 at 8:23 a.m., Resident #5 was observed with a PICC line in their right arm.Resident #5's 5-day PPS scheduled assessment, dated 08/31/25, showed the resident had central IV access. The assessment showed the resident had diagnosis of other major orthopedic surgery.Resident #5's care plan, revised 09/08/25, did not document the use of a PICC line.On 10/13/25 at 1:57 p.m., RN #1 stated the resident had a PICC line since admit to the facility.On 10/13/25 at 2:27 p.m., the MDS coordinator stated all PICC lines should be included in the resident's care plan.On 10/13/25 at 2:29 p.m., the MDS coordinator stated Resident #5's care plan did not include the use of a PICC line. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure physicians orders were followed for medication administration and colostomy care in order to receive timely intervention to prevent a new stoma from becoming necrotic.On [DATE] at 1:59 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On [DATE] at 3:04 p.m., the administrator and corporate nurse consultant were notified of the IJ situation and the IJ template was provided.On [DATE] at 8:37 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY.Summary of Details which lead to outcomesFailed to ensure timely intervention for a necrotic stoma for Resident #7.The notification of the alleged immediate jeopardy states as follows:The facility failed to ensure a resident received timely intervention for an odorous necrotic stoma.How other residents with the potential to be affected by the same deficient practice will be identified. Residents requiring colostomy care are at risk.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.a. Resident #7 was discharged to hospitalb. Audit of current residents inhouse was performed to ensure stoma is patent and healthy appearing.c. Stoma site will be evaluated daily with care on the treatment record.d. DON/designee will provide education to all clinical staff on completion of colostomy care, evaluation, and documentation on the treatment record by 11:59 pm on [DATE].Involvement of Medical DirectorThe Medical Director has been notified of IJ status on [DATE] at 4:23 pm.Involvement of QA [quality assurance]An Ad Hoc [for this purpose] QAPI [quality assurance and performance improvement] meeting was held on [DATE] with the Medical Director, Facility Administrator, and Director of nursing to review the plan of removal.Who is responsible for the implementation of the process?The Administrator/designee will be responsible for the implementation of the New Process. The New Process/system will be started on [DATE] and no licensed staff will be able to return to work until they complete the above stated education. To be completed by 11:59pm on 10-14-25.The IJ was lifted, effective [DATE], when all components of the plan of removal had been verified as completed. Multiple staff on different shifts were interviewed regarding the in-service they received and able to verbalize understanding. Audit of residents with a colostomy including orders for colostomy care, assessment, and documentation in treatment records were reviewed. The deficiency remained at an isolated level with the potential for more than minimal harm.Based on record review and interview, the facility failed to ensure:a. medications were administered per physicians' orders,b. daily assessment for colostomy care was performed in order to receive timely intervention to prevent a new stoma from becoming necrotic for 1 (#7) of 3 sampled residents reviewed for assessment, monitoring, and intervention; andc. daily assessment was completed for 1 (#3) of 9 sampled residents whose daily assessments were reviewed.The DON identified 52 residents resided in the facility and one resident had a colostomy.Findings:A policy titled POUCHING A COLOSTOMY OR AN ILLEOSTOMY, revised [DATE], read in part, Observe stoma for type, location, color, swelling, sutures, trauma, or irritation .Record the procedure in the record.A policy titled CHANGE OF CONDITION, revised [DATE], read in part, The practitioner needs a detailed description of the patient's condition to determine whether a symptom is problematic or simply a normal or expected variant.A policy titled DOCUMENTATION, revised [DATE], read in part, The Daily Skilled Note will trigger if the patient's payor is Medicare A or insurance and for the first 7 days from admit for other payors.1.A hospital Discharge summary, dated [DATE], showed Resident #7's gastrointestinal was soft, non-distended, nontender, ostomy was pink, patent, and protruding. The summary showed Resident #7 had physician orders for:a. Colace (a laxative medication) 100 mg, give one capsule in the evening,b. polyethylene glycol (a laxative medication) 17 gm/scoop powder to give one capful in the morning,c. diltiazem (a heart medication) HCl 240 mg capsule, extended release 24 hours. Take 240 mg by mouth in the morning, andd. metoprolol succinate (a blood pressure medication) 200 mg tablet, extended release 24 hours. Take 200 mg by mouth in the morning.Resident #7's physician orders, dated [DATE], showed:a. comprehensive metabolic panel one time only related to volvulus. The order was set to start on [DATE],b. complete blood count with auto differential one time only related to volvulus. The order was set to start on [DATE],c. acetaminophen (a pain medication) 500 mg tablet, give two tablets by mouth every six hours for 10 days related to unspecified pain,d. output check every two shift related to volvulus,e. colostomy care day shift one day related to volvulus, andf. pain scale check every two shift related to volvulus.Resident #7's |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>Based on observation, record review, and interview, the facility failed to administer IV medication as ordered for 1 (#5) of 2 sampled residents reviewed for IV therapy.The travelling DON identified seven residents received IV therapy in the facility. Findings: On 10/07/25 at 8:28 a.m., LPN #1 was observed to start Resident #5's infusion. The rate was set at 125ml/hr on the dial of the IV tubing.A policy titled INTRAVENOUS FLUID AND DRUG ADMINISTRATION GENERAL POLICIES, dated 10/2024, read in part, The nurse should assess the rate of the solution/medication ordered .The nurse will verify that the container's label coincides with the prescriber's order. Verify contents, dose, prescribed rate, and expiration date of the solution.A physician's order, dated 09/20/25, showed meropenem (an antibiotic) 1gm powder for solution one intravenous every eight hours related to atherosclerosis of native arteries of right leg with ulceration. There was no rate of infusion Resident #5's antibiotic order in the physician's order and medication administration record.On 10/07/25 at 8:28 a.m., LPN #1 stated there was no specific ordered rate by the physician for the meropenem. They stated they would infuse the antibiotic at a rate of 125ml/hr because that was what they do. On 10/07/25 at 8:30 a.m., Resident's #5's meropenem bag was observed infusing. The bag showed to infuse at a rate of 100ml/hr every eight hours. On 10/07/25 at 8:47 a.m., LPN #1 stated they were to double check orders for the right medication, right route, allergies, and date of birth prior to administration.On 10/07/25 at 8:48 a.m., LPN #1 stated if an IV medication did not have a rate, they would contact the physician. They stated they had not contacted the physician. LPN #1 stated the physician should be contacted prior to infusing the medication. On 10/07/25 at 8:49 a.m., LPN #1 stated they had reviewed the medication bag prior to infusing and it had the resident's name, date of birth , and dose.On 10/07/25 at 8:51 a.m., LPN #1 stated they did see the rate on the bag and did not infuse the medication at the rate of 100ml/hr. They stated they would change the rate.On 10/07/25 at 12:49 p.m., the DON stated nurses were to verify orders against the bag for IV medication administration. They stated they were to follow the five rights of medication administration.On 10/07/25 at 12:50 p.m., the DON stated an IV infusion needed to have the rate to be administered.On 10/07/25 at 12:51 p.m., the DON stated Resident #5's antibiotic order did not have the rate for infusion, but they mostly infused them over 30 minutes. They stated their policy showed the label should have the rate to be infused.On 10/07/25 at 12:54 p.m., the DON stated the importance of having rates on the resident's order was for interactions and side effects. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to:a. ensure a hospital's discharge orders were transcribed and administer as ordered for 1 (#7); andb. administer medications as ordered for 1 (#4) of 5 sampled residents reviewed for medications as ordered.The DON identified 52 residents resided in the facility. Findings:A policy titled Non-Controlled Medication Orders, dated 01/2023, read in part, Implement a transfer order without further validation if is signed and dated by the resident's current physician, unless the order is unclear or incomplete.A policy titled Medication Administration, dated 01/2024, read in part, Medications are administered as prescribed.1. Resident #7's hospital Discharge summary, dated [DATE], showed a physician's order for:a. Colace (a laxative medication) 100 mg, give one capsule in the evening,b. polyethylene glycol (a laxative medication) 17 gm/scoop powder to give one capful in the morning,c. diltiazem (a heart medication) HCl 240 mg capsule, extended release 24 hours. Take 240 mg by mouth in the morning,d. metoprolol succinate (a blood pressure medication) 200 mg tablet, extended release 24 hours. Take 200 mg by mouth in the morning,e. aspirin (a non-steroidal anti-inflammatory drug medication) 81 mg chewable tablet. Chew 81mg in the morning,f. calcium carbonate (an antacid medication) 600 mg chewable tablet. Chew 600 mg in the morning,g. cholecalciferol (vitamin D3) 50 micrograms (2,000 unit), take one capsule in the morning,h. Lasix (a diuretic medication) 20 mg tablet. Take 20mg in the evening,i. potassium chloride (a supplement) 10 milliequivalent extended-release tablet. Take one tablet by mouth in the morning, andj. oxycodone (an opioid pain medication) 5 mg immediate release, take one tablet by mouth every six hours if needed for severe pain (pain scale 7-10) for up to five days.A review of Resident #7's December 2024 physician orders showed oxycodone, aspirin, calcium carbonate, cholecalciferol, diltiazem, metoprolol, polyethylene glycol, and potassium were ordered by the facility on 12/25/24. The physician orders showed the facility did not order Lasix and Colace.Resident #7's 5 -day scheduled assessment, dated 12/26/24, showed the resident was admitted to the facility on [DATE]. The assessment showed the resident had diagnoses which included volvulus, heart failure, and chronic kidney disease. On 10/14/25 at 1:14 p.m., the DON stated their preference for transcribing hospital discharge orders was to have the individual putting the orders in and to initial and have the DON or assistant DON check and initial off on the orders.On 10/14/25 at 1:16 p.m., the DON stated an acceptable timeframe for new admits to receive their prescribed medications would be three hours.On 10/14/25 at 1:21 p.m., the DON reviewed Resident #7's discharge medication orders. They stated oxycodone, aspirin, calcium carbonate, cholecalciferol, diltiazem, metoprolol, polyethylene glycol, and potassium were ordered by the facility on 12/25/24.On 10/14/25 at 1:22 p.m., the DON stated the facility did not order the Lasix and Colace. They stated both medications should have been ordered on admit.2. Resident #4's 5-day PPS scheduled assessment, dated 04/19/25, showed the resident had diagnoses which included diabetes, hypertension, and abnormalities of gait and mobility. The assessment showed the resident had occasional pain and received pain medication. A physician's order, dated 05/22/25, showed Lortab (an opioid pain medication) 7.5/325 mg. Give one tablet by mouth every six hours for pain.Resident #4's May 2025 MAR showed letter H on the following administration times:a. on 05/23/25 at 7:00 a.m., 1:00 p.m., and 7:00 p.m. The pain rating for these administration times was 8 out of 10. , andb. on 05/24/25 at 7:00 a.m., and 7:00 p.m. There was no pain rating at the 7:00 a.m. dose and the pain rating was 8 out of 10 on the 7:00 p.m. dose.On 10/15/25 at 8:58 a.m., the travelling DON stated CMAs administered routine pain medications.On 10/15/25 at 1:32 p.m., CMA #1 stated if they held medications due to parameters or if the resident was not available, they were to let the nurse know.On 10/15/25 at 1:38 p.m., CMA #1 stated H on the resident's MAR meant the medication was held.On 10/15/25 at 1:39 p.m., CMA #1 stated if a medication was not available, they were to let the nurse know and call the pharmacy. They stated if the pharmacy did not have the medication, they were to let the physician know about it.On 10/15/25 at 1:46 p.m., CMA #1 stated they could not see why the medication was held on 05/23/25 at 7:00 a.m. and 1:00 p.m. On 10/15/25 at 1:48 p.m., CMA #1 stated the dose for 05/23/25 at 7:00 p.m. was held because the medication was not available. They stated they could not locate any notes showing staff communicated with pharmacy or the facility staff.On 10/15/25 at 1:53 p.m., CMA #1 stated the dose for 05/24/25 at 7:00 a.m. was held because the medication was on the nurse's cart. They stated there was no documentation why the dose on 05/24/25 at 7:00 p.m. was held.On 10/15/25 at 1:58 p.m., CMA #1 stated it was important for residents to receive their pain medications because they could be in pain and may have been on their pain |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review, and interview, the facility failed to handle intravenous tubing to prevent cross contamination and follow EBP protocol during IV medication infusion for 1 (#5) of 2 sampled residents reviewed for IV therapy.The travelling DON identified 21 residents on EBP in the facility. Findings:On 10/07/25 at 8:01 a.m., IV tubing was observed without an end cap and hanging about 2 to 3 inches above the floor in Resident #5's room. The tubing was connected to a new bag of meropenem 1 gram /50 milliliters (an antibiotic medication). The tubing had no date. Two empty bags of meropenem and a white syringe cap were observed in the trashcan. There was a small amount of clear liquid in the trashcan.On 10/07/25 at 8:23 a.m., Resident #5 was observed with a PICC line in their right arm. LPN #1 was observed to pick up the IV tubing and pole and bring it closer to resident. With gloves on, LPN #1 wiped the end tubing with an alcohol prep wipe. LPN #1 wiped the PICC hub with an alcohol prep wipe and connected the tubing to the PICC line. On 10/07/25 at 8:28 a.m., LPN #1 was observed to start Resident #5's infusion.LPN #1 did not have a gown on while administering the IV medication.A policy titled ADMINISTRATION SET CHANGE, revised 10/2024, read in part, For intermittent administration sets that are used more than once in 24-hour period, attached a new single use sterile cap on the end of the set after each intermittent use .Label the administration set with the date, and time hung, date set is due to be replaced, and initials .Change intermittent primary and secondary sets every 24 hours.A policy titled ENHANCED BARRIER PRECAUTIONS, revised 03/2025, read in part, This facility utilizes Enhanced Barrier Precautions (EBP) as a strategy to decrease transmission of CDC [Centers for Disease Control and Prevention]-targeted and epidemiologically important MDROs [multidrug-resistant bacteria] when Contact Precautions do not apply .Device care or use: Central line. Resident #5's 5-day PPS scheduled assessment, dated 08/31/25, showed the resident had central IV access. The assessment showed the resident had diagnosis of other major orthopedic surgery.Resident #5's physician's order, dated 09/20/25, showed meropenem 1gm powder for solution one IV every eight hours related to atherosclerosis of native arteries of right leg with ulceration.On 10/07/25 at 8:00 a.m., LPN #1 stated they just set up Resident #5's antibiotic for when they returned to their room for infusion.On 10/07/25 at 8:58 a.m., LPN #1 stated they were not sure of the frequency of IV tubing change in the facility. They stated it was their fifth day of work. They stated IV tubing was usually changed every 24 hours. LPN #1 stated they did not change Resident #5's IV tubing and it had no date.On 10/07/25 at 9:00 a.m., LPN #1 stated they were not sure if the resident was supposed to be on EBP and did not know what it meant.On 10/07/25 at 9:01 a.m., LPN #1 stated the IV tubing was supposed to have an end cap for infection control. They stated Resident #5's tubing did not have an end cap. They stated the tubing initially had a normal saline syringe white cap on it, so they discarded it. On 10/07/25 at 12:37 p.m., the DON stated the IV tubing should be discarded after use if used once in 24 hours. They stated if the tubing was used for multiple administrations in the day, the tubing should have an end cap and discarded after 24 hours. The DON stated the tubing should have the date and time it was hung, and date and time it should be changed with staff initials.On 10/07/25 at 1:14 p.m., the DON stated a gown and gloves were needed for EBP. |