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	05/28/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure a discharge plan was completed, reviewed with resident, and a copy was provided to the resident and/or family for 2 (#5 and #11) of 3 sampled residents reviewed for discharges.The DON identified 188 residents had been discharged in the past 90 days.Findings:A facility policy titled Discharge Plan, dated 04/26/24, read in part, as a minimum, the post discharge plan will include,.social services will review the plan with the resident and family before the discharge is to take place,.a copy of the post discharge plan will be provided to the resident and a copy will be filed in the resident's medical records.1. A record of admission document, dated 03/11/26, showed Resident #5 admitted with diagnoses which included acute systolic and diastolic heart failure, type 2 diabetes mellitus, acute kidney failure, end stage renal disease, and dependence on renal dialysis. The medical record showed Resident #5 was discharged on 04/14/26.A discharge planning document for Resident #5, dated 03/18/26, showed incomplete documentation for goals, members participating, and discharge planning. 2. A record of admission document, dated 04/02/26, showed Resident #11 was with diagnoses which included fracture of left femur, atherosclerotic heart disease, peripheral vascular disease, and hypersomnia. The medical record showed Resident #11 was discharged on 04/12/26. There was no documentation to show Resident #11 was provided discharge planning prior to discharge from the facility. On 05/27/26 at 2:45 p.m., Resident #11 stated they received instructions regarding medications to continue, but they were not clear on the discharge day or time until they were told they were ready to go home and needed to have someone pick them up.On 05/28/26 at 9:20 a.m., the social services director stated there was not a care plan meeting or discharge planning meeting held for Resident #11 due to the length of time the resident resided in the facility. They stated they kept notes regarding planning and conversations, but the notes were not in the medical record and copies of the notes were not provided to the resident or family. On 05/28/26 at 11:05 a.m., the DON stated the discharge planning form should have been completed by all members of the disciplinary team and should have been in the medical record. They stated they did not know if a copy had been given to the Resident #5 and Resident #11 or their family as there was no documentation in the electronic medical record.

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, record review, and interview, the facility failed to ensure licensed nurses had the necessary competency skills to administer medication via PEG tube for 1 (#1) of 1 sampled resident reviewed for PEG tube medication administration. The DON identified two residents with PEG tubes. Findings: On 05/27/26 at 9:25 a.m., a PEG tube medication administration was observed for Resident #1. LPN #2 prepared the mediation to be administered per Resident #1's peg tube. LPN #2 donned a gown and a pair of gloves and entered the resident's room. LPN #2 stopped the tube feeding and checked for placement and residual. LPN #2 poured water into a 30 ml cup with the crushed medication. LPN #2 held the PEG tube and attempted to pour the diluted medication directly into the tube without the use of a syringe. The diluted medication spilled out over and around the tube. LPN #2 obtained another 30 ml cup with diluted crushed medication. LPN #2 obtained a syringe but did not know how to connect the syringe to the peg tube. LPN #2 hesitated, activated the call light, and stated they would call for assistance. On 05/27/26 at 9:48 a.m., the DON was observed to enter Resident #1's room. The DON provided instructional assistance to LPN #2 regarding the process of administering medication through a PEG tube.A facility policy titled Medication Administration Enteral Tubes, dated 05/2023, read in part, The nursing care center assures the safe and effective administration of enteral formulas and medications.In-service training on safety, administration, and monitoring of enteral solutions and medications via the enteral tube is provided by the nursing care center to nursing personnel.An undated record of admission form showed Resident #1 had diagnoses which included an unstageable pressure ulcer of the sacral region, pain, and aphasia following cerebral infarction.A physician order, dated 10/14/25, showed to flush Resident #1's PEG tube with 30 ml of water before and after medications. The order showed to use 15 ml of water to flush between each medication administration.On 05/27/26 at 10:20 a.m., LPN #2 stated they were unsure how much medication Resident #1 received when the diluted medication spilled during administration. On 05/27/26 at 10:47 a.m., the DON stated licensed nurses completed a skills competency check list when they were hired and yearly during a skills fair. The DON stated LPN #2 did not correctly administer medication via the PEG tube for Resident #1. The DON stated the medication was spilled and the resident did not receive the full dose of the medication. The DON stated LPN #2 should have notified the physician.On 05/28/26 at 11:58 a.m., the DON stated the facility did not have a staff competency policy, but a skills competency list was completed upon hire. The DON stated LPN #2 did not have a skills competency check list completed upon hire. The DON stated the facility had 90 days to complete the skills competency check list upon hire. The DON stated LPN #2 was past the 90 days to complete the skills check list. The DON stated a process was needed to ensure completion of skills competencies.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medications were available for administration per physician orders for 2 (#5 and #11) of 6 sampled residents reviewed for medication administration.The administrator identified 53 residents resided in the facility.Findings1. A physician order for Resident #11, dated 04/02/26, showed Xalatan 0.005% solution (a medicated eye drop for glaucoma) one drop into both eyes nightly at bedtime, with a start date of 04/02/26.A physician order for Resident #11, dated 04/02/26, showed Modafinil (a medication to promote wakefulness) 200 mg one time a day, with a start date of 04/03/26.A medication administration record for Resident #11, dated 04/02/26 through 04/12/26, showed the following:Modafinil 200 mg tablet was held or missed from 04/03/26 through 04/11/26. Documentation showed the medication was not available.Xalatan 0.005% eye drops were held or missed from 04/04/26 through 04/10/26. Documentation showed the medication was not available.A Record of Admission form, dated 05/28/26, showed Resident #11 admitted to the facility on [DATE] with diagnoses which included unspecified fracture of left femur, muscle weakness, chronic pain, and hypersomnia. 2. A physician order for Resident #7, dated 05/17/26, showed Cefdinir (an antibiotic used to treat infections) 300mg one capsule by mouth every 12 hours for three days with a start date of 05/18 26 and end date of 05/21/26.A physician order for Resident #7, dated 05/17/26, showed ipratropium bromide-albuterol (a medication used to increase air flow in the lungs) one inhalation every eight hours.A medication administration record for Resident #7, dated 05/01/26 through 05/26/26, showed Cefdinir 300 mg capsule was documented as held on 05/21/26 for the 9:00 a.m. dose. Documentation showed the medication was not available. A treatment administration record for Resident #7, dated 05/01/26 through 05/26/26, showed ipratropium bromide-albuterol was documented as held on 05/18/26 at 5:00 p.m., 05/19/26 at 5:00 p.m., 05/21/26 at 1:00 a.m., and 05/21/26 at 9:00 a.m. Documentation showed the medication was on order.A Record of Admission form, dated 05/28/26, showed Resident #7 admitted to the facility on [DATE] with diagnoses which included hypertension, saddle embolus of pulmonary artery and mild intermittent asthma.A policy titled Medication Ordering and Receiving from Pharmacy Provider, dated 01/2023, read in part, timely delivery of new orders is required so that medication administration is not delayed.On 05/28/26 at 10:20 a.m., the DON stated the medications were ordered for Resident #7 and Resident #11 and were not documented as given per the medical record. The DON stated the medications should have been available and administered to the residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to perform hand hygiene and wear a gown during wound care per enhanced barrier precautions for 1 (#1) of 3 sampled residents reviewed for wound care and infection control. The DON identified 19 residents with wounds and 21 residents with enhanced barrier precautions.Findings: On 05/26/26 at 11:40 a.m., LPN #1 was observed to complete wound care to the right calf of Resident #1. LPN #1 gathered supplies, entered the room of Resident #1, and donned a pair of gloves. LPN #1 was not observed to don a gown. LPN #1 positioned the legs of Resident #1 and removed a dressing from their right calf. LPN #1 was observed to change their gloves but was not observed to perform hand hygiene prior to donning another pair of gloves. LPN #1 cleaned the wound to the right calf with gauze moistened with wound cleanser, applied topical gentamicin (an antibiotic medication) with a tongue depressor, applied Santyl ointment (a medicated wound ointment), and calcium alginate (a wound care dressing) to the wound bed. LPN #1 was observed to change their gloves but was not observed to wash their hands or perform hand hygiene before they donned another pair of gloves. LPN #1 placed a dressing to right calf of Resident #1 and removed their gloves. LPN #1 was not observed to perform hand hygiene before they exited the room.A facility policy titled Hand Hygiene for Staff and Residents, dated 07/2018, read in part, Hand hygiene is the most important component for preventing the spread of infection.Hand hygiene is done: .Before: A. resident contact,.G. taking part in a medical or surgical procedure. After: A. contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. B. resident contact. C. contact with a contaminated object or source where there is a concentration of microorganisms, such as, mucous membranes, non-intact skin, body fluids or wounds.H. removal of medical/surgical or utility gloves.A facility policy titled ENHANCED BARRIER PRECAUTIONS, dated 04/01/24, read in part, EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact care activities that provide opportunities for transfer of MDROs to staff hands and clothing. High Contact Resident Care Activities:.h. Wound Care any skin opening requiring a dressing. Indicate the residents who are on EBP by subtle means, such as alternate color of the resident's name badge on door.An undated record of admission form showed Resident #1 had diagnoses which included paroxysmal atrial fibrillation, an unstageable pressure ulcer of the sacral region, problems related to social environment, pain, and aphasia following cerebral infarction. A physician order, dated 03/05/26, showed to apply Santyl (a medicated wound ointment) 250 units/1 gram ointment topically on day shift. A physician order, dated 03/25/26, showed to apply gentamicin sulfate (an antibiotic cream) 0.1% cream topically to the right calf daily. A physician order, dated 04/03/26, showed Resident #1 was to have enhanced barrier precautions. On 05/26/26 at 11:55 a.m., LPN #1 stated they had heard of enhanced barrier precautions but did not know which residents required enhanced barrier precaution. LPN #1 stated they had not had any training/education about enhanced barrier precautions. LPN #1 stated they would wash their hands when visibly soiled and at the end of wound care. On 05/27/26 at 11:42 a.m., the DON stated residents with enhanced barrier precautions were identified by the colored name badge on their door. The DON stated staff were to wear a gown and gloves during contact care for residents with wounds, a peg tube, or a catheter. The DON stated staff should have worn a gown during wound care for Resident #1. The DON stated hand washing/ hand hygiene was to be completed before donning gloves and with each glove change.