

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 01/15/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>45583</p> <p>Based on record review and interview, the facility failed to ensure the abuse policy was implemented and abusive behavior was reported to the abuse coordinator in a timely manner within 2 hours of occurrence to prevent further risk to other residents for one (#21) of one resident sampled for abuse.</p> <p>The administrator identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>An Abuse, Neglect and Exploitation and Misappropriation of Resident Property policy, reviewed 02/2020, read in part, All staff members have a duty to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the Administrator of the facility, who serves as the Abuse Coordinator. The policy also read, Upon learning of a suspected incident of resident abuse, neglect, exploitation, and/or misappropriation of resident property, the Charge Nurse or her Department Manager or Supervisor must immediately notify the Abuse Coordinator the DON of the incident. The policy also read, Upon receiving and allegation abuse .the abuse coordinator will notify .a. not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>Resident #21 had diagnoses which included end stage renal disease and legally blind.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nurses Note, dated 01/12/25 at 11:07 p.m., read in part, At about [8:30 a.m.] Pt asked for PRN pain med, that [they] was in pain. This nurse asked the med aide if [they] had given pt. [their] night meds. The med aide said no but [they] was on [their] way down there. This nurse added Pt's pain medicine with [their] night meds. The med aid returned with the message that this Pt. also wanted [their] PRN Flexeril [muscle relaxer]. this nurse was in the middle of another pt's wound care. This nurse said the Flexeril will be taken to this Pt when current wound care is done. After wound care was done, the Flexeril was taken to this pt. This Pt's told this nurse that the CNA was lying about the time that [they] told me about Pt's request for pain med. CNA came in the room and said [they] was not, I asked CNA to leave the room and calmed this patient down telling that it might have been a misunderstanding or miscommunication, I asked this patient if [they] needed anything else and this pt said [they] was fine. At approximately [10:00 p.m.] this patient's [family member] called the facility yelling and saying that this nurse and the CNA was intimidating [their] [Resident #21] and [they] was going to get our licenses revoked. This nursed politely asked Pt's [family member] to calm down and tell this nurse what the problem was, Pt's [family member] refused and kept yelling on the phone, saying that this nurse called the DON and told [them] that this Pt. had lied. This nurse denied calling the DON about this issue and that this nurse has no idea what [they] was this pt's [family member] was talking about. This Pt's [family member] said this was condescending and said [they] would come to facility in the am and hung up.</p> <p>The CNA time detail report for 01/12/25 documented CNA #3 start time was 2:55 p.m. on 01/12/25, and the end time was 12:15 a.m. on 01/13/25.</p> <p>An OSDH Incident Report Form, dated 01/13/24 (date year error), documented Resident involved was Resident #21. Part B read in part, Administrator informed that patient had an incident last night. When discussing with the patient [they] stated that the PRN [person] [they] call [name withheld] was very nice at the beginning of the shift. Later in the shift when [they] had asked for [their] pain medication [the PRN person] became rude and was making fun of [their] eyes and talking about [their] family. Patient felt this is abusive behavior. CNA [name withheld] suspended pending investigation. Investigation ongoing.</p> <p>An undated OSDH Notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment or Misappropriation of Property form, documented CNA #3 was suspended on 01/13/24. (Dates are incorrect and do not correlate with the nurse note).</p> <p>On 01/13/25 at 10:41 a.m., Resident #21's family member was present with resident and stated there had been an incident the night before stating Resident #21 had stated they were scared after an incident with the evening CNA and nurse. They stated Resident #21 called them stating CNA #3 brought the meal in and they were asked to get pain medication. They stated they kept pushing the button because it had taken them too long to come. Then CNA #3 became frustrated and stated, You were not the only one here. They stated they asked that the CNA stay out of their room and they kept coming back arguing and cursing and saying Resident #21's concerns were not as much as other people there. The family member stated they reported the verbal abuse concerns to the charge nurse LPN #4 who told them to have the resident look past the CNA as they were young. Resident #21 stated they were made to feel so bad.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/13/25 at 11:24 a.m., the administrator stated they were made aware of an allegation of abuse regarding Resident #21 on the morning of 01/13/25 and that it was regarding the way a staff member had spoke to them by making fun of them and were being inappropriate. They stated the resident stated it was abuse the way they were talking to them.</p> <p>On 01/14/25 at 9:10 a.m., LPN #4 stated the details of the nurses note, they did not feel was abuse, but that was a misunderstanding. They stated there was some back and forth between Resident #21 and CNA #3 about the details of when the resident requested the pain medication. LPN #4 stated they had to ask the CNA to leave the room because things began to escalate and then calmed the resident down. LPN #4 stated they reported the incident to the DON the next morning. LPN #4 stated the resident had been upset by the incident. LPN #4 stated the meaning of abuse was anything verbally or physically harming the patient. They stated the abuse process for something like that incident was to have the CNA leave the room, talk to the patient, and see what's going on. LPN #4 stated CNA #3 took care of the other patients for the remainder of the shift and told them not to go into Resident #21's room.</p> <p>On 01/14/25 at 10:28 a.m., the administrator stated in the presence of the corporate nurse, they were the abuse coordinator. They stated they were notified of the allegation of abuse by reading the clinical notes and were not informed by the staff in the facility. The administrator stated they would have expected to have been notified by their staff at the time of the incident.</p> <p>On 01/14/25 at 10:35 a.m., the administrator stated they had also suspended the nurse that worked that evening as well since they did not notify the administrator.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344</p> <p>Based on observation, record review, and interview, the facility failed to ensure toileting was provided in a timely manner for one (#142) of three sampled residents reviewed for timely ADLs.</p> <p>The DON identified 46 residents who needed assistance with ADLs resided in the facility.</p> <p>Findings:</p> <p>Resident #142 had diagnoses which included shortness of breath.</p> <p>Resident #142's care plan for elimination, dated 01/10/25, documented the resident would have a decrease in the number of incontinent episodes by implementation of a scheduled toileting program over the next 90 days.</p> <p>On 01/14/25 at 9:10 a.m., during medication administration, Resident #142 informed CMA #1 they needed to urinate. CMA #1 turned on the resident's call light and exited the room.</p> <p>On 01/14/25 at 9:14 a.m., Resident #142's call light remained on and was beeping.</p> <p>On 01/14/25 at 9:19 a.m., CMA #1 and LPN #2 were observed on the resident's hall. LPN #2's cart was positioned opposite the resident's room. Resident #142's call light remained on and was beeping.</p> <p>On 01/14/25 at 9:28 a.m., the wellness director went past the resident's room. The call light was still on and beeping.</p> <p>On 01/14/25 at 9:30 a.m., the DON went into the resident's room. They came out immediately and the call light was off. They proceeded to go to room [ROOM NUMBER], then left the hall.</p> <p>On 01/14/25 at 9:37 a.m., Resident #142 was in bed. They stated they were still waiting to use the urinal. The resident stated they did not see anyone come into their room or turn off the call light. They stated their eyes must have been closed.</p> <p>On 01/14/25 at 9:55 a.m., the DON stated Resident #142 was asleep when they went into the resident's room to turn off the call light. They stated the process for answering a call light was to find out what the resident needed. They stated they did not ask the resident what they needed or why the call light was on.</p> <p>On 01/14/25 at 9:56 a.m., the DON stated they should have asked Resident #142 what they needed.</p> <p>On 01/14/25 at 9:57 a.m., the DON went to Resident #142's room. The resident informed the DON they needed to urinate and they used a urinal because it was easier. The DON informed the resident they would assist. They walked out of the room and had CNA #4 to assist the resident. CNA #4 told the DON they were not aware the resident need to urinate.</p> <p>On 01/14/25 at 10:00 a.m., the DON stated the resident's needs were not met in a timely manner.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583</p> <p>Based on record review and interview, the facility failed to ensure the admission weight and weekly weights were obtained for a resident on dialysis for one (#21) of one sampled resident reviewed for dialysis.</p> <p>The DON identified three dialysis residents resided in the facility.</p> <p>Findings:</p> <p>A Weight monitoring policy, reviewed 05/2023, read in part, Newly admitted and readmitted residents are weighed upon admission and weekly x 4 and then monthly thereafter, unless otherwise indicated by physician's order. The policy also read, Weekly weights and reweighs results are to be recorded in the EHR.</p> <p>Resident #21 was admitted on [DATE] with diagnosis which included end stage renal disease and dependence on dialysis.</p> <p>A physician order, dated 12/28/24, read in part, Weekly weights every Wednesday on day shift 28 days on admission then x 4 weeks then monthly if stable.</p> <p>The Resident weight record, had only one weight for 01/01/25 at 2:24 p.m.</p> <p>On 01/12/25 at 11:36 a.m., Resident #21 stated they did not get weighed weekly.</p> <p>On 01/14/25 at 11:34 a.m., CNA #1 stated they do monthly weights on the first and third of the month. They stated the weekly weights, the nurse gave them a list and we got them. They stated the nurse documents the weights. They stated they only document the physical function things they assist the residents with.</p> <p>On 01/14/25 at 11:39 a.m., LPN #3 stated the weights were documented in the EHR and they popped up on the system to do. They stated they make a list to delegate to the aides to do and if not done then they did themselves. They stated Resident #21 had one weight in the EHR for 01/01/25 of 132 pounds. LPN #3 stated the physician order documented weights weekly every Wednesday on day shift. They stated the weights for Resident #21 had not been done as ordered.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>48344</p> <p>Based on observation, record review, and interview, the facility failed to ensure a discharge hospital order for a fluid restriction was followed upon admission for one (#241) of three sampled residents reviewed for fluid restrictions.</p> <p>The administrator identified three residents on fluid restrictions resided in the facility.</p> <p>Findings:</p> <p>The FLUID RESTRICTION policy, revised 04/14/23, read in part, The Dining Services Department will coordinate with nursing services to verify that the resident's order for fluid restriction is implemented.</p> <p>Resident #241 had diagnoses which included chronic kidney disease and pulmonary edema.</p> <p>A hospital After Visit Summary, dated 12/26/24, documented fluid restriction, no more than 2000 milliliters in a 24 hour period.</p> <p>Resident #241 had no fluid restriction orders.</p> <p>On 01/13/25 at 12:28 p.m., Resident #241 stated staff were not sure if they were on fluid restriction. There was a water pitcher observed on the bedside table with 700 ml clear fluids.</p> <p>On 01/14/25 at 10:39 a.m., CNA #2 stated the nurses would inform them if a resident was on a fluid restriction.</p> <p>On 01/14/25 at 10:40 a.m., CNA #2 stated the ADON informed them Resident #241 was not on fluid restriction due to confusion on the resident's fluid restriction status when they admitted .</p> <p>On 01/14/25 at 12:12 p.m., LPN #3 stated if a resident was on fluid restriction it would be on their orders.</p> <p>On 01/14/25 at 12:15 p.m., LPN #3 reviewed Resident #241's orders. They stated they did not have an order for a fluid restriction.</p> <p>On 01/14/25 at 12:16 p.m., the ADON stated the DON and ADONs put in the hospital orders when a resident admitted to the facility.</p> <p>On 01/14/25 at 12:21 p.m., the ADON reviewed Resident #241's discharge orders. They stated the resident should have been on a fluid restriction of no more than 2000 ml in 24 hours. They stated they would correct and inform the provider.</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>48344</p> <p>Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered and a resident was supervised during the administration of a nebulizer treatment for one (#243) of one sampled resident reviewed for respiratory care.</p> <p>The DON identified 20 residents who received continuous oxygen therapy in the facility.</p> <p>Findings:</p> <p>The Medication Administration, Nebulizers Updraft policy, revised 01/2023, read in part, Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer.</p> <p>Resident #243 had diagnoses which included acute respiratory failure, unspecified whether with hypoxia or hypercapnia.</p> <p>A physician's order, dated 01/08/25, documented oxygen 2 liters per minute inhalation every two shifts via nasal cannula, oxygen saturation check related to acute respiratory failure, unspecified whether with hypoxia or hypercapnia.</p> <p>A physician's order, dated 01/09/25, documented albuterol sulfate 2.5mg/3 ml (0.083%) solution for nebulization, one vial inhalation three times per day. Minute check 15.</p> <p>On 01/12/25 at 1:35 p.m., Resident #243 was observed receiving a nebulizer breathing treatment in their room via a mask. There was no staff in the room or outside of the resident's room. The oxygen concentrator was set at 3.5 liters per minute.</p> <p>On 01/12/25 at 1:36 p.m., Resident #243 asked the surveyor if they could turn off the nebulizer. They were informed to call for assistance using their call light. The resident stated staff administered the breathing treatment, but they were unsure what time.</p> <p>On 01/12/25 at 1:40 p.m., Resident #243 turned off the nebulizer treatment. The medicine chamber was empty. Resident #243 had a moist cough.</p> <p>On 01/12/25 at 1:42 p.m., Resident #243 stated they were on 3.5 liters per minute oxygen.</p> <p>On 01/12/25 at 1:47 p.m., CNA #2 entered Resident #243's room. They stated to the Resident, Oh you turned off the treatment. CNA #2 put the nebulizer mask in a bag. The resident informed CNA #2 they would like another breathing treatment.</p> <p>On 01/12/25 at 1:50 p.m., LPN #2 came and assessed the resident's oxygen saturation. They stated it was 93%.</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 01/12/25 at 1:54 p.m., LPN #2 stated the process for administering nebulizer treatment was to administer and check on the resident in about two to three minutes. They stated they had about three to four nebulizer treatments on different residents at the same time and could not stay in the resident's room during the treatment.</p> <p>On 01/12/25 at 2:03 p.m., LPN #2 observed the resident's oxygen concentrator. They stated the concentrator was set at 3.5 liters per minute.</p> <p>On 01/12/25 at 2:08 p.m., LPN #2 stated the nurses were responsible for stopping the nebulizer treatments. They stated they stopped Resident #243's treatment, but could not recall or verify on the resident's TAR what time. They stated the resident may have given themselves a breathing treatment.</p> <p>On 01/12/25 at 2:10 p.m., LPN #2 stated Resident #243's order was for 2 liters per minute oxygen. They stated they had notified the resident's provider on 01/08/25 the Resident was on 3.5 liters per minute oxygen at home and had the order to keep the resident on 3.5 liters per minute. They stated they could not locate documentation to support the communication they had with the provider.</p> <p>On 01/12/25 at 2:19 p.m., Resident #243 stated they did not self-administer the nebulizer treatment.</p> <p>On 01/13/25 at 11:29 a.m., the DON stated staff was to follow physician orders. They stated all orders were to be updated in the electronic health record.</p> <p>On 01/13/25 at 11:31 a.m., the DON stated staff were to stay with the residents during nebulizer treatments.</p> <p>On 01/13/25 at 12:37 p.m., the DON stated Resident #243 was not assessed to self-administer nebulizer treatment.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>45583</p> <p>Based on record review and interview, the facility failed to ensure dialysis communication forms were consistently filled out for one (#21) of one sampled resident reviewed for dialysis.</p> <p>The administrator identified three residents in the facility received dialysis services.</p> <p>Findings:</p> <p>A Dialysis-Hemodialysis policy, reviewed 04/2023, read in part, c. Post Dialysis: Community nurse to complete Section B with dialysis center information. Community nurse to assess and complete Section C.</p> <p>Resident #21 had diagnoses which included end stage renal disease.</p> <p>A physician's order, dated 12/28/24, documented Resident #21 was to receive dialysis every Tuesday, Thursday, and Saturday.</p> <p>A Dialysis Pre/Post Communication Report, dated 01/09/25, did not have any documentation for the This section to be completed by the nursing home staff upon return part of the form. The section was to included the vital signs and assessment of the resident.</p> <p>A Dialysis Pre/Post Communication Report, dated 01/11/25, did not have any documentation for the This section to be completed by the nursing home staff upon return part of the form. The section was to included the vital signs and assessment of the resident.</p> <p>On 01/12/25 11:36 a.m., Resident #21 stated the staff did not take their vital signs or assess them prior to or after returning from dialysis.</p> <p>On 01/14/25 at 11:55 a.m., LPN #2 was asked to review the dialysis communication forms for Resident #21 for 01/09/25 and through 01/11/25. They stated there was no documentation for the post dialysis section. LPN #2 stated the post dialysis section should have been completed.</p> <p>On 01/14/25 at 01:19 p.m., the DON stated they verified they did not have the post dialysis forms for 01/09/25 and 01/11/25 and they had spoke to the resident who stated they did not do it.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48344</p> <p>Based on observation, record review and interview, the facility failed to ensure a topical pain medication was administered as ordered for one (#85) of five sampled residents reviewed for unnecessary medications.</p> <p>The administrator identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>The Medication Administration policy, dated 01/2024, read in part, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so.</p> <p>Resident #9 had diagnoses which included pain.</p> <p>A physician's order, dated 01/08/25, documented Voltaren arthritis pain 1% topical gel. Apply by topical every 12 hours right knee for pain.</p> <p>The January 2025 MAR documented x for Resident #85's Voltaren arthritis pain 1% topical gel for the 9:00 a. m. administration on the 9th, 11th, 12th, 13th and the 9:00 p.m. administration on the 11th. It documented due to special parameters on the above dates.</p> <p>There was no documentation to explain what due to special parameters was for the above dates.</p> <p>On 01/15/25 at 8:42 a.m., Resident #85 stated they did not receive any topical medication for their knee. They stated they would not mind having a topical pain medication. Resident #85's family member was at their bedside. They stated they had never seen staff apply any pain cream to the resident's knee.</p> <p>On 01/15/25 at 9:14 a.m., LPN stated the nurses administered topical pain medications.</p> <p>On 01/15/25 at 9:18 a.m., LPN #1 reviewed Resident #85's MAR. They stated they were not sure what the x, or due to special parameters meant on the resident's January 2024 MAR.</p> <p>On 01/15/25 at 9:19 a.m., LPN #1 stated they had cared for the Resident #85 during their current stay. They stated they had not administered any topical pain gel for the resident.</p> <p>On 01/15/25 at 9:28 a.m., the DON reviewed Resident #85's January 2025 MAR. They stated the x meant the medication was not administered. They stated the medication was added to the med aide MAR and they would change it to the nurses discipline. The DON stated due to parameters could be related to vital signs.</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 01/15/2025
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>45583</p> <p>Based on observation, record review and interview, the facility failed to ensure a medication error of less than five percent for one (#142) of four residents observed during medication administration. The medication error rate was 7.14%</p> <p>The administrator identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>A Medication Administration policy, dated 01/2024, read in part, Medications are administered as prescribed in accordance with the manufacturers' specifications, good nursing principle and practices. The policy also read, Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. The policy also read, Medications are administered in accordance with written orders of the prescriber. The policy also read, Medications to be given on an empty stomach or before meals are to be scheduled for administration 30 minutes to 2 hours prior to meals. The policy also read, Verify medication is correct three (3) times before administering the medication. The policy also read, Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing center.</p> <p>Resident #142 had diagnoses which included hypothyroidism.</p> <p>A physician's order, modified date of 01/13/25, documented levothyroxine 200 mcg tablet (hormone) 1 tablet by mouth at 5:00 a.m. The patient to take with 25mcg dose to equal 225mcg. The date of administration for 01/14/25 was documented 9:10 a.m.</p> <p>A physician's order, dated 01/13/25 documented levothyroxine 25mcg tablet 1 tablet by mouth at 5:00 a.m. The patient to take with 200mcg dose to equal 225mcg. The date of administration for 01/14/25 was documented 9:10 a.m.</p> <p>On 01/14/24 at 9:01 a.m., CMA #1 was observed to prepare medication for Resident #142. They were observed to prepare and administer levothyroxine 200mcg 1 tab and levothyroxine 25mcg 1 tab by mouth to the resident.</p> <p>On 01/14/25 at 2:36 p.m., LPN #2 was asked about the medication since the CMA had gone home for the day. LPN #2 stated both the levothyroxine dose orders were to be administered every morning at 5:00 a.m. They stated they were administered at 9:10 a.m. LPN #2 stated they were aware the medication was given after 5:00 a.m. They stated the outgoing agency nurse told the CMA that morning they had given all the meds due, but during observation of the meds the CMA had noticed the levothyroxine had not been given, therefore, LPN #2 stated they told the CMA to ask the resident if they received the medication and if they had not then to administer the medication.</p> <p>On 01/14/25 at 2:28 p.m., LPN #2 stated both doses of the levothyroxine were not administered according to physician orders.</p> <p>(continued on next page)</p>		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 8:42 a.m., the DON stated they had called and notified the resident's physician and nurse practitioner of the levothyroxine being given and no new orders were received.		