STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375573	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Timbers Nursing and Rehabilitation	1400 Buena Vista Avenue Midwest City, OK 73110

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 20960 Based on record review and interview, the facility failed to ensure discharged residents clinical record contained documentation of the discharge for three (#4, #5 and #6) of three sampled discharge residents. The administrator identified six residents discharged from the facility since 12/01/23. Findings: 1. Resident #4 had diagnosis of dysphagia, cognitive communication deficit, depression, brief psychotic disorder, Insomnia, and Schizophrenia. A health status progress note, dated 01/08/24 at 2:50 p.m., read in part, .send resident out d/t hgb 6.6 and hct 20.1 . There was no documentation in the clinical record where the resident was discharged to. A discharge assessment, dated 01/08/24, documented the resident had an unplanned discharge and would return to the facility. A social service progress note, dated 01/15/24 at 8:34 p.m., read in part, .called case manager .to follow up on status. Resident is still admitted at [Name deleted hospital] . There was no documentation in the clinical record in the clinical to indicate the facility could not meet the needs of Resident #4. 2. Resident #5 had diagnosis of hyperlipidemia, depression, end stage renal disease, and anxiety. A discharge summary progress note, dated 01/16/24 at 3:03 p.m., read in part, . Resident could be heard yelling .wants to go to the hospital. This nurse tried to communicate with resident on reason why .Resident stated, I can't breathe, I am going to die .if I lay back down, I will start coughing . A discharge assessment, dated 01/16/24, documented the Resident had an unplanned discharge and would not return to the facility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's progress note, dated 01/17/24 at 2:43 a.m., documented the resident was still in the hospital. There was no documentation in the clinical to indicate the facility could not meet the needs of Resident #5 and involuntarily discharged them. 3. Resident #6 had diagnosis of Schizophrenia, depression, hypertension and hyperlipidemia. A discharge assessment, dated 02/13/24, documented the resident had an unplanned discharge and would return to the facility. A review of Resident #6 progress notes contained no documentation of where the resident was discharged to and what lead to the discharge. There was no documentation in the clinical record to indicate the facility could not meet Resident #6 needs and the facility would not take them back. On 03/14/24 at 2:25 p.m., MDS Coordinator #1, a Licensed Practical Nurse, stated Resident #4, Resident #5 and Resident #6 had no documentation in the clinical record to indicate the facility could not provide care and the facility could not meet the residents needs. On 03/14/24 at 2:45 p.m., the Social Service Director, stated Resident #4, Resident #5 and Resident #6 had no documentation in the clinical record the facility could need meet the needs of the residents. The social service director stated there was no documentation where Resident #6 resident was discharged to.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 20960 Based on record review and interview, the facility failed to ensure thirty day notices of involuntary discharge was provided for three (#4, #5 and #6) of three sampled discharged residents. The administrator identified six residents who were discharged from the facility since 12/01/23 and did not return from the facilty. Findings: An undated facility policy, Transfer or Discharge, Facility-Intimated, read in parts, .notice of transfer or discharge .the resident and his or her representative are given a thirty day (30)- day advance written notice of an impending transfer or discharge from this facility .residents who are sent emergently to an acute care setting, such as a hospital are permitted to return to the facility . 1. Resident #4 had diagnosis of dysphagia, cognitive communication deficit, depression, brief psychotic disorder, Insomnia, and Schizophrenia. A health status progress note, dated 01/08/24 at 2:50 p.m., read in part, .send resident out d/t hgb 6.6 and hct 20.1 . There was no documentation in the clinical record where the resident was discharged to. A discharge assessment, dated 01/08/24, documented the resident had an unplanned discharge and would return to the facility. A social service progress note, dated 01/15/24 at 8:34 p.m., read in part, .called case manager .to follow up on status. Resident is still admitted at [Name deleted hospital] . There was no documentation in the clinical record of a thirty day notice of discharge notice being provided to Resident #4. 2. Resident #5 had diagnosis of hyperlipidemia, depression, end stage renal disease, and anxiety. A discharge summary progress note, dated 01/16/24 at 3:03 p.m., read in part, . Resident could be heard yelling .wants to go to the hospital. This nurse tried to communicate with resident on reason why .Resident stated, I can't breathe, I am going to die .if I lay back down, I will start coughing . A discharge assessment, dated 01/16/24, documented the Resdient had an unplanned discharge and would not return to the facility. A nurse's progress note, dated 01/17/24 at 2:43 a.m., documented the resident was still in the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation in the clinical record of a thirty day notice of discharge notice being provided to Resident #5. 3. Resident #6 had diagnosis of Schizophrenia, depression, hypertension and hyperlipidemia. A discharge assessment, dated 02/13/24, documented the Resdient had an unplanned discharge and would return to the facility. A review of Resident #6 progress notes contained no documentation of where the resident was discharged to and what lead to the discharge. There was no documentation in the clinical record of a thirty day notice of discharge notice being provided to Resident #6. On 03/13/24 at 1:57 p.m., the hospital case manger, stated Resident #4 and #5 came from Cross Timbers. The case manager stated they talked with the director of nursing about the residents coming back to the facility because they were ready for discharge. They stated the director of nursing had told them Resident #4 and Resident #5 were not accepting either Resident back. The case manager further stated that the director of nursing when asked about the 30 day notice stated the facility had the provocative to not accept the residents back. On 03/14/24 at 2:25 p.m., MDS Coordinator #1, a Licensed Practical Nurse, stated all residents were required to receive a 30 day notice of discharge. I was told the facility could not meet the residents needs and would not be returning. The MDS Coordinator stated they did not see any documentation for Resident #4, Resident #5 and Resident #6 received a 30 day notice of discharge. On 03/14/2024 at 2:45 p.m., the social service director, stated the facility followed the regulations on discharge from the facility. The social service director stated they did not know where the 30 day notice of dischargers were located for Resident #4, Resident #5 and Resident #6. The social service director stated they would look for the discharge summary for Resident #4, Resident #5 and Resident #6, because they did not know where they were located because they had been off. They looked through the clinical records and stated there were no 30 day discharge notices for any of the residents. On 03/14/24 at 2:55 p.m., the DON stated Resident #5 was sent out to the hospital in January because of being blind and having issues with their ears. He then stated the facility could not provide care appropriately. The DON stated the facility told the hospital they would not take Resident #4 and Resident #5 back from the hospital. The DON stated Resident #4 had gone out to the hospital and there was no additional documentation on the discharge for them. The DON further stated the IDT decided the residents would not come back, and stated the IDT consisted of themselves, the administrator, business office manager and the social service director. When asked about a 30 day discharge notice, the DON stated he did not have any additional information that 30 day notices were provided to Resident #4, Resident #5 and Resident #6. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/14/24 at 3:40 p.m., the business office manager stated, Resident #4, Resident #5 and Resident #6 were sent out without the intention to take them back. The Business Office manager stated the residents were not provided with a 30 day notice of discharge. They further stated they had been tasked with issuing the 30 day notices and there was no information in the charts of the need for the discharge. On 03/14/24 at 3:50 p.m., the Administrator stated Resident #5 would be a liability if they came back to the facility. The administrator then stated they did not have any documentation of the discharge and/or of a 30 day notice being provided to Resident #4, Resident #5 and Resident #6. On 03/15/24 at 1:45 p.m., Licensed Therapist #1, stated Cross Timbers brought Resident #6 to their facility without calling and/or consulting with them. The Licensed Therapist stated the facility did not provide them with any information just dropped Resident #6 off. They stated they called and spoke with the social service director who informed them the facility did not want to take Resident #6 back. The Licensed Therapist then stated, I was shocked this was happening.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 20960 Based on record review and interview, the facility failed to ensure discharge summaries were completed for three (#4, #5 and #6) of three sampled discharged residents. The administrator identified 26 residents who were discharged from the facility since 12/01/23. Findings: An undated facility policy, Discharge Summary and Plan read in parts, .when a resident's discharge in anticipated, a discharge summary .is developed .includes a recapitulation of the residents stay at the facility . 1. Resident #4 had diagnosis of dysphagia, cognitive communication deficit, depression, brief psychotic disorder, Insomnia, and Schizophrenia. A health status progress note, dated 01/08/24 at 2:50 p.m., read in part, .send resident out d/t hgb 6.6 and hct 20.1 . A social service progress note, dated 01/15/24 at 8:34 p.m., read in part, .called case manager .to follow up on status. Resident is still admitted at [Name deleted hospital] . There was no documentation in the clinical record a discharge summary was completed for Resident #4 2 Resident #6 had diagnosis of Schizophrenia, depression, hypertension and hyperlipidemia. A discharge assessment, dated 02/13/24, documented the resident had an unplanned discharge and would return to the facility. A review of Resident #6 progress notes contained no documentation of where the resident was discharged to and what lead to the discharge. There was no documentation in the clinical record to indicate the resident had returned to the facility. There was no documentation in the clinical record a discharge summary was completed for Resident #6. On 03/14/24 at 2:25 p.m., the MDS Coordinator #1, stated Resident #4 and #6 did not have discharge summaries completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 20960 Based on record review and interview, the facility failed to have two staff present during a bed bath for one (#1) of three sampled residents who required two person assistance with bathing. One staff person left the room during the bad bath and Resident #1 fall from the bed onto the floor. The director of nursing identified 12 residents who required two person assistance with bathing and hygiene. Findings: Resident #1 had diagnosis which included multiple sclerosis, and neurogenic bladder. A quarterly MDS, with reference assessment date of 12/04/23, documented Resident #1 cognition was severly impaired and was dependent on two or more staff for bathing and showering. A care plan, last revised 01/27/23, documented Resident #1 needed assistance with bed mobility and required two person to assist with repositioning. A facility incident report and an incident progress note, dated 02/27/24 at 1:32 p.m., read in part, .This nurse was informed by CNA that resident fell off the bed. CNA x 2 assisting resident with bed bath. One CNA left room to obtain draw sheet, other CNA was whipping water off right side of bed and resident rolled off left side On 03/14/24 at 12:37 p.m., LPN #1 stated Resident #1 was bed bound and required staff asssistance with bathing and grooming. LPN #1 stated the resident required two person asssistance at all times when being bathed. The LPN stated two aides were providing a bed bath, one aide stepped out to get a draw sheet and the resident fell from the bed. On 03/14/24 at 1:55 p.m., CNA #1, stated Resident #1 required staff to do everything for them. CNA #1 stated Resident #1 required two people when being provided a bed bath. They stated on 02/27/24 CNA #2 and themselves were providing a bed bath to the resident and not all the supplies were brought into the room prior to the bed bath. CNA #1 stated CNA #2 left the room to get supplies and the resident fell from the bed. On 03/14/24 at 2:08 p.m., CNA #2 stated they and CNA #1 were providing a bed bath to Resident #1 on 02/27/24. CNA #2 stated they left the room to get supplies that were not brought in before the bath began and by the time they had returned Resident #1 had fallen out of the bed. CNA #2 stated the supplies should have been brought into the room before hand to allow to people in the room while providing the care. On 03/14/24 at 2:25 p.m., the MDS Coordinator #1, stated Resident #1 was a substantial to total assists with bed mobility and transfer. The MDS coordinator stated Resident #1 required two persons throughout the whole bathing process. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/14/24 at 2:55 p.m., the DON stated Resident #1 was an extensive assistance of two for all care. The DON stated Resident #1 had a fall in the morning of 02/27/24, and their family was present. The DON stated the fall occurred when one aide went to get supplies and the resident fell from the unattended side. On 03/14/24 at 4:42 p.m., Resident #1 family stated Resident #1 had a fall to the left side when one aide left the room to get supplies.