STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375579	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Higher Call Nursing Center	407 Whitebird Street Quapaw, OK 74363

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 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 34270 On 03/26/24 at 3:33 p.m., an Immediate Jeopardy (IJ) situation was determined to exist related to the facilities failure to ensure Resident #1's right to remain in their room was not violated. Resident #1 was made to leave their room after stating repeatedly they did not feel well and did not want to go to the dining hall for a meal. On 03/25/24 at 3:30 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On 03/25/24 at 3:33 p.m., the administrator was notified of the immediate jeopardy situation. On 03/28/24 at 1:21 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility plan of removal, dated 03/26/24 at 6:00 p.m., read in part, Grievance book has been established and is an ongoing measure to ensure issues are being taken care of in a timely manner . At Quality Assurance Performance Improvement (QAPI) meeting we discussed our policy and facility policy on the residents right to refuse any care, activities, or anything they want to refuse . In-service staff on Self Determination on March 26 2024 . Risk management will monitor the facility issues weekly during regularly scheduled meetings throughout the remainder of the year . QAPI will monitor quarterly for the remainder of this year . The IJ was lifted effective 03/28/24 at 2:18 p.m., when all components of the plan of removal had been completed. The deficiency remains at an isolated level with a potential for harm. Based on observation, record review, and interview, the facility failed to ensure a resident's right to remain in their bed and to decline a meal for one (#1) of four sampled residents reviewed for resident rights. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Resident List Report, dated 01/23/24, documented 31 residents were residing at the facility. Findings: A Resident Rights, policy, undated, read in part, .The Resident has a right to a dignified existence, self-determination, and communication with an access to persons and services inside and outside the Facility . Resident #1 had diagnoses which included atherosclerotic heart disease, chronic obstructive pulmonary disease, Alzheimer's Disease, and generalized muscle weakness. A facility video recording of the interior of the building, dated 11/02/23, shows at 8:22 a.m. LPN #1 walking Resident #1 from their room to the dining room using a gait belt. A progress note, dated 11/02/23 at 10:25 a.m., written by LPN #1 documented LPN #1 ignored Resident #1's refusals to remain in bed and physically removed the resident from their room and moved them to the dining room. On 01/24/24 at 12:41 p.m., CNA #2 stated that on 11/02/23 Resident #1 had informed them and LPN #1 they did not want to get out of bed as they did not feel well. CNA #2 stated LPN #1 forced the resident out of their room and into the dining room using a gait belt. On 01/24/24 at 1:06 p.m., CNA #1 stated that on 11/02/23 they stated they observed LPN #1 walking behind Resident #1 in the hallway. They stated they heard the resident state they were out of breath and did not want to continue. They stated LPN #1 told the resident they had to walk because it was part of their therapy. On 01/24/24 at 1:20 p.m., CMA #1 stated that on 11/02/23 they observed LPN #1 bring Resident #1 into the dining room using a gait belt. They stated LPN #1 was basically dragging the resident through the dining room. On 01/25/23 at 9:30 a.m., the DON stated by not allowing Resident #1 to remain in bed on 11/02/23, LPN #1 had violated the resident's rights.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34270 Based on record review and interview the facility failed to notify a resident's family of a significant weight loss for one (#5) of three sampled residents reviewed for weight loss. A Resident List Report, dated 01/23/24, documented 31 residents residing at the facility. Findings: A facility policy titled, Notification of Changes, dated 10/2023, read in part, .The facility must inform the resident, consult with the resident's physician and / or notify the resident's family member or legal representative when there is a change requiring such a notification .2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health . A monthly weight report, dated April 2023 through March 2024, documented Resident #5 weight 124.8 pounds in January 2024. It further documented the resident's weight declined to 97.0 pounds in February 2024 which was a 22.28% decline in total body weight in one month. On 03/26/24 at 1:20 p.m., a family member of Resident #5 stated the facility had failed to inform them of the resident's weight loss. They stated they only found out about it when a family friend visited the resident and reported their condition to them. They stated they want to know anytime the resident's condition changes or their treatment changes. At 2:27 p.m., the DON stated they were unable to find any documentation Resident #6 had been informed of the significant weight loss. They stated they had told the facility staff many times of they must contact the family when such changes occur. They stated the staff did not follow policy in that situation.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 On [DATE] at 3:33 p.m., and Immediate Jeopardy (IJ) situation was determined to exist related to the facilities failure to prevent mental and physical abuse to Resident #1 using a gait belt to walk the resident from their room to the dining hall after the resident had stated they did not want to leave their room. Three employees that witnessed the abuse did not intervene to stop the abuse. On [DATE] at 3:30 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On [DATE] at 3:33 p.m., the administrator was notified of the immediate jeopardy situation. On [DATE] at 1:21 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility plan of removal, dated [DATE] at 5:00 p.m., read in part, Grievance book has been established and is an ongoing measure to ensure issues are being taken care of in a timely manner . At Quality Assurance Performance Improvement (QAPI) meeting we discussed our policy and facility policy on not allowing abuse or neglect in the facility . In-service staff on abuse and neglect [DATE] . Monitoring will happen weekly in Risk management and quarterly in QAPI through regularly scheduled meetings . The IJ was lifted effective [DATE] at 2:18 p.m., when all components of the plan of removal had been completed. The deficiency remains at an isolated level with s potential for harm. Based on observation, record review, and interview, the facility failed to protect a resident's right to be free from mental and physical abuse by a staff member for one (#1) of four residents reviewed for abuse. A Resident List Report, dated [DATE], documented 31 residents were residing at the facility. Findings: An Abuse Prevention Policy and Procedure, revised date [DATE], read in part .The facility shall not condone any acts of resident mistreatment, neglect, verbal, sexual, physical and/or mental abuse, corporal punishment, involuntary seclusion or misappropriation of resident property by a facility staff member . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 had diagnoses which included atherosclerotic heart disease, chronic obstructive pulmonary disease, Alzheimer's Disease, and generalized muscle weakness. A care plan focus, dated [DATE], documented that Resident #1 was a full code. A facility video recording of the interior of the building, dated [DATE], recorded LPN #1 walking Resident #1 from their room to the dining room using a gait belt. It documented Resident #1 falling and being picked up by LPN #1 and then continuing to be walked through the dining area. It recorded Resident #1 falling for the final time and being placed in a wheelchair by three staff and removed from the dining room. A progress note, dated [DATE] at 10:25 a.m., written by LPN #1 documented Resident #1 had informed staff they did not feel well and did not want to get out of bed and go to the dining room for a meal. The note documented LPN #1 dismissed the resident's statements of not feeling well. It documented Resident #1 reported being cold, having tremors, being dizzy, and not wanting to walk. It documented LPN #1 had heard this excuse from Resident #1 each morning and they had to encourage the resident every morning to walk to the dining room. It documented the LPN felt the excuses were the same as every other morning. It documented LPN #1 physically moved Resident #1 from their room to the dining room using a gait belt. It documented the resident had fallen in the dining room and had become unresponsive. It documented once in bed the resident did not have respiration or blood pressure. It did not document if the resident had received CPR from facility staff. It did document EMS staff did initiate CPR when they arrived. On [DATE] at 12:41 p.m., CNA #2 stated that on [DATE] they had asked if Resident #1 wanted to go to the dining room to eat. They stated the resident had declined because they felt dizzy and unwell. They stated they informed LPN #1 of what the resident had said. They stated LPN #1 said the resident must go to the dining room because they were a feeder [a term used to describe residents that required assistance with eating meals]. CNA #2 stated they informed Resident #1 they had to go to the dining room. They placed a gait belt on the resident and sat them on the side of the bed. They stated the resident reported the room was spinning, did not feel well, and did not want to eat so the CNA laid the resident back down then informed LPN #1. They stated LPN #1 went to Resident #1's room and told the resident they had to get up then grabbed the gait belt and pulled the resident to a standing position. The resident then attempted to sit back down saying they were dizzy and did not want to eat. They stated LPN #1 lifted the resident back up and they repeated that scenario three of four times. LPN #1 instructed CNA #2 to get the residents walker and they and the resident departed the resident's room. CNA #2 stated as they walked LPN #1 would continue to lift the resident up with the gait belt and one time LPN #1 told the resident You're not stupid. CNA #2 stated they became irritated with the situation and departed to assist other residents. They stated when they saw the resident next, they were in a wheelchair going to the resident's room and the resident appeared limp. They stated about twenty minutes later LPN #1 came to the dining room and said the shit was going to hit the fan because the resident was a full code. (continued on next page)

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Higher Call Nursing Center	407 Whitebird Street Quapaw, OK 74363

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:06 p.m., CNA #1 stated on [DATE] they witnessed LPN #1 using a gait belt to assist Resident #1 move down the hallway toward the dining room. They stated the resident was using a walker and appeared unstable. They stated they heard LPN #1 tell the resident they had to walk because it was part of their therapy. They stated LPN #1 was holding the gait belt about mid back of the resident and when they got to the dining room the resident looked like they were going to fall. CNA #1 stated at that time they had gone to help other residents. They stated the next time they saw the resident they were in a wheelchair. LPN #1 pushed the wheelchair out of the dining room and CNA #1 observed the resident's face and lips were blue. On [DATE] at 1:20 p.m., CMA #1 stated they had observed LPN #1 bring Resident #1 into the dining room on [DATE] about 8:30 a.m. They stated they saw the LPN bring the resident in by a gait belt and that the resident was very unstable. They stated the resident was using a walker and LPN #1 was basically dragging the resident in by the gait belt. They stated the resident slumped forward on the walker and then fell . They stated LPN #1 made the resident get up then walked another ten to fifteen feet and fell again. LPN #1 made the resident get up again then the resident fell for the last time. They stated LPN #1 stood over the resident for two to three minutes then told CMA #1 to get a wheelchair. When they returned, they placed the resident in the wheelchair and returned the resident to their room. They stated they put the resident in their bed, and they told LPN #1 that the resident was not breathing. They stated LPN #1 replied it did not matter because the resident was a DNR [do not resuscitate]. They stated between ten and fifteen minutes later they looked at the resident's chart and found out the resident was a full code. They stated LPN #1 said they guess they should go back and break some ribs. CMA #1 stated they had not seen anyone attempt CPR on Resident #1. On [DATE] at 9:30 a.m., the DON stated that LPN #1 conduct toward Resident #1 on [DATE] was absolutely abuse and violated their abuse policy.

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 34270 Based on observation, record review, and interview, the facility failed to prevent the use of a gait belt as a physical restraint for one (#1) of four sampled residents reviewed for resident rights. A Resident List Report, dated 01/23/24, documented 31 residents were residing at the facility. Findings: Resident #1 had diagnoses which included atherosclerotic heart disease, chronic obstructive pulmonary disease, Alzheimer's Disease, and generalized muscle weakness. A facility video recording of the interior of the building, dated 11/02/23, shows at 8:22 a.m. LPN #1 walking behind Resident #1 who was hunched over a walker. LPN #1 was holding a gait belt that was secured around the lower chest of Resident #1. LPN #1's grip on the belt was between the shoulder blades of the resident. At 8:23 a.m., the recording shows the two inside the dining room. LPN #1 continued to walk behind Resident #1 holding the gait belt secured to the resident. A progress note, dated 11/02/23 at 10:25 a.m., written by LPN #1 documented Resident #1 declined to leave their room to go to the dining room for a meal. If further documented LPN #1 ignored the resident's statements and used a gait belt to remove the resident from their room and took them to the dining room. On 01/24/24 at 12:41 p.m., CNA #2 stated that on 11/02/23 they had asked Resident #1 if they wanted to get up for breakfast. CNA #2 stated the resident declined stating they did not feel well and felt dizzy. CNA #2 stated they informed LPN #1 who stated the resident had to go to the dining room because they were a feeder [a term used to describe residents that required assistance with eating meals]. CNA #2 stated although Resident #1 stated repeatedly, they did not want to get out of bed LPN #1 used the gait belt to force the resident out of bed and to walk to the dining room. At 1:06 p.m., CNA #1 stated that on 11/02/23 they observed LPN #1 walking Resident #1 out of the resident's room. They stated LPN #1 was holding a gait belt attached to Resident #1. CNA #1 stated they were behind the two and heard the resident state they were out of breath and could not walk. They heard LPN #1 respond that it was part of the resident's therapy to walk and continued to force the resident to walk using the gait belt. They stated they observed LPN #1 holding the gait belt around the mid back of the resident. They stated the resident was visibly out of breath. At 1:20 p.m., CMA #1 stated that on 11/02/23 they observed LPN #1 bring Resident #1 into the dining room using a gait belt. They stated the resident was holding onto a walker and was obviously unstable. They stated LPN #1 was basically dragging the resident through the dining room. On 01/25/24 at 9:30 a.m., the DON stated the way LPN #1 had used the gait belt on Resident #1 made it a physical restraint.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on observation, record review, and interview, the facility failed to protect residents from potential abuse by delaying an investigation of possible abuse for one (#1) of four residents reviewed for abuse. A Resident List Report, dated [DATE], documented 31 residents were residing at the facility. Findings: An Abuse Prevention Policy and Procedure, revised date [DATE], read in part .An immediate investigation into the alleged incidence, during the shift if [sic] occurred on .The facility will take all steps necessary to ensure that further potential abuse will not occur while the investigation is in progress . Resident #1 had diagnoses which included atherosclerotic heart disease, chronic obstructive pulmonary disease, Alzheimer's Disease, and generalized muscle weakness. A facility video recording of the interior of the building, dated [DATE], recorded LPN #1 walking Resident #1 to from their assigned room to the dining room by use of a gait belt. The video recorded the resident falling repeatedly and eventually being placed in a wheelchair and removed from the dining room. A progress note, dated [DATE] at 10:25 a.m., written by LPN #1 documented Resident #1 had informed staff they did not feel well and did not want to get out of bed and go to the dining room for a meal. The note documented LPN #1 ignored the resident's statements of not feeling well as well as the resident's complaints of being cold, having tremors, and being dizzy and physically moved Resident #1 to the dining room using a gait belt. On [DATE] at 2:44 p.m., the DON stated she received a telephone call from LPN #1 at about 8:50 a.m. on [DATE] in which the LPN stated Resident #1 had died . The DON stated they then went to the facility, arrived about 9:10 a.m. and found LPN #1 in Resident #1's room performing chest compressions. She stated there was no crash cart, no back board and LPN #1 was alone. The DON stated they informed LPN #1 to document everything that happened. They stated they were informed by a family member that Resident #1 had not died in their room but the dining room. They stated that information prompted them to investigate but they did not start the investigation until Monday [[DATE]]. The DON stated they had started the investigation at 6:00 a.m. on Monday and suspended LPN #1 by 9:00 a.m. On [DATE] at 3:10 p.m. the ADON stated that on [DATE] between 9:00 a.m. and 10:00 a.m., CNA #1 and CNA #2 had approached them and stated that LPN #1 had made Resident #1 get up from bed against their will and go to the dining room. The CNA's stated the resident died in the dining room. The ADON stated they informed the DON that morning of what they had been told by the CNA's. They stated they and the DON talked to LPN #1 about resident rights. They stated Saturday [[DATE]] they received more information from a family member about what had occurred. The family member stated a resident had called the family member and told them what had happened. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 8:44 a.m., CNA #1 stated that on [DATE] they had informed the ADON that LPN #1 had held Resident #1 up by a gait belt and moved them to the dining room. They also stated they informed the ADON of the inconsistency between the time LPN #1 said the resident had died and the time they started CPR. On [DATE] at 8:56 CNA #2 stated that on [DATE] they had informed the ADON that LPN #1 had yanked Resident #1 from their bed using a gait belt. I told her the resident had looked blue when they were taken out of the dining room. On [DATE] at 9:30 a.m., the DON stated they found out about Resident #1's death on the day they died [[DATE]]. They stated a family member spoke to them on Saturday [[DATE]] and reported that LPN #1 had called the family over the weekend to tell them the resident had died while in bed. The DON stated they found out about the resident being forced to walk to the dining area on Monday [[DATE]] when they started the investigation. They stated they did not start an investigation over the weekend because the weekend staff was not on duty when the resident died . They stated they did not instruct LPN #1 not to enter the building until Monday because they knew LPN #1 was not scheduled to work over the weekend. They stated LPN #1 started work Monday as scheduled and had access to the residents prior to being suspended later that morning.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure cardio-pulmonary resuscitation was provided according to standards of practice to Resident #1 who had become unresponsive and failed to assess a resident when they became unresponsive. On [DATE] 6:45 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On [DATE] at 6:50 p.m., the Administrator was notified of the Immediate Jeopardy situation. On [DATE] at 5:00 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility's plan of removal, dated [DATE] at 5:00 p.m., read in part, .LPN #1 was terminated following results of investigation on [DATE] . The DON or designee educating all licensed nurses on the facility's policy and procedure for initiating CPR and location of code status for each resident . RN shift supervisor given responsibility to direct/assign staff roles during code/initiation of code . A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented. DON to monitor for code status compliance by interviewing licensed nurses about facility CPR policy and procedure, as well as requesting return demonstration of CPR process. Compliance checks will be conducted 2 times monthly for three months. Findings will be reported at the monthly QAA Committee meeting . DON or designee will audit new admissions to compare the resident's advance directives to the physician orders for accuracy. This audit will continue weekly for three months. Findings will be reviewed at the monthly QAA Committee meeting . DON or designee performed a Code Blue drill and was performed with licensed nursing staff on all shifts until every nurse had participated at least once. Code Blue drills will continue to be held 2 times a month for 3 months. Findings will be reviewed at the monthly QAA Committee meeting . The IJ was lifted, effective [DATE] at 12:54 p.m., when all components of the plan of removal had been completed. The deficiency remains at an isolated level with s potential for harm. Based on record review, observation, and interviews, the facility failed to ensure a resident who had become unresponsive was immediately assessed by a licensed nurse and received cardio-pulmonary resuscitation (CPR) according to standards of practice for one (#1) of three sampled resident reviewed for abuse. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Resident List Report, dated [DATE], documented 31 residents residing at the facility. Findings: A Cardiopulmonary Resuscitation (CPR) policy, implemented date [DATE], read in part, .If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services . Resident #1 had diagnoses which included atherosclerotic heart disease, chronic obstructive pulmonary disease, Alzheimer's Disease, and generalized muscle weakness. A care plan focus, dated [DATE], documented that Resident #1 was a full code. A facility video recording of the interior of the building, dated [DATE], recorded LPN #1 walking Resident #1 from their room to the dining room. It recorded Resident #1 falling three times during the walk. It recorded LPN #1 and PT #1 standing over the resident after the last fall at 8:26 a.m. It recorded LPN #1, PT #1, and CMA #1 transferred Resident #1 from the floor to a wheelchair at 8:30 a.m. It recorded the three staff members then departing the dining area with the resident at 8:31 a.m. As they departed the dining area CMA #1 could be heard on the recording saying the resident's ankle was dragging on the floor and LPN #1 replying they were aware. A progress note, written by LPN #1, dated [DATE] at 10:25 a.m., documented at approximately 8:00 a.m. LPN #1 was informed Resident #1 did not want to leave their bed. It documented LPN #1 spoke with Resident #1 and although the resident objected, they did walk to the dining room. It documented that at some point Resident #1 sat on the dining room floor and became unresponsive. It documented LPN #1, CMA #1, and PT #1 transferred the resident to a wheelchair and moved the resident to their assigned room. It documented the resident was placed into their bed and then LPN #1 determined the resident was without respiration and blood pressure. It documented LPN #1 placed a backboard under Resident #1, began CPR, and called 911. The note documented the emergency responders had taken over CPR when they arrived. On [DATE] at 12:41 p.m., CNA #2 stated that on [DATE] they observed LPN #1 walk Resident #1 to the dining room where the resident fell several times. CNA #2 stated they departed the area to help other residents and when they returned Resident #1 was being pushed out of the dining area by LPN #1 and the resident appeared limp in the wheelchair. They stated about twenty minutes later LPN #1 came back to the dining room and said the shit was going to hit the fan because the resident was a full code. At 1:06 p.m., CNA #1 stated on [DATE] they witnessed LPN #1 using a gait belt to assist Resident #1 move down the hallway toward the dining room. They stated the resident looked unsteady. They stated they then went to assist other residents. They stated the next time they observed the resident they were being pushed out of the dining room by LPN #1. CNA #1 stated Resident #1's face and lips appeared blue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375579	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Higher Call Nursing Center	407 Whitebird Street Quapaw, OK 74363

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 1:20 p.m., CMA #1 stated they had observed LPN #1 bring Resident #1 into the dining room on [DATE] at about 8:30 a.m. They stated they observed the resident fall several times. They stated the last time the resident fell LPN #1 stood over the resident for about two to three minutes. The stated LPN #1 told CMA #1 to get a wheelchair and when they returned, they placed the resident into the wheelchair. They stated they moved the resident to their assigned room and placed them in their bed. They stated at that point they told LPN #1 the resident was not breathing to which the LPN replied that it did not matter as Resident #1 was a DNR [do not resuscitate]. CMA #1 stated about 15 to twenty minutes later they checked the resident's records and discovered the resident was a full code [a phrase that indicates the use of basic life support measures and CPR was desired by the resident]. They stated LPN #1 had then said they should go back and break some ribs. On [DATE] at 9:10 a.m., CMA #1 stated they had not seen anyone perform CPR on Resident #1 on [DATE]. On [DATE] at 11:41 a.m., the DON stated they received a telephone call at approximately 8:45 a.m. on [DATE]. They stated LPN #1 had called and stated Resident #1 had died . They stated they informed the LPN the resident was a full code and LPN #1 had argued the resident was not. They stated they arrived at the facility a little after 9:00 a.m. and went directly to Resident #1's room. They stated when the entered the room LPN #1 was performing compressions on Resident #1 who was laying on a bed. They stated LPN #1 was performing compressions while holding their cell phone to their face with their shoulder. They stated a nasal cannula was inside the resident mouth, there was no back board under the resident, and the LPN was pushing too deep. She stated they believed the compressions would have caused broken ribs. They stated they observed the compressions for one to two minutes after which they assessed the resident and found no pulse or respirations. The DON stated LPN #1 should have assessed Resident #1 when they had the final fall and became unresponsive in the dining room. They stated LPN #1's attempt at CPR was very bad as the resident was in a bed without a backboard, the nasal cannula providing oxygen was in the resident's mouth, and the chest compressions were too deep. They stated LPN #1 did not follow facility policy during the incident. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:43 p.m., PT #1 stated they had entered the dining room on [DATE] at 8:30 a.m. and noticed Resident #1 falling. They stated LPN #1's back was to them and was unsure if they were assisting the resident or not. They stated they did not see anyone assess the resident in the dining room. They stated they believed the resident was on the floor of the dining room for about five minutes. They stated CMA #1 arrived with a wheelchair and stated the resident's lips were turning blue to which LPN #1 replied, No they are not. They stated at that time the residents bottom dentures were coming out of their mouth, so they removed them. They stated LPN #1, CMA #1, and themselves placed the resident in a wheelchair and moved them to their room. They stated the resident's feet were dragging on the ground while in the wheelchair. They stated they attempted to communicate with the resident on the way to their room, but the resident never responded. They stated, once in the resident's room and while the resident was in the wheelchair, they and LPN #1 both felt for a pulse. PT #1 stated they did not find a pulse. They stated they left the room to retrieve a pulse oximeter [a device placed on a patient's finger to assess vital signs]. They stated the device never indicated a pulse was present. They stated LPN #1 had said the resident was dead and there was nothing more to do as the resident was a DNR. They stated LPN #1 departed the room and while they were gone, they and CMA #1 transferred the resident to the bed. They stated LPN #1 returned to the room with a stethoscope and listed for heart and lung sounds from the resident. They stated LPN #1 then said they needed to make some calls, and everyone left the room. PT #1 stated they left the room before 9:00 a.m. They stated after the resident was taken from the facility LPN #1 came to them, gave them a hug and stated, Don't worry I'll change some things. On [DATE] at 3:30 p.m., LPN #1 returned the surveyor's telephone call and agreed to an interview. They stated that on [DATE] they had walked Resident #1 to the dining room for the morning meal. They stated the resident had complained several times on the way to the dining room that they felt they would fall and did fall just prior to reaching the table. They stated they could tell the resident was not breathing and they instructed a staff member to get a wheelchair. They stated they told PT #1 the resident was not breathing and needed to be taken back to their room. They stated they checked the resident's pulse in the dining room and found no pulse. They stated they believed the resident was a DNR because of a conversation with the DON six months earlier about the resident's code status. LPN #1 stated they took responsibility for not performing CPR as they believed the resident was a DNR. They stated after the resident was placed in a bed, they called the DON and asked if the resident was a DNR. They stated the DON did not say the resident was a full code. They stated when they got off the phone they went outside and smoked a cigarette. They stated, after smoking the cigarette they retrieved a back board and returned to the resident's room. They stated they then performed CPR for an unknown period and called 911. They stated they were not sure if the DON observed them perform CPR.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34270 Based on record review and interview the facility failed to conduct skin and wound assessments and as ordered by a physician for one (#6) of three sampled residents reviewed for wound care. A Resident List Report, dated 01/23/24, documented 31 residents residing at the facility. Findings: Resident #6 had diagnoses which included pressure ulcers and quadriplegia. A physician order, dated 01/22/24, documented starting on 01/23/24 a skin assessment was to be performed on Resident #6 daily and documented in the resident's electronic medical record. A physician order, dated 01/22/24, documented wound assessments were to be conducted weekly on Thursday and documented in the resident's electronic medical record starting on 01/25/24. A review of Resident #6's electronic medical record from the dates of 01/23/24 through 03/26/24 found daily skin assessments were not documented in the resident's electronic medical record on 03/16/24, 02/28/24, 02/17/24, 02/12/24, 02/11/24, 02/10/24, and 02/04/24. The medical record was reviewed from 01/25/24 through 03/26/24 for weekly wound assessments on Thursdays. There were no assessments documented on 02/01/24, 02/08/24, 02/15/24, 02/29/24, 03/07/24, 03/14/24, and 03/21/24. On 03/26/24 at 10:30 a.m., LPN #3 reviewed Resident #6's electronic medical record and stated skin and wound assessments were missing. They stated those documents were not kept in any other location in the medical record. On 03/26/24 at 11:00 a.m., the DON stated they could not locate the mission assessment documentation and so they must not have been completed. They stated all physician orders were expected to be followed.