

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Holiday Heights Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 301 East Dale Norman, OK 73069	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387</p> <p>Based on observation, record review, and interview, the facility failed to ensure MDS assessments were accurately entered for three (#3, #14 and #30) of four sampled residents reviewed for MDS accuracy.</p> <p>ADON #1 identified 41 residents resided in the facility.</p> <p>Findings:</p> <p>1. Res #3's annual MDS, dated [DATE], documented the resident had a restraint.</p> <p>On 07/21/24 at 10:03 a.m., Res #3 was observed in their bed. A circular half rail was observed on the right side of the bed. The resident stated they had the rail for positioning, and it was their preference to have the rail.</p> <p>A record review documented the required consents and assessments were completed for the rail.</p> <p>On 07/23/24 11:39 a.m., the MDS coordinator stated there were no residents in the facility with restraints. They stated they coded the MDS incorrectly.</p> <p>2. Res #14's annual MDS, dated [DATE], documented the resident had a wound infection.</p> <p>On 07/21/24 at 8:58 a.m., Res #14 stated they had not had any infections in months and did not have any wound infections they could remember.</p> <p>A record review documented Res #14 did not have a wound infection during the review period for the annual MDS.</p> <p>On 07/23/24 11:39 a.m., the MDS coordinator stated the infection was coded incorrectly.</p> <p>3. Res #30's quarterly MDS, dated [DATE], documented the resident had a restraint.</p> <p>On 07/21/24 at 10:38 a.m., the resident was observed in their room in their wheelchair. Half side rails were observed at the head of the bed on both sides of the resident's bed. The resident stated they liked the rails and used them to pull themselves up in bed.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Holiday Heights Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 301 East Dale Norman, OK 73069	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review documented the required consents and assessments were completed for the rail.</p> <p>On 07/23/24 11:39 a.m., the MDS coordinator stated there were no residents in the facility with restraints. They stated they coded the MDS incorrectly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Holiday Heights Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 301 East Dale Norman, OK 73069	

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 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>46582</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were obtained per physician's order for one (#15) of five residents reviewed for unnecessary medications.</p> <p>ADON #1 identified 41 residents who resided in the facility.</p> <p>Findings:</p> <p>Res #15 had diagnoses which included cerebral infarction, polyneuropathy, and diabetes mellitus.</p> <p>A physician's order, dated 12/04/21, documented to obtain a lipid profile yearly in June.</p> <p>There were no results of the lipid profile for June 2024 found in Res #15's medical record.</p> <p>On 07/23/24 at 8:35 a.m., the corporate nurse consultant was asked to provide the results of the June 2024 lipid profile.</p> <p>On 07/23/24 at 8:45 a.m., the corporate nurse consultant stated the lipid profile lab had not been obtained per order.</p>