STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375582	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Healthcare and Rehab	1530 NE Grand Blvd Oklahoma City, OK 73117

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 49701 Based on record review and interviews, the facility failed to provide mail delivery to residents on Saturdays. The DON identified 47 residents resided in the facility. Findings: A Resident Rights policy, undated, read in part, Mail will be delivered by facility staff and on weekends will be delivered by the RN supervisor. On 08/20/24 at 2:29 p.m., eight members of resident council stated the mail did not get distributed on the weekends. On 08/20/24 at 2:44 p.m., the activities director stated mail gets delivered Saturdays but does not get passed out until Monday. On 08/22/24 at 8:43 a.m., the DON stated we will have our charge nurse be responsible for passing out mail on the weekend. They stated they had added that to the policy.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45583 Based on record review and interview, the facility failed to ensure the physician was notified upon receipt of the culture and sensitivity results from a urinalysis for one (#26) of five sampled residents reviewed for unnecessary medication. The DON identified 47 residents resided in the facility. Findings: The Notification of Changes policy, dated 2/2023, read in part, The purpose of this policy is to ensure the facility promptly consults the resident's physician. The policy also read, Circumstances that require a need to alter treatment. Resident #26 had diagnosis which included acute cerebrovascular insufficiency, communication deficit, urinary tract infection. Review of the antibiotic stewardship book and documentation did not have the culture and sensitivity with the urinalysis. Review of the progress notes with no documentation of physician notification of the culture results. A physicians order dated 08/14/24 documented Cephalexin 500 mg twice daily for seven days. An infection note dated 08/20/24 documented resident continued on Cephalexin 500 mg twice daily for UTI for seven days. The results were received from the lab 08/23/24 after requested by surveyor, it documented a first release date of 08/14/24 at 3:14 p.m., and a final release date of 08/18/24 at 03:49 p.m. On 08/23/24 at 1:20 p.m. the ADON stated the culture and sensitivity report first release to the facility documented 08/14/24 and the final documented 08/18/24. They were asked when the physician was notified. The ADON looked through Resident #26 EMR and stated they did not see a progress noted where they notified the physician.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49701 Based on record review and interview, the facility failed to ensure residents were free from abuse for one (#147) of thirteen sampled residents reviewed for abuse. The DON identified 47 residents resided in the facility. Findings: Resident #147 was admitted [DATE] and had diagnoses which included hemiplegia, schizoaffective disorder, and epilepsy. Resident #147's care plan had not been initiated until 8/20/24. Their admission assessment was not due to be completed yet and had not been completed. An Initial and Final State Reportable Incident form, dated 08/15/24, documented an allegation of abuse/mistreatment. It documented that Resident #148 was in the human resources office voicing concerns over their camera being taken down off the wall. Resident #148 began to curse at the administrator. The administrator responded to resident say that to my face after slamming their hands on the desk. Resident #147 was removed from the situation and the administrator was suspended pending investigation. The ADON took statements from staff and witnesses, in-serviced staff on abuse policies and procedures. Administrator was suspended and a report was made to the administration board on 08/19/24. On 08/19/24 at 1:50 p.m., Resident #148 stated someone took their camera down, but they eventually got it back. On 08/19/24 at 3:22 p.m., the DON stated the camera was taken down because the administrator believed the resident was not allowed to have audio. The DON stated the resident did not have a roommate at the time and the family had signed consent for the audio and video, due to the family put it in place. The DON stated it seemed like the administrator snapped. On 08/22/24 at 2:45 p.m., CNA # 3 , stated they were to report abuse to the abuse coordinator which is currently the DON. They were unaware of any recent abuse. On 08/22/24 at 2:50 p.m., LPN # 1, stated they were to report abuse to the administrator or DON, but they did not currently have an administrator. They stated they were aware of an allegation of abuse concerning their administrator.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days of admission for one (#148) of 13 sampled residents reviewed for assessments. The DON identified 47 residents resided in the facility. Findings: Resident #148 was admitted to the facility on [DATE]. The 5 day/admission assessment had a reference day set for 08/09/24. On 08/21/24 at 9:51 a.m., the MDS stated the admission should have been completed by 08/18/24. On 08/23/24 at 9:28 a.m., the admission assessment is still incomplete.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583 Based on record review and interview, the facility failed to ensure a baseline care plan was completed in a timely manner for two (#27 and #147) of 13 sampled residents reviewed for baseline care plans. The DON identified 47 residents resided in the facility. Findings: A Baseline Care Plan policy, dated 02/2023, read in part, The baseline care plan will be developed within 48 hours of a residents admission. 1. Resident # 27 readmitted on [DATE] and diagnosis which included metabolic encephalopathy, chronic kidney disease, ESRD, and cognitive impairment. There was no baseline care plan located for Resident # 27. On 08/21/24 at 12:13 p.m. the ADON was asked where the baseline care plan was located. They stated it did not look like one had been done. They stated it should have been done on admission. They stated the date of the current care plan was initiated on 07/09/24. 2. Resident #147 was admitted on [DATE]. Resident #147's baseline care plan documented a completion date of 08/20/24. On 08/22/24 at 10:12 a.m., nurse consultant #1 stated resident #147's baseline care plan was not initiated in a timely manner. They stated a baseline care plan was to be completed within 48 hours of admission. 49701

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45583 Based on record review and interview, the facility failed to implement a care plan for one (#27) of 13 sampled residents who's care plans were reviewed. The DON identified 47 residents resided in the facility. Findings: A Comprehensive Care Plans policy, dated 02/25/23 read in part, It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Resident #27 had diagnosis which included ESRD, chronic kidney disease. There was no dialysis or nutrition care plan located. On 08/21/24 at 12:13 p.m. the ADON was asked to locate the dialysis and nutrition care plan for Resident # 27. They stated there was a fluid volume overload care plan for dialysis. The ADON was asked if the care plan for fluid volume overload had the requirements for assessing and nutrition monitoring for a dialysis resident. They stated, no, and there should be a care plan for dialysis and nutrition.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583 49701 Based on observations, record review, and interview, the facility failed to ensure that an ongoing activity program was designed to meet residents needs individually or as a group. This failure increased the potential for residents to be socially isolated and increased the potential for residents' well-being to be adversely affected. Findings: On 08/21/24 at 10:25 a.m., the Activities Director was observed walking around the nurses' station. When asked where the activity that was scheduled for that time was being held, they stated that no one wanted to participate with the word search. They stated they walk down the halls and ask residents if they want to participate. They stated the residents have stated they don't like kid games. The Activities Director stated they just recently started the position, and they just go by the activities that were scheduled by the previous Activities Director. They stated they have been using their own funding to buy crafts that the residents like, but they don't have money for that. Resident #25's Admission MDS,dated 03/27/24, documented a BIMS score of 15 indicating good cognitive functioning. The MDS section F0500- Activities Preferences identified being around animals, listening to music, doing things with a group of people and religious services as being very important to this resident. Resident #39's Admission MDS, dated [DATE], documented a BIMS score of 14 indicating good cognitive functioning. The MDS section F0500- Activities Preferences identified being around animals and keeping up with the news as being very important to this resident. On 08/22/24 at 11:00 a.m., the DON stated they don't believe they have adequate funding to provide sufficient activity options. They stated they have a plan to meet to identify resident preferences for activities. They stated they are trying to get some religious services scheduled and currently have a staff member that has agreed to do it if they are unable to find services through another avenue.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45583 Based on record review and interview, the facility failed to ensure orders for dialysis were completed for one (#27) of one sampled residents who were reviewed for dialysis. The DON identified 47 residents resided in the facility and one residents who received dialysis. Findings: The Hemodialysis Policy, dated 2/2023, read in part, This facility will provide the necessary care and treatment, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. The policy also read, The facility will coordinate .Documentation requirements are met .The facility will ensure that the physician's orders for dialysis include: a. The type of access for dialysis and location; b. The dialysis schedule; c. The nephrologist name and phone number; d. The dialysis facility name and phone number; e. Transportation arrangements to and from the dialysis facility; F. Any medication administration or withholding of specific medications prior to dialysis treatments; g. Any fluid restriction if ordered by a physician. The policy also read, The policy also read, The nurse will ensure that the dialysis access site is checked before and after dialysis treatments ad every shift for patency by auscultating for a bruit and palpating for a thrill. Resident #27 had diagnoses which included chronic kidney disease, esrd, and cognitive impairment. There were no orders for monitoring or assessing the shunt, name, location, or chair time for treatment. On 08/21/24 at 10:05 a.m. Resident #27 was observed in the dining room sitting in their wheelchair with their head on the table. On 08/21/24 at 10:06 a.m. CNA # 1 stated the resident went to dialysis on Tuesday, Thursday and Saturday. They stated they did not really talk but loved to eat. They stated their shunt was in their left upper arm and still had the bandage on it. On 08/21/24 at 10:08 a.m. observation of an undated bandage on resident #27 left upper arm. On 08/21/24 at 11:40 a.m. LPN #1 stated the process for monitoring and assessing dialysis residents was to get their weight and vital signs before they left and when they returned. They stated the nurse should see the fistula and dressing to ensure it was clean, dry, intact and monitor for any behaviors. LPN #1 stated they had not assessed the residents shunt today. LPN #1 was unable to state why the residents still on had the bandage from dialysis. On 08/21/24 at 12:13 p.m. The ADON was asked how staff would know a resident was on dialysis and what they need to do for them. They stated their should be an order. They looked at resident #27's electronic medical record and stated they did not see any order for where, when, or what to do. They stated there should have been an order. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The orders were added after the interview with the ADON.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 49701 Based on observation and interview, the facility failed to ensure staffing information, which included the facility name, date, actual hours worked for RNs, LPNs, CMAs, and CNAs, and the resident census was updated. The DON identified 47 residents resided in the facility. Findings: On 08/21/24 at 11:17 a.m. the staffing sheet was observed to be completed for 08/19/24 and partial information that included all but the actual hours worked on each shift for RN's, LPN's, CNA's, and CMA's for 08/20/24. There was no staffing information included for 08/21/24. On 08/22/24 at 9:35 a.m., the staffing sheet remained the same as observed on 08/21/24 with no staffing information included for 8/21/24 or 8/22/24. On 8/22/24 at 10:50 a.m., the staffing sheet was observed to be completely updated. The DON stated they had been waiting to total the actual hours worked for RN's, LPN's, CNA's, and CMA's and had just updated the sheet.

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	375582	A. Building B. Wing	08/23/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45583 Based on observation and interview, the facility failed to ensure medications were secured for one (Hall 500) of two medication/treatment carts observed for medication storage during medication administration observation. The DON identified 47 residents resided in the facility. Findings: On 08/22/24 at 9:20 a.m., LPN #1 was observed to walk away from the unlocked cart and into Resident room to administer medication. On 09/22/24 at 9:24 a.m., LPN #1 stated the cart was not locked because they were flustered. They stated the policy was to make sure the carts were locked.

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	375582	A. Building B. Wing	08/23/2024

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 49701 Based on record review and interview, the facility failed to ensure snacks were offered in the evening for four (#5,19, 37, and #39) of eleven sampled residents reviewed for snacks. The DON identified 46 residents who received meals from the kitchen. Findings: The Offering/Serving Bedtime Snacks policy, undated, read in part, It is the practice of this facility to offer and serve residents with a nourishing snack in accordance with their needs, preferences and requests at bedtime on a daily basis. The residents that were not offered snacks all resided in hall 100 and required extensive help to leave their room. On 08/22/24 at 8:53 a.m., the DM stated they prepare the snacks before the kitchen closes at 7 p.m. and drop them off at the nurses' station for them to deliver as the 8 pm snack. They stated they were aware that residents complain about not getting a snack, so they had asked their staff to take a picture of the snacks that were delivered to the nurses' station. On 08/22/24 at 10:34 a.m., Resident #37 stated they had not been offered an evening snack last night. They stated they never were. There was no documentation indicating they were offered a bedtime snack on 8/12, 8/13, 8/14, 8/15, 8/17, 8/19, 8/20, 8/21, or 8/22/24. On 08/22/24 at 10:35 a.m., Resident #5 stated they had not been offered a snack last night. There was no documentation indicating they were offered a bedtime snack on 8/12, 8/13, 8/14, 8/15, 8/17, 8/19, 8/20, 8/21, or 8/22/24. On 08/22/24 at 10:37 a.m., Resident #39 stated they had not been offered a snack last night. They stated the facility probably ran out. There was no documentation indicating they were offered a bedtime snack on 8/14, 8/17, 8/19, 8/20, 8/21, or 8/22/24. On 08/22/24 at 10:38 a.m., Resident #19 stated they had not been offered a snack last night. There was no documentation indicating they were offered a bedtime snack on 8/12, 8/13, 8/14, 8/15, 8/17, 8/19, 8/20, 8/21, or 8/22/24. On 08/22/24 at 9:45 a.m., the DON stated they were aware it was a problem in the past, but they put a stop to it. They stated when they work the staff pass the snacks.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions were utilized for one resident (#39) with a foley and pressure wound and one resident (#40) with a gastric tube of two sampled residents observed with indwelling devices. The DON identified 47 residents resided in the facility. The DON identified one resident with a gastric tube. The Resident Matrix, dated 08/20/24, documented four residents with urinary catheters resided in the facility. Findings: An Enhanced Barrier Precautions policy, dated March 2024, read in part, EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. It also read, Indwelling medical devices include central lines, urinary catheters, feeding tubes and tracheostomies. It also read, Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside of the resident rooms. 0n 08/19/24, upon initial tour, it was observed there were no signs indicating EBP requirements on any of the doors. There was a PPE cart that contained gowns and gloves at the end of hall 600. 1. Resident #39 was admitted on [DATE] with diagnoses which included pressure ulcer of sacral region, unstageable and unspecified urethral stricture, male. A quarterly MDS assessment, dated 06/18/24, documented Resident #39 had an indwelling catheter and two stage 4 pressure ulcers. On 08/21/24 at 11:20 a.m., CNA #2 was observed exiting Resident #39's room. On 08/21/24 at 11:22 a.m., CNA #2 stated they did not use anything besides regular gloves when performing activities of daily living like transferring, bathing, and emptying the colostomy and urinary catheter. They stated the facility probably didn't have a gown big enough to fit them. They stated enhanced barrier protection was a cream that is to be applied. On 08/23/24 at 10:13 a.m., LPN #2 was observed providing wound care, they were only wearing gloves. There was still no EBP sign posted on the door. On 08/23/24 at 10:28 a.m., LPN #2 stated they forgot the skin prep when asked about enhanced barrier protection. They were unaware what the term even meant. 2. Resident #40 was admitted on [DATE] with diagnoses that included dysphagia following cerebral infarction and gastrostomy status. (continued on next page)

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	375582	A. Building B. Wing	08/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A quarterly MDS assessment, dated 06/18/24, documented Resident #40's cognitive skills for daily decision making was severely impaired. On 08/21/24 at 10:20 a.m., surveyor waited outside Resident #40's door while LPN #1 was administering enteral feeding. The surveyor was denied permission to observe the feeding because Resident #40 was cognitively unable to give consent and the responsible party did not answer the phone. On 08/21/24 at 11:34 a.m., LPN #1 stated they used hand sanitizer and gloves when administering the 10 am enteral feeding for Resident #40. LPN #1 stated they were also responsible for flushing 2 urinary catheters that day. They stated no other PPE was used while providing care. They stated they were unsure what enhanced barrier protection was. On 08/21/24 at 12:05 p.m., the DON and ADON stated there was no EBP signage on the doors. Neither of them were able to identify who required EBP in the facility at this time. The DON stated the consultants were here and they were going to initiate a new policy for EBP.

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	375582	A. Building B. Wing	08/23/2024

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Park Place Healthcare and Rehab	1530 NE Grand Blvd Oklahoma City, OK 73117

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 45583 Based on record review and interview, the facility failed to ensure the antibiotic stewardship program policy was followed for one (#26) of five sampled residents reviewed for unnecessary medications. The DON identified 47 residents resided in the facility. Findings: An Antibiotic Stewardship policy, dated 12/2016, read in part, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The policy also read, When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. An Infection Treatment/Tracking Report dated 08/19/24 documented it had been revised on 08/19/24 due to UA results. It also documented date the culture was obtained as 08/14/24 and date culture received as 08/18/24. It also had the treatment listed as Cephalexin 500 mg one by mouth for seven days. The form was not completed to include the follow up of the physician notification. A physicians order dated 08/14/24 documented Cephalexin 500 mg twice daily for seven days. Resident # 26 had diagnosis which included UTI, communication deficit, and cerebrovascular insufficiency. Review of the antibiotic stewardship documentation located in the infection control book provided by the facility did not have the culture and sensitivity results will the urinalysis results. On 08/23/24 at 11:47 a.m. the DON provided the culture and sensitivity report after requesting from the lab. They were asked how it was determined what antibiotic to give the resident. They stated they just text the physician and they prescribe it. The DON stated they would not know if the antibiotic prescribed was appropriate since they did not receive the culture. The DON reviewed the report and stated the antibiotic was not listed. On 08/23/24 at 12:31 a.m. the DON stated the physician often prescribes antibiotics before the C&S was received and they were to have a talk with the physician. The prescribed Cephalexin was not located on the culture and sensitivity results. Resident received Cephalexin 500 mg daily for seven days from 08/15/24 through 08/21/24. The resident was then sent to the hospital related to behaviors. On 08/23/24 at 1:20 p.m. the ADON stated they did not see a progress note where they notified the physician and the antibiotic stewardship policy was not followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 49701 Based on observation and interview, the facility failed to ensure emergency call cords were long enough to be reached by the one (#13) resident if they were lying in bed of 13 sampled residents reviewed for access to call light. The DON identified 47 residents resided in the facility Findings: On 08/20/24 at 9:52 a.m., the call light was observed on the floor next to Resident #13 who was sitting in the wheelchair next to the bed. They were asking for it so they could request to be put back to bed, it was not in reach of the resident. On 08/21/24 at 1:34 p.m., CNA # 3 was observed bringing the lift out of Resident 13's room. Upon observation, Resident #13 was sitting in their wheelchair next to the bed and the call light was observed on the floor and out of reach of the resident. On 08/21/24 at 1:38 p.m., CNA # 3 stated the call light was on the floor and out of reach of the resident. They stated the call light cord is too short to reach the bed, but the roommate will call with their call light if assistance is needed. They stated the policy is to have the call light within reach. On 08/22/24 at 11:45 p.m., the DON reported they provided a longer call cord to Resident #13.