STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375583	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parc Place Medical Resort	1400 East Memorial Road Oklahoma City, OK 73131

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review and interview, the facility failed to ensure residents were offered the choice to formulate advanced directives for two (#31 and #163) of 15 sampled residents reviewed for advanced directives. The Administrator identified 58 residents resided in the facility. Findings: 1. Resident #31 was admitted on [DATE] and had diagnoses which included status post displaced comminuted fracture of shaft of humerus right arm. The resident's clinical records did not document the resident and/or their representative was offered the choice to formulate an advanced directive. 2. Resident #163 was admitted on [DATE] and had diagnoses which included aftercare following joint replacement surgery left knee. The resident's clinical records did not document resident and/or their representative were offered the choice to formulate an advanced directive. On 04/23/24 at 10:51 a.m., the Admissions Coordinator was asked if Resident #31 or Resident #163 had been offered the choice to formulate advanced directives. They stated no, it would be offered as part of the admission contract signing process and neither resident had completed the contract signing process yet.

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49701 Based on record review and interview, the facility failed to obtain a discharge order for one (#61) of three discharged residents reviewed. The Executive Director identified 58 residents resided in the facility. Findings: Resident #61 had diagnoses which included conversion disorder with seizures. A Transfer and Discharge (including AMA) policy, revised 2023, read in part, Obtain physicians' orders for transfer or discharge . A progress note, dated 01/25/24, read in part, Date/Time of Discharge/Death: 1/25/24 @1300 . On 04/23/24 at 1:38 p.m., the DON stated there was not a physician's order for discharge.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49701 Based on record review and interview, the facility failed to ensure a baseline care plan was completed within 48 hours for one (#28) of 15 sampled residents reviewed for baseline care plans. The Executive Director identified 58 residents resided in the facility. Findings: A Baseline Care Plan policy, dated 2023, read in part, The baseline care plan will . be developed within 48 hours of a resident's admission. Resident #28 admitted on [DATE] with diagnoses which included acute kidney failure and gastrointestinal hemorrhage. There was no baseline care plan located in the resident's clinical record. On 04/24/24 at 11:05 a.m., MDS Coordinator #2 stated the baseline care plan was not developed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on observation, record review and interview, the facility failed to develop and implement a comprehensive care plan for two (#9 and #28) of 15 residents reviewed for care plans. The Executive Director identified 58 residents resided in the facility. Findings: A Comprehensive Care Plans policy, dated 2023, read in part, The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment .The comprehensive care plan will describe, at a minimum .the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 1. Resident #9's comprehensive care plan, initiated on 02/13/24, documented the ability to walk in the room and hallway with staff assistance and the use of a walker. An admission assessment, dated 02/18/24, documented resident #9 required substantial assistance with bed mobility and did not attempt to transfer or walk due to medical or safety concerns. On 04/24/24 at 1:08 p.m., Nurse #4 stated resident was a lift transfer and had not been able to walk. On 04/24/24 at 1:10 p.m., MDS Coordinator #1 stated the care plan was inaccurate and did not correspond with the admission assessment conducted on 02/18/24. On 04/24/24 at 1:26 p.m., a physical therapist was observed using a gait belt to assist resident #9 with a stand pivot transfer from the wheelchair into the bed. 2. Resident #28 admitted on [DATE] with diagnoses which included acute kidney failure and gastrointestinal hemorrhage. There was no comprehensive care plan located in the resident's clinical record. On 04/24/24 at 11:05 a.m., MDS Coordinator #2 stated the care plan was not developed.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 49701 Based on record review and interview, the facility failed to ensure a discharge summary was complete for one (#61) of three sampled residents reviewed for discharge. The Executive Director identified 58 residents resided in the facility. Findings: Resident #61 had diagnoses which included conversion disorder with seizures. A Discharge Summary policy, dated 2023, read in part, The discharge summary should include . reconciliation of all pre-discharge medications with the resident's post discharge medication to include prescription and over the counter medications . A Discharge Summary, dated 01/25/24, documented the resident received skilled nursing services and therapy services. The discharge summary documented the resident was stable and the resident and representative were educated to see the PCP for follow up after discharge. A Clinical Discharge Instruction Form, dated 01/25/24, had a section for medications sent home. That section was observed to be incomplete. On 04/23/24 at 1:38 p.m., the DON stated medication reconciliation was not documented.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 49701 Based on record review and interview, the facility failed to complete a nurse aide performance review once every 12 months for two (CNA #1 and CNA #2) of two CNA records reviewed for annual competencies. The staff roster, dated 04/24/24, documented 31 CNAs are employed by the facility. Findings: A Competency Evaluation policy, dated 2023, read in part, subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations .employee competency forms are maintained in the Staff Development Coordinator's office for current training year, then forwarded to the Human Resources Director for placing into the employee's personnel file. CNA #1 had a hire date of 11/23/21. There was no CNA annual competency review located in the employee's file. CNA #2 had a hire date of 07/20/22. There was no CNA annual competency review located in the employee's file. On 04/25/24 at 1:38 p.m., the DON and Executive Director stated CNA competency reviews were completed upon hire and annually. The DON stated employee skills checks were scheduled for May, but competencies from last year were unable to be located.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49701 Based on observation, record review, and interview, the facility failed to administer medications as ordered for one (#264) of five sampled residents observed for medication administration. The Executive Director identified 58 residents resided in the facility. Findings: The Medication Administration policy, dated 2024, read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician . Resident #264 had a diagnosis of hypertension. A physician's order, dated 04/24/24, documented losartan potassium-HCTZ 100-25 mg give 1 tablet by mouth daily for hypertension. Hold if systolic BP is less than 105 or diastolic is less than 65 and notify physician. On 04/24/24 at 7:55 a.m., RN #2 was observed documenting that she was holding the losartan due to a low pulse. RN #2 did not administer the medication. On 04/24/24 at 10:24 a.m., RN #2 stated the order was to hold the medication if the BP was low and to notify the physician. RN #2 stated they would clarify the order with the physician.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 47453 Based on record review and interview, the facility failed to have a proper indication for the use of ordered medications for two (#4 and #262) of six sampled residents reviewed for unnecessary medications The Executive Director indicated 58 residents resided in the facility. Findings: A Unnecessary Drugs-Without Adequate Indication for Use policy, undated, read in parts, indication for use is the identifed, documented clinical rationale for administering a medication .will be determined by assessing the resident's underlying condition . 1. Resident #4 had diagnosis which included dementia and pain. A Active Order summary, dated 04/25/24, read in part, Lorazepam [antianxiety medication] 0.5mg give one tab by mouth two times a day for pain . On 04/25/24 at 3:21 p.m., the DON was asked if pain was a proper indication for the Lorazepam use. They stated No, it is not 49701 2. Resident #262 had physicain orders for: a. torsemide 20mg 3 tablets daily for diuretics, and b. apixaban 5mg every 12 hours for anticoagulant therapy. On 04/25/24 at 11:31 a.m., the DON stated that neither medications had an appropriate indication for use documented and they would get clarification from the physician

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45462 Based on observation, record review, and interview, the facility failed to ensure: a. food items in the refrigerator were properly labeled and had identified use by dates, b. food items were discarded on or before the manufacturer expiration dates, c. leftovers in the refrigerator were dated and used within at least 3 days, d. food items were stored at the appropriate temperatures, e. only clean utensils were used when accessing bulk foods, f. staff in the kitchen with beards wore beard restraints, g. clean dishware was not exposed to splash and covered or inverted, and h. dishwasher rinse cycles were routinely tested for proper chemical sanitization. The Administrator identified 58 residents resided at the facility. Fifty-six residents received meals prepared by dietary services. Findings: A 'Dishwashing Machine Use' policy, revised August 2010, read in parts, A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution .once a week . A 'Food Safety Requirements' policy, undated, read in parts, Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) . A 'Date Marking for Food Safety' policy, undated, read in part, 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded .4. The marking system shall consist of . the day/date of opening, and the day/date the item must be consumed or discarded .5. The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest . On 04/22/24 at 10:54 a.m., during the initial tour of the kitchen, [NAME] #1 was observed with a beard and wearing no beard restraint. When asked if they should have a covering over their beard when inside the kitchen, they stated yes. The following observations were made during the initial tour of the kitchen: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The paper towel dispensers at both handwashing sinks were empty. There was a large roll of brown paper towels on the top rack of a tall, uncovered cart sitting in the dirty dish room that Dietary Aide #2 said they were using to dry their hands. Dietary Aide #2 stated the items on the cart were clean and that was where they put things to air dry. The cart was observed to be sitting directly in front of the dirty dish area where the person washing dishes would spray debris from the dishes. On a shelf over the prep table was a 1lb jar of grape jelly, opened and dated 01/30/24. The manufacturer's label read 'refrigerate after opening'. Under the prep table was a large bin labeled flour which was 1/2 full with the scoop buried inside the flour; a large bin labeled corn meal which was practically empty; and a large bin labeled rice which was practically empty. The lids on all the bins were very dirty and greasy with red spills and crumbs stuck to them. The following observations were made in the walk-in cooler: a. two 5lb bags of cut up grilled chicken pieces fully thawed, no label or use-by date b. six peeled hard boiled eggs wrapped in clear plastic, dated 03/01/24 c. 1/2 gallon carton of Heavy Cream- open, 1/2 full with no opened date d. 1/2 gallon carton of liquid Scrambled eggs- open with no opened date e. 5lb container of Sour Cream- opened and dated 03/01/24, manufacturers expiration date on container was 02/09/24 f. 5lb container of Cottage Cheese, opened and dated 02/09/24 g. 5lb container of Ricotta Cheese, opened and dated 02/09/24, manufacturers expiration date on container was 02/08/24 The following observations were made in the large refrigerator: a. a quart sized container of Lemon juice blend, opened and 1/4 full, was dated 12/01/23. The manufacturers expiration date on the container was 02/21/24 and the container was swollen and hard. On 04/22/12:45 p.m., Dietary Aide #2 was observed during the dishwashing process. During rinsing of soiled dishes, water was noted to be splashing directly across the room onto the items on the cart that was holding the clean items for drying. Dietary Aide #2 was asked if the dishes would still be considered clean and he stated, No, thats why I wash those things again before we use them. I immediately observed Dietary Aide #3 come into the dishwashing room and remove five empty water pitchers from the large rack. Dietary Aide #2 was asked to check the sanitizer level of the rinse for the dishwasher and stated he did not know how. There were no sanitizer levels documented on the 'Dish Washer Temperature/Chemical Record' log for April 2024. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/23/24 at 12:51 p.m., the Cert. Dietary Mgr. was asked the facility policy on food storage and handling. They stated all food should be labeled and dated when it is opened, and anything opened should be discarded within three days. They stated food thawing in the refrigerator should be labeled as to when it was put in the fridge to thaw. The Cert. Dietary Mrg. was asked how often the dishwashers rinse cycle sanitizer level should be checked. They stated in the morning and in the evening each day. The Cert. Dietary Mgr. was made aware of the above findings and stated that proper procedures for food handling and storage had not been followed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49701 Based on observation, record review, and interview, the facility failed to disinfection a glucometer before or after its use on a resident. RN #2 identified three residents required the use of this glucometer for blood glucose monitoring. Findings: A Glucometer Disinfection policy, dated 2023, read in part, The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use . On 04/23/24 at 11:30 a.m., RN #2 was observed completing glucose monitoring with a glucometer. RN #2 did not disinfect the glucometer before or after the use. On 04/23/24 at 11:33 a.m., RN #2 stated the glucometer gets cleaned by the night shift. They provided a Glucometer Control Log that documented that the glucometer was in range, but did not document any cleanings.