STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37E024	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carnegie Nursing Home, Inc.	225 North Broadway Carnegie, OK 73015

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 34270 Based on record review and interview the facility failed to accurately code minimum data set (MDS)assessments for three (#13, 24, and #84) of 12 sampled resident reviewed for accurate MDS assessments. The facility administrator reported 31 residents resided in the facility. Findings: The facility's MDS policy, dated 10/08/20, read in part, To provide key information unique to the resident. 1. Resident #13 had diagnoses which included congestive heart failure. A physician's order, dated 02/15/24, documented the resident had been prescribed Lasix [a diuretic medication] one and one half tablets of Lasix 40 mg tablets was to be taken daily for congestive heart failure. An administration record, dated 03/01/24 through 03/31/24, documented the resident was administered Lasix tablets each day on 03/01/24 through 03/28/24. A quarterly MDS assessment, dated 04/01/24, did not document in section N that the resident had been administered a diuretic medication during the seven day look-back period. 2. Resident #24 had diagnoses which include major depressive disorder. A physician's order, dated 03/26/24, documented the resident had been prescribed Remeron [an antidepressant medication] one tablet of 15 mg was to be taken every 12 hours for a depressive disorder. A medication administration record, dated 03/26/24 through 03/31/24, documented the resident had been administered Remeron 15 mg tablets on each day from 03/36/24 through 03/31/24. A quarterly MDS assessment, dated 04/01/24, did not document in section N that the resident had been administered an antidepressant medication during the seven day look-back period. 3. Resident #84 had diagnoses which included pain. (continued on next page)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 03/25/24, documented the resident had been prescribed Hydrocodone [an opioid pain medication] 10-325 mg 1 tablet to be taken once every 4 hours as needed for pain. A medication administration record, dated 03/25/24 through 03/31/24, documented the resident had been administered Hydrocodone 10-325 mg tablets on 03/28/24, 03/29/24, and 03/31/24. An admission MDS assessment, dated 04/03/24, documented the resident had entered the facility on 03/25/24. Section J did not document the resident had received as needed pain medication during the five day look-back period. Section N of the assessment did not document the resident had been administered an opioid medication since admission. On 04/17/24 at 11:59 a.m. the ADON stated they had not documented section N correctly in the MDS assessments of the three residents [#13, 24, and #84] because they had just missed them. They stated they had a process where LPN #1 and the DON would check their work with the MDS assessments. At 12:06 p.m., LPN #1 stated they did not double check the work of the ADON regarding the MDS assessments and does not believe anyone does. On 04/18/24 at 8:47 a.m., the DON stated it was important the MDS assessments be completed correctly. They stated they do not believe there was a process to current process to check the work of the ADON regarding the completion of MDS assessments but they believed their needed to be one.

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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. 43023 Based on observation, interview, and record review, the facility failed to develpo/implement a care plan for one (27) of 16 residents review for care plans. The ADON reported 31 residents resided inthe facility. Findings: A care plan, dated 04/01/24, contained no documentation of bedrails. On 04/15/24 at 10:50 a.m., the resident was observed resting in bed with bedrails observed to be in use for both sides of the resident's bed. On 04/16/24 at 1:39 p.m., the ADON reported the bed rails should have been care planned.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview the facility failed to conducted interdisciplinary team [IDT] meetings following quarterly assessments for the purpose of review and revision of the comprehensive care plan for two (#21 and #22) of 12 sampled residents reviewed for care plans. The administrator reported 31 residents resided at the facility. Findings: 1. Resident #21's admission summary documented the resident was admitted to the facility on [DATE]. A review of the resident's medical record did not locate documentation of care plan meetings having occurred for Resident #21 for the period of 04/15/23 through 04/15/24. 2. Resident #22's admission summary documented the resident was admitted to the facility on [DATE]. A review of the resident's medical record did not located documentation of care plan meetings having occurred for Resident #22 for the period of 04/15/23 through 04/15/24. On 04/15/24 at 10:19 a.m., Resident # 22 stated they were not aware what care plan meetings were or if they had attended. On 04/17/24 at 9:28 a.m., the ADON stated there had been no quarterly meetings of the IDT following MDS assessments in the past year. They stated the person that had taken care of those meeting no longer worked at the facility and the duty needed to be assigned to someone else. On 04/17/24 at 9:46 a.m., Resident #21 stated they were unsure if they had attended care plan meetings. On 04/18/24 at 8:47 a.m., the DON stated they did not know who planned and conducted the care plan meetings. They stated they had not attended any care plan meetings. They stated they did not believe the facility had a policy and procedure for care plan meetings. They stated the facility needs to start having care plan meetings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43023 Based on observation, record review, and interview the facility failed to ensure residents were free from accident hazards for two (#27 and #7) of four sampled residents. The ADON reported 31 residents resided in the facility. Findings: 1. Res #27 admitted to the facility with diagnoses of multiple sclerosis, diabetes mellitus, and pressure ulcer of the sacrum. On 04/15/24 at 10:50 a.m., the resident was observed resting in bed with bedrails observed on the resident's bed with a low loss air flow mattress in use. The resident's record did not contain a risk assessment for the use of bedrails with an air flow mattress. 2. Res #7 admitted to the facility with diagnoses of multiple sclerosis, congenital malformation, acquired absence of left leg, and acquired absence of right leg. The resident's record did not contain a risk assessment for the use of bedrails with an air flow mattress. On 04/15/24 at 8:30 a.m., Res #7 was observed in bed. The bed was observed with full bedrails raised on both sides. An air flow mattress was observed on the bed. A motor for an air flow mattress was observed on the foot of the bed powered on and functioning. On 04/15/24 at 11:49 a.m., Res #7 was observed in bed. The bed was observed with full bedrails raised on both sides. An air flow mattress was observed on the bed. A motor for an air flow mattress was observed on the foot of the bed powered on and functioning. On 04/16/24 at 8:12 a.m., Res #7 was observed in bed. The bed was observed with full bedrails raised on both sides. An air flow mattress was observed on the bed. A motor for an air flow mattress was observed on the foot of the bed powered on and functioning. on 04/16/24 at 1:33 p.m., the ADON/LPN reported Resident #7 has had the low loss air flow mattress for 2 years, reports he just got a new one. Reports had had bed rails for positioning since 07/20/23. On 04/16/24 at 1:39 p.m., the ADON she did not have a risk assessment completed regarding the use of bedrails with an air flow mattress. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/24 at 8:47 a.m., the DON stated they did not assess residents prior to their use of bed rails. They stated the charge nurses were to do that and report any problems to them. They stated informed consent and assessments had to precede the use of bed rails and they did not believe the nurses understood that process.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 34270 Based on observation, record review, and interview the facility failed prevent the use of bed rails until: a. alternatives to the use of bed rails had been attempted, and b. informed consent had been obtained and documented, and c. an assessment of the resident's ability to safely use a bed rail was conducted for one (#84) of three sampled residents reviewed for accident hazards. The ADON stated seven residents had side rails attached to their beds and in use. Findings: A facility Restraint policy and procedure, dated 06/01/2017, documented resident were to be assessed for their ability to reposition themselves using bed rails and the bed rails were to be checked monthly for safety. The policy and procedure did not document the requirements for using alternative methods to using bed rails prior to their use, assessing the residents for safety prior to the use of bed rails, or obtaining informed consent prior to the use of bed rails. A review of Resident #84's records contained no documentation of the attempted use of alternatives to the use of bed rails, a safety assessment related to bed rails, or informed consent. On 04/15/24 at 10:43 a.m., Resident #84 was observed to have full bed rails attached to each side of their bed. The resident stated they did no like the bed rails and preferred they not be there. They stated they think the staff put them there to keep them from falling out of bed. They stated they were unsure if the staff had tried alternative to the bed rails prior to them being put on the bed. The resident did not know if they had signed a consent form or had been assessed for safety. On 04/17/24 at 9:55 a.m., CMA #2 stated the resident's bed rails were for them to position themselves. They were unaware of the procedures required prior to the use of bed rails. At 2:16 p.m., the ADON stated no alternative to bed rails had been attempted prior to Resident #83 using the bed rails. They stated they did not have any documentation of the resident being assessed for safety related to the use of bed rails prior to their use. They stated they did not have documentation of informed consent for the use of bed rails having been obtained. On 04/18/24 at 8:47 a.m., the DON stated they had not performed a bed rail safety assessment for Resident #84. They stated they knew there was a procedure for using bed rails but did not believe the charge nurses were aware of what was required. They stated the facility needed to put a procedure in place for the use of bed rails and do some education.

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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. 43023 Based on record review and interview, the facility failed to perform annual nurse aid performance reviews. The ADON reported 31 residents resided in the facility. Findings: An employee staff list documented five CNA's who had hire dates greater than one year. On 04/15/24 at 2:00 p.m. the annual nurse aid perform reviews were requested. On 04/17/24 at 1:55 p.m., the assistant administrator stated she could not find the performance reviews.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 43023 Based on observation and interview the facility failed to ensure a medication/storage closet was locked when left unsupervised. The ADON reported 31 residents resided in the facility. Findings: On 04/15/24 at 8:45 a.m., a medication/storage closet on the north hall was observed to be unlocked and unsupervised. The closet was observed to contain over-the-counter medications and medical supplies. On 04/15/24 at 8:51 a.m., CMA #1 was asked if the medication/storage closet door is supposed to be locked. CMA #1 reported yes.

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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. 34270 Based on record review and interview, the facility failed to create a water management plan to prevent water borne pathogens. The facility administrator reported 31 residents resided in the facility. Findings: Facility policy and procedures were reviewed. No water management plan to prevent waterborne pathogens was located. On 04/18/24 at 9:59 a.m., the assistant administrator stated they had not heard of the water management plan to prevent waterborne pathogens. At 10:07 a.m., the assistant administrator stated the facility had not created a water management plan as of that time.