STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37E082	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seiling Nursing Center	914 NE Highway 60 Seiling, OK 73663

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 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. 21731 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed for the use of bed rails, an order had been obtained, or the care plan had been updated prior to installation for one (#5) of one sampled resident reviewed for bed rails. The DON identified two residents with bedrails. Findings: Resident #5 had diagnoses which included repeated falls and dementia A significant change assessment, dated 03/08/24, documented Resident #5 had severely impaired cognition. It documented Resident #5 required substantial and total assistance for position changes. On 06/10/24 at 10:29 a.m., Resident # 5 was observed resting in bed with half bed rails in up position on either side of the bed. On 06/13/24 at 9:48 a.m., the DON stated Resident #5's bed rails were for positioning. The DON stated during a care plan in March, it was decided bed rails would assist with the resident during care. The DON stated there was no documentation of an assessment, order, nor the care plan had been updated.

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 41318 Based on observation and interview, the facility failed to post nurse staffing information included all the required components. The administrator identified 17 residents resided in the facility. Findings: On 06/13/23 at 12:20 p.m., a staffing board was observed in the hallway, outside the med room. It was not observed to contain the facility name, total number and actual hours worked by following the categories of licensed and unlicensed nursing staff, or the resident census. On 06/13/24 at 12:25 p.m., the DON reported she was not aware of all the components required.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. 41318 Based on record review and interview, the facility failed to monitor for side effects related to the use of Xarelto for two (#2 and #8) of five sampled residents reviewed unnecessary medications. The DON identified five residents received anticoagulants. Findings: An Unnecessary Drugs policy, dated 06/01/17, documented an unnecessary drug was any drug used without adequate monitoring. 1. Resident #2 had diagnoses which included paroxysmal atrial fibrillation. A Physician's order, dated 01/25/24, documented the resident received Xarelto twice a day. There was no documentation in the resident's clinical record the resident had been monitored for side effects of Xarelto. 2. Resident #8 had diagnoses which included unspecified atrial fibrillation. A Physician's order, dated 07/07/21, documented the resident received Xarelto once a day. There was no documentation in the resident's clinical record the resident had been monitored for side effects of Xarelto. On 06/13/24 at 12:22 p.m., the DON stated side effect monitoring was completed on the TAR. She stated they weren't aware they should be monitoring side effects for Xarelto.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41318 Based on record review and interview, the facility failed to ensure side effects were monitored for an antidepressant for one (#2) of five sampled residents reviewed for unnecessary medications The DON identified nine residents received antidepressants. Findings: Resident #2 had diagnoses which included depression. A Physician's order, dated 07/11/23, documented the resident was to receive citalopram once a day. The resident's clinical record did not contain side effect monitoring for citalopram. On 06/13/24 at 12:22 p.m., the DON stated side effect monitoring was documented on the TAR. She stated she didn't know why Resident #2 didn't have it on their TAR.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41318 Based on observation, record review, and interview, the facility failed to ensure an insulin pen was discarded and not used after 28 days for one (#14) of one sampled resident observed for insulin administration. The DON identified two resident received insulin. Findings: An Insulin Pens policy, dated [DATE], documented the facility shall ensure insulin pens were used in accordance with manufacture instructions. TheHumalog manufacture instructions, dated ,d+[DATE], documented to discard the Humalog pen after using for 28 days even if insulin is left in the pen. On [DATE] at 11:20 a.m., LPN #1 was observed to prepare the Humalog insulin pen for administration for Resident #2. There was a ,d+[DATE] written on the label of the insulin pen. LPN #1 stated that was the date they first started using the pen. LPN #1 clarified it was ,d+[DATE] of 2024. LPN #1 was observed to administer six units of the insulin to Resident #2. LPN #1 stated the look at the use by date on the insulin pen to determine when the insulin was expired. LPN #1 was asked how they determined how long to use the pen after its first use. They stated they just went by the expiration date on the label. On [DATE] at 11:52 a.m., the DON stated insulin was good for 45 days after first use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41318 Based on observation and interview, the facility failed to ensure the ice machine was clean. The administrator identified 17 residents who resided at the facility. Findings: A weekly cleaning schedule, undated, documented the ice machine was to be cleaned. There was no documentation the ice and water dispenser was cleaned. A blank cleaning schedule, dated June 2024, documented the ice machine (outside and tray) was to be cleaned daily. There was no documentation the ice and water dispenser was cleaned. On 06/10/24 at 9:10 a.m., the ice machine was observed in the dining room. It was observed to have a separate ice and water dispenser. A paper towel was wiped on the inside water dispenser. Black residue was observed on the paper towel. A paper towel was wiped on the inside of the water dispenser. Orange/pink residue was observed on the paper towel. On 06/15/24 at 9:12 a.m., the CDM stated the ice and water dispensers were cleaned weekly. She was unable to provide documentation.

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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. 21731 Based on observation, record review, and interviews, the facility failed to ensure enhanced barrier precautions were implemented for a resident with an indwelling catheter for one (#1) of one sampled resident reviewed for infection control with a catheter. The DON identified one resident had an indwelling with a catheter. Findings: Resident #1 had diagnoses which included retention of urine. A Physician's order, dated 09/29/23, documented foley catheter to bedside drainage. A Quarterly assessment, dated 05/25/24, documented Resident #1 had moderately impaired cognition. It documented the resident had a urinary catheter. Resident #1's care plan did not contain documentation of enhanced barrier precautions. On 06/10/24 and 06/12/24 Resident #1 was observed with a catheter bag attached to their wheelchair. There was no signage observed on Resident #1's door indicating the resident was on enhanced barrier precautions. On 6/12/24 at 11:02 a.m., CNA #1 and CNA #4 was observed providing catheter care to Resident #1. They were not observed to wear any PPE other than gloves. Staff were asked if they had been provided education regarding enhanced barrier precautions. They both stated not regarding catheters. On 06/12/24 at 11:10 a.m., the DON was asked what was the facility's policy they had in place for enhanced barrier precautions. The DON stated they hadn't wrote a policy. The DON stated the policy would address the extra or expanded precautions for the use of PPE. The DON was asked when the enhanced precautions would need to be used during resident care. The DON reviewed a paper they identified as receiving from a seminar. They stated residents with catheters should have enhance barrier precautions. She stated the facility should have already had it in place.