STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375146	A. Building B. Wing	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Care & Rehab Center	1622 East Broadway Muskogee, OK 74403

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation, interview, and record review, it was determined the facility failed to ensure dignity during meals was maintained for one (#37) of ten sampled resident observed for dignity. The facility identified 10 residents who required assistance with eating. Findings: Resident #37 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease, osteoporosis, and dementia. A quarterly assessment, dated 06/17/21, documented the resident was severely impaired with cognition and required extensive assistance with eating. On 08/04/21 at 11:21 a.m., while observing the noon meal, licensed practical nurse (LPN) #3 was observed standing while assisting resident #37 eating her meal. LPN #3 was observed to stand while assisting the resident during the entire meal. On 08/16/21 at 1:05 p.m., the assistant director of nursing (ADON) stated the staff should stay eye level and sit while assisting a resident to eat. She stated it made the residents feel more comfortable. On 08/16/21 at 1:18 p.m., LPN #3 was asked how she would assist a resident with eating. She stated she would sanitize her hands, help the resident with an apron, and sit while she assisted the resident. LPN #3 was asked why she stood and assisted resident #37. She stated stated she thought it was easer to maneuver and that was why she stood. She stated she did not think to move to the other side of the table and sit.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 25225 Based on interview and record review, it was determined the facility failed to notify eight (#3, #21, #30, #31, #35, #40, #41, and #58) of 25 residents or representatives, whose payer source was Medicaid, when their resource balances were within $200 of the amount allowed for each resident. The facility identified 40 residents as having Medicaid as a payer source. Findings: Review of residents' trust fund account balances, effective 08/16/21, revealed the following: ~ resident #21 had a balance of $6,303.66; ~ resident #41 had a balance of $5,076.32; ~ resident #3 had a balance of $4,309.46; ~ resident #31 had a balance of $5,937.16; ~ resident #35 had a balance of $7,082.60; ~ resident #58 had a balance of $5,677.27; ~ resident #30 had a balance of $6,806.55; and ~ resident #40 had a balance of $4,370.99. On 08/16/21 at 12:45 p.m., the business office manager stated all the residents had Medicaid as their payer source. She stated the residents had all received stimulus checks, and those credits had increased the balances of their trust accounts. When deducting the amounts of the credits for the stimulus checks, it was noted the residents had the following balances: ~ resident #21 - $4303.66; ~ resident #41 - $3076.32; ~ resident #3 - $2309.46; ~ resident #31 - $3937.16; ~ resident #35 - $5082.60; ~ resident #58 - $4277.27; (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ resident #30 - $4806.55; and ~ resident #40 - $2970.99. These amounts were still over the $2000.00 resource limit allowed by Medicaid, and there was no documentation to show the residents or their representatives had been notified the accounts were within $200 of reaching the resource limit. On 08/16/21 at 1:03 p.m., the business office manager was asked what the resource limit was for a resident receiving Medicaid services as a payer source. She stated, I hear it is $2000, but I keep hearing they are being lenient on it. She was asked why the account balances were greater than $2000 for each resident, even after deducting for the stimulus checks. She stated, We don't have anything to spend the money on. She stated many of the residents already had burial arrangements taken care of, and the facility had not identified anything the residents needed, or they said they did not want anything. The business office manager stated she was not aware the residents could lose Medicaid as their payer source if they exceeded their resource limit. On 08/16/21 at 12:55 p.m., the administrator stated she was not aware of any leniency or that the account balances were so high.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 25225 Based on interview and record review, it was determined the facility failed to provide assurance of the funds deposited in the residents' trust fund account. This had the potential to affect 25 of 25 residents whose funds were held in the trust account. Findings: Review of the facility's Long-Term Care Facilities Residents Fund Bond, dated 08/23/16, revealed the facility had a surety bond covering the residents' trust fund account in the amount of $10,000. Review of bank statements for the residents' trust fund account revealed the following: ~ 05/2021 - the high daily balance in the account was $93,791.62 on 05/03/21; ~ 06/2021 - the high daily balance in the account was $79,674.61 on 06/03/21; and ~ 07/2021 - the high daily balance in the account was $71,882.89 on 07/06/21. On 08/16/21 at 2:30 p.m., the administrator was asked how much the surety bond was for. She stated it was for $10,000. On 08/17/21 at 2:15 p.m., the corporate administrator stated the insurance company had been contacted, and they were in the process of securing a new bond with an amount high enough to cover the high daily balances in the trust account.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41809 Based on interview and record review, it was determined the facility failed to inform, provide written information, and/or assist in formulating advance directives for six (#4, #7, #16, #19, #51 and #64) of seven residents sampled for advance directives. This had the potential to affect 64 who resided at the facility. Findings: The facility's policy on advance directives, dated 12/2018, documented, . Provide information about the facility's resident/patient's rights policies to all residents/patients and/or the authorized representatives or sponsors . prior to or upon admission . Inquire as to the existence of an Advance Medical Directive at the time of admission . Document in the resident/patient's medical record whether or not an Advance Medical Directive has been executed by the resident/patient . Place a copy of such Advance Medical Directive in the permanent medical record . 1. Resident #7 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, chronic obstructive pulmonary disease, and acute and chronic respiratory failure. On 08/05/21 at 3:22 p.m., resident #7 was asked if she had an advance directive. She stated yes, the facility did go over that with her. Review of the resident's medical record revealed no documentation of an advance directive. On 08/13/21 at 10:00 a.m., the business office manager was asked to locate the resident's advance directive. She stated the facility had a form that was signed by a resident when they were offered the advance directive. She stated a few resident did not get the form. At 10:47 a.m., the business office manager stated resident #7 did not have a do not resuscitate (DNR) order or a signed paper for the advance directive. 2. Resident #51 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, heart failure, and end stage renal disease. On 08/05/21 at 1:13 p.m., resident #51 stated she had an advance directive. Review of the resident's medical record revealed she had a DNR but not an advance directive. On 08/13/21 at 10:00 a.m., the business office manager was asked to locate the resident's advance directive. At 10:45 a.m., the business office manager stated the resident had a DNR in her file, but no advance directive or document showing she had been offered an advance directive. 25225 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #64 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease, congestive heart failure, hypertension, and a femur fracture. An Advance Directive Acknowledgement form, dated 07/16/21, documented the resident requested assistance in completing an advance directive and/or Oklahoma DNR form. Review of the resident's clinical record revealed no documentation of either an advance directive or DNR form. Physician's orders, dated 07/16/21, documented the resident was a full code, meaning she would receive cardiopulmonary resuscitation in an emergency event. On 08/13/21 at 10:28 a.m., the business office manager stated there was a form in the admission packet where residents could notate if they wanted help filling out an advance directive. She stated if a resident requested help, the form was given to the nurse so they could assist the resident. At 10:48 a.m., the business office manager stated it appeared the facility did not follow through with assisting resident #64 in filling out an advance directive. She stated she was putting a system in place to ensure this was done in the future. 38495 4. Resident #4 was admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome, Parkinson's disease, and post traumatic stress disorder. Review of the resident's medical record revealed no advance directive. There was no documentation the resident or representative had been offered information or assistance with formulating an advance directive. The record revealed the resident was a full code. On 08/13/21 at 9:56 a.m., the office manager stated she offered information on advance directives to residents on admission. She stated if a resident wanted an advance directive, she would get a nurse to help the resident formulate one. She stated when she first started as the business manager, she was unaware the resident needed to decline and have a copy of the declination in the chart. She stated she had started trying to get those declinations for all residents, including those who had been at the facility for some time. On 08/13/21 at 10:47 a.m., the office manager stated she had a hard time getting the family of resident #4 to sign the admission paperwork for the resident. She stated she did not find any documentation of an advance directive or refusal in the resident's chart. 5. Resident #16 was admitted to the facility on [DATE] with diagnoses that included cerebral artery occlusion and stenosis, fetal alcohol syndrome, and epilepsy. Review of the resident's medical record revealed no documentation of an advance directive. There was no documentation the resident or representative had been offered information or assistance with formulating an advance directive. The record revealed the resident was a full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/21 at 10:48 a.m., the office manager stated the resident did not have an advance directive, nor was there any documentation the resident or representative had been offered information or assistance in formulating one. 6. Resident #19 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, metabolic encephalopathy, and vascular dementia. Review of the resident's medical record revealed no documentation of an advance directive. There was no documentation the resident or representative had been offered information or assistance with formulating an advance directive. The record revealed the resident was a full code. On 08/05/21 at 9:50 a.m., registered nurse (RN) #2 was asked to provide the resident's advance directive or the form documenting one had been refused. She reviewed the clinical record and stated she did not find either form. On 08/13/21 at 10:46 a.m., the office manager stated the family member of resident #19 had taken the paperwork home, and he had not returned it.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist when the facility failed to notify the physician when a resident had a significant change in condition. Resident #68 was admitted to the facility on [DATE] with diagnoses that included a history of deep vein thrombosis, atrial fibrillation, atrial flutter, multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, and acute intraoperative massive pulmonary embolism. On [DATE], [DATE], and [DATE], the resident exhibited signs of symptoms of a change in her respiratory status. Staff did not notify the physician when the resident showed signs of a change in her respiratory status. On [DATE], the resident was found unresponsive. Cardiopulmonary resuscitation was started but was unsuccessful. The resident expired on [DATE]. At 11:46 a.m., the Oklahoma State Department of Health verified the existence of the IJ situation. At 11:49 a.m., the administration, director of nursing, and corporate administrator were notified of the IJ situation related to the facility's failure to notify the physician of a significant change in condition. On [DATE] at 3:57 p.m., an acceptable plan of removal was provided. The plan of removal documented, . 1. All residents in the facility who currently have oxygen will be reassessed by a Licensed Nurse to ensure that the oxygen liter flow being delivered matches the physician order for oxygen administration. Pulse Ox [pulse oximetry] will be obtained for all residents currently receiving oxygen. All findings will be documented in their medical record. [Physician name withheld] will be notified of any abnormal findings . " 2. In-services will be initiated immediately for all Licensed Nurses concerning respiratory assessment. These in-services will be continued/conducted for Licensed Nurses as they report to work for their shifts to ensure all Licensed Staff receive training. This will include: ~ Symptoms of low O2 sats [oxygen saturation] and high O2 sats, ~ Following treatment orders for breathing treatments such as nebulizers which will include checking MD order for the treatment and documentation on the MARS/TARS [medication administration sheets/treatment administration sheets] after the treatment is administered. ~ Ensuring all oxygen flow is delivered per physician order ~ Notifying the physician for any abnormal pulse ox reading, changes in mental status complaints of SOB [shortness of breath], cough, and abnormal lung sounds . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. In-service will be initiated immediately for all Licensed Nurses concerning notification of physician for any resident change in condition. This will include any new resident complaints, any subtle changes in resident's ADL [activities of daily living] abilities, subtle changes in resident's level of consciousness or cognition, changes in vital signs, increased SOB, etc. This in-service will also include notification of physician if any medication is not available for administration - Nurse may not 'hold' a medication without a physician order . 4. In-service will be initiated immediately for all Licensed Nurses concerning addressing O2 flow rates . 5. Pharmacy will conduct medication audit for all residents in the facility to ensure that all ordered medications are present for administration. These audits will be initiated this afternoon . 6. Direct Care Nursing staff to be in-serviced immediately concerning notification to Charge Nurse any changes noted in a resident's condition. This will include any resident complaint of discomfort, changes in resident's ability to perform ADLs, changes in resident's cognition, changes in resident's level of alertness, changes in resident's communication, noted increased weakness or balance issues . 7. Direct Care staff will be questioned upon completion of the above in-service, if they have any resident that has had changes in condition. Any resident noted will be reassessed by a Licensed Nurse with the assessment documented in the resident's medical record and notification of the changes, if noted, to the physician . 8. Nurse Managers will check the Oxygen Administration for all residents receiving oxygen daily x the next week to ensure that the oxygen flow rates are being administered according to physician orders . 9. Facility has posted the INTERACT Care Path for symptoms of SOB and the INTERACT Care Path for Acute Mental Status Change . 10. Any employee who was unable to come to facility for in service will be taken off of the schedule until they can be in services . The immediate jeopardy was removed on [DATE] at 10:20 p.m. when all components of the plan of removal were carried out. The deficient practice remained at a pattern of actual harm. Based on interview and record review, it was determined the facility failed to notify the physician of a significant change in condition for one (#68) of 24 sampled residents reviewed for change in condition after the resident exhibited signs of a change in respiratory status. This had the potential to affect 64 of 64 residents who resided at the facility. Findings: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A hospital history and physical report for resident #68, dated [DATE] and located in the facility's scanned documents, documented, . PMH [past medical history] of . atrial fibrillation previously on Eliquis who presents . with CC [chief complaint] of numbness and tingling to her left lower leg . intermittent numbness and tingling to left lower leg and occasionally similar symptoms to the right lower leg and bilateral wrists. Her symptoms have been progressive. Over the last month, she has had more constant numbness and tingling to the left lower leg and foot. She now reports a cold feeling to the limb. She had not previously sought medical attention after losing her job and health insurance . No chest pain or shortness of breath . palpitation intermittently. She stopped taking her Eliquis about 3 to 5 days ago after running out of medication . Hospital discharge documentation, dated [DATE] and located in the facility's scanned documents, documented, . Your Diagnosis[:] Atrial Flutter, physical deconditioning, right leg deep vein thrombosis (DVT) . multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, acute intraoperative massive pulmonary embolism - s/p [status post] catheter direct TPA [tissue plasminogen activator, used to dissolve blood clots] thrombolysis, subacute thrombotic occlusion of the left iliac artery and left femoral-popliteal trifurcation vessels, acute kidney injury, anemia, hypertension, hypertension, hypokalemia,, moderate aortic regurgitation, ventricular septal defect, multiple fractures of ribs . Home needs: oxygen; 'Contact physician for: increased swelling, chest pain' 'Contact physician for: increased shortness of breath . ' Education: . Atrial Flutter . get help right away if you have: . shortness of breath . Peripheral Vascular Disease . get help right away if: . you have chest pain or trouble breathing . Deep Vein Thrombosis . get help right away if: . you have . shortness of breath . Cardiogenic shock . what are the signs or symptoms . shallow, quick breathing, or shortness of breath . Get help right away if you: . Have shortness of breath . Discharge physician orders documented the resident was to receive Apixaban (Eliquis, an anticoagulant) 5 milligrams (mgs) twice daily for the prevention of blood clots. Resident #68 was admitted to the facility on [DATE] with diagnoses that included atrial flutter, chronic embolism, and deep vein thrombosis. A medication administration note, dated [DATE] at 8:23 p.m., documented, . waiting on pharmacy . A medication administration note, dated [DATE] at 9:10 a.m., documented, . Apixaban Tablet 5 MG Give 1 tablet by mouth two times a day related to chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A medication administration note, dated [DATE] at 9:44 a.m., documented, . Pharmacy notified that medication Apixaban has not made it to facility, pharmacist stated the medication needed insurance approval and he would be sending a form over to the facility to fill out. Apixaban Tablet 5 MG placed on hold until paperwork can be submitted to insurance . Review of facility medication administration records revealed the resident did not receive Eliquis, as ordered by the physician from admission on [DATE] until 8:00 p.m. on [DATE]. There was no documentation to show the physician was notified the resident did not receive the ordered medication. The resident's care plan, dated [DATE], documented the resident had a problem related to an imbalance between oxygen supply and demand. The goal was the resident would maintain blood pressure, pulse, and respirations within prescribed limits during activity through the review date. Interventions included to administer medications as prescribed; assess for signs and symptoms of activity intolerance such as statements of fatigue and weakness, exertional dyspnea, and chest pain; and to report decreased activity tolerance to the physician. An admission assessment, dated [DATE], documented the resident was moderately impaired in cognitive skills for daily decision making; required limited assistance for most activities of daily living; had diagnoses that included blood clots and heart failure; and was receiving oxygen therapy. The assessment documented the resident was not receiving an anticoagulant medication. A progress note, dated [DATE] at 4:34 p.m., documented, . Resident arrived in facility . No acute distress or discomfort noted . One person limited assist is required for transfers and ambulation due to general weakness. Continent of bowel and bladder with occasional episodes of incontinence requiring extensive assist. Staff strive to keep call light and fluids within easy reach. A progress note, dated [DATE] at 1:40 a.m., documented, . respirations unlabored via nasal cannula, in place and patent . A health status note, dated [DATE] at 7:13 a.m., documented, . Respirations are even and unlabored, clear to auscultation . Resident uses oxygen via nasal cannula, respirations unlabored . O2 at 2LPM [two liters per minute] via nasal cannula . for Shortness of Breath related to acute respiratory failure with hypoxia . A health status note, dated [DATE] at 7:45 a.m., documented, . respirations easy on room air 02 off for awhile giving nose a rest continues with good 02 Sat on room air . A health status note, dated [DATE] at 9:57 a.m., documented, . Respiration with ease 02 flowing at 2LPM via NC. [nasal cannula] . A health status note, dated [DATE] at 11:40 a.m., documented, . focused assessment r/t [related to] resident requesting breathing treatment. no orders for breathing treatment. [physician name withheld] office notified with a request of breathing treatments . Review of the resident's clinical record revealed no documentation the resident's respiratory status was assessed and monitored. There was no documentation the physician's office was notified of the resident's request for a breathing treatment. There was no documentation an order was received for a breathing treatment or that one was provided. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A health status note, dated [DATE] at 1:48 p.m., documented, . focused assessment r/t resident continues to tell staff she can't breath, 02 sat [blood oxygen level] 99%. 02 bumped up to 3L/NC. resident setting on side of bed leaning forward, nurse spoke with resident about trying to relax and breath in through her nose out through her mouth . Review of the resident's clinical documentation reveals no documentation the resident's physician was notified after the resident complained of being unable to breath on [DATE]. There was no documentation the facility notified the physician of the increase in the oxygen flow rate. There was no documentation of any previous reports that the resident was unable to breath. A health status note, dated [DATE] at 11:10 a.m., documented, . focused assessment r/t residents breathing pattern. Resident is breathing with her mouth open and her oxygen in her mouth. Residents O2 sat 94 on 3L . Review of the resident's clinical record revealed no documentation the resident's physician was notified of the resident's decreased blood oxygenation level and continued difficulties with breathing on [DATE]. A health status note, dated [DATE] at 1:49 a.m., documented, . [12:50 a.m.] entered resident room and noted resident wasn't breathing. Resident assisted to floor with assist of 3 staff CPR [cardiopulmonary resuscitation] started nurse from back nurses station called EMS [Emergency Medical Services]. EMS here at 1 am CPR stopped at that time. EMT's [emergency medical technicians] received order to stop CPR at that time . On [DATE] at 9:59 a.m., licensed practical nurse (LPN) #5, who was the resident's nurse, was asked what the resident's admitting diagnoses were. She stated atypical atrial flutter, chronic embolism of the deep veins of the lower extremities, hypertension, anemia, heart failure at one time, acute kidney failure, and acute respiratory failure with hypoxia. LPN #5 was asked what things were monitored for with these diagnoses. She stated, Pulse ox [blood saturation level], breathing, color of the skin, if diaphoretic. LPN #5 was asked what the facility did when the resident requested a breathing treatment on [DATE]. She stated, I guess I should have followed up with that. She stated she had notified the physician, received an order, and then started with the breathing treatment he had ordered. She was asked where the order was documented. She reviewed the clinical record and stated, I don't see it do I. I don't see one. She stated there was no documentation a breathing treatment had been given. LPN #5 was asked what the facility did after the resident complained of being unable to breath on [DATE]. She stated, I made sure the head of the bed was raised and repositioned her. She stated, With mouth breathing, I put the oxygen in her mouth and turned it up to make sure she was breathing it in. She stated the resident's blood oxygen saturation levels were in the middle 90's. She stated, I didn't do very good charting. LPN #5 was asked if she notified the physician. She stated, I always fax him. She was asked where it was documented the physician was notified of the resident's complaint of being unable to breath and that she had turned the oxygen flow rate up. She stated, Should be in the chart. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LPN #5 was asked if the physician was notified on [DATE] and how he was notified. She stated, We have to fax him every time. She was asked if she faxed him on this date. She shook her head in a yes motion and stated it should be on the chart. LPN #5 was asked if there was any other place the information might be documented. She stated, Everything I would have charted would be in this area right here [pointed at the progress note section of the electronic medical record]. Other than me doing it, it it's not charted, it's not done. On [DATE] at 10:18 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were asked where the physician's order was for a breathing treatment on [DATE]. They reviewed the clinical record, and the ADON stated, I don't see an order. The DON stated, I don't either. They were asked where the documentation was the resident received a breathing treatment. The ADON stated, I don't see it on any MAR [medication administration sheet]. The DON and ADON were asked what the staff did when the resident began to have complaints of being unable to breath on [DATE]. The ADON stated, It looks like they did the deep breathing and breathing through her mouth for that day. They were asked where it was documented the physician was notified. They reviewed the clinical record, and the ADON stated, I did not see any in the notes. The DON and ADON were asked how the staff assessed and monitor the resident on [DATE] after she was noted to have a change in her breathing pattern, breathing with her mouth open, and her oxygen in her mouth. The ADON stated, I don't see any assessments. The DON and ADON were asked how the physician was notified of the resident's continued difficulties with breathing on [DATE]. The ADON stated the staff would have notified him via fax. She was asked where that information was. She stated it should be on the chart. The surveyor informed her there was no documentation the physician was notified. They were asked why the staff did not notify the physician. The ADON stated, I can't answer that. I'm not the nurse. On [DATE] at 11:09 a.m., the resident's physician was asked if the facility had notified him the resident had missed dosage of Eliquis from admission on [DATE] until 8:00 p.m. on [DATE]. He stated he did not recall it, but they may have. He stated sometimes they had trouble getting insurance companies to pay for Eliquis. He was asked what the dangers were of a resident not receiving their Eliquis. He stated they could certainly have a pulmonary embolis or stroke. He stated he would normally place a resident on Lovenox (an anticoagulant) until a resident was able to get their Eliquis. The physician was asked what the staff should have been monitoring the resident for. He stated oxygen levels, normal vitals signs, and respiratory status. He was asked if the facility notified him on [DATE] when the resident stated she was have difficulty breathing. He stated he could remember being called on her, but he could not state what days or for what reason. He was asked if staff had notified him they had increased her oxygen flow rate. He stated he did not specifically remember the conversation. He was asked if the facility notified him on [DATE] when the resident continued to have difficulties breathing. He stated he did not remember. He was asked what his expectation was if a resident began to have a change in condition or began to show signs and symptoms of distress. He stated he expected to be notified.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation, interview, and recored review, it was determined the facility failed to Findings: Resident #19 FTag Initiation [NAME] Resident #19 Writing tag F605 for chemical restraints admitted : [DATE] Unnecessary Medications [DATE] 08:46 AM resident was laying in her bed this morning facility the wall under the covers. She stated she would rather take her nap this morning than do the interview. [DATE] 04:00 PM The resident was observed sitting on the side of her bed with the overbed table in from of her waiting on her dinner. DX: I63.9 CEREBRAL INFARCTION, UNSPECIFIED SLP Acute Neurologic [DATE] Primary Admitting Dx [DATE] jwade view F29 UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION Medical Management [DATE] Secondary History [DATE] cbraden K59.00 CONSTIPATION, UNSPECIFIED N/A, not an acceptable Primary Diagnosis [DATE] Secondary During Stay [DATE] sharbison R19.7 DIARRHEA, UNSPECIFIED N/A, not an acceptable Primary Diagnosis [DATE] Secondary During Stay [DATE] jwade G43.009 MIGRAINE WITHOUT AURA, NOT INTRACTABLE, WITHOUT STATUS MIGRAINOSUS N/A, not an acceptable Primary Diagnosis [DATE] Secondary History [DATE] jwade F33.3 MAJOR DEPRESSIVE DISORDER, RECURRENT, SEVERE WITH PSYCHOTIC SYMPTOMS Medical Management [DATE] Secondary Admission [DATE] cbraden R27.0 ATAXIA, UNSPECIFIED Acute Neurologic [DATE] Secondary Admission [DATE] jwade (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I69.319 T UNSPECIFIED SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS FOLLOWING CEREBRAL INFARCTION SLP Medical Management [DATE] Secondary Admission [DATE] jwade R53.83 OTHER FATIGUE N/A, not an acceptable Primary Diagnosis [DATE] Secondary Admission [DATE] jwade I48.91 UNSPECIFIED ATRIAL FIBRILLATION Cardiovascular and Coagulations [DATE] Secondary Admission [DATE] jwade Z91.81 HISTORY OF FALLING N/A, not an acceptable Primary Diagnosis [DATE] Secondary History [DATE] jwade G47.00 INSOMNIA, UNSPECIFIED N/A, not an acceptable Primary Diagnosis [DATE] Secondary Admission [DATE] jwade I10 ESSENTIAL (PRIMARY) HYPERTENSION N/A, not an acceptable Primary Diagnosis [DATE] Secondary Admission [DATE] jwade R56.9 UNSPECIFIED CONVULSIONS Medical Management [DATE] Secondary Admission [DATE] jwade B02.9 ZOSTER WITHOUT COMPLICATIONS Acute Infections [DATE] Secondary History [DATE] jwade F41.9 ANXIETY DISORDER, UNSPECIFIED Medical Management [DATE] Secondary Admission [DATE] jwade R55 SYNCOPE AND COLLAPSE Medical Management [DATE] Secondary History [DATE] jwade view E86.0 DEHYDRATION Medical Management [DATE] Secondary History [DATE] jwade R42 DIZZINESS AND GIDDINESS N/A, not an acceptable Primary Diagnosis [DATE] Secondary Admission [DATE] jwade R41.82 ALTERED MENTAL STATUS, UNSPECIFIED N/A, not an acceptable Primary Diagnosis [DATE] Secondary Admission [DATE] jwade G93.41 METABOLIC ENCEPHALOPATHY Acute Neurologic [DATE] Secondary History [DATE] jwade F03.90 UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE Medical Management [DATE] Secondary Admission [DATE] jwade Z79.01 LONG TERM (CURRENT) USE OF ANTICOAGULANTS N/A, not an acceptable Primary Diagnosis [DATE] Secondary Admission [DATE] jwade I48.3 TYPICAL ATRIAL FLUTTER Cardiovascular and Coagulations [DATE] Secondary Admission [DATE] jwade E78.5 HYPERLIPIDEMIA, UNSPECIFIED Medical Management [DATE] Secondary Admission [DATE] jwade (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F01.51 VASCULAR DEMENTIA WITH BEHAVIORAL DISTURBANCE N/A, not an acceptable Primary Diagnosis [DATE] Secondary Admission [DATE] jwade F48.2 PSEUDOBULBAR AFFECT Medical Management [DATE] Secondary Admission ********** MEDICATIONS: Keppra Tablet 500 MG (levETIRAcetam) Give 1 tablet by mouth two times a day related to UNSPECIFIED CONVULSIONS (R56.9) Pharmacy Active [DATE] 19:00 [DATE] Apixaban Tablet 5 MG Give 1 tablet by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILLATION (I48.91) Pharmacy Active [DATE] 19:00 [DATE] Atorvastatin Calcium Tablet 40 MG Give 1 tablet by mouth at bedtime related to HYPERLIPIDEMIA, UNSPECIFIED (E78.5) Pharmacy Active [DATE] 20:00 [DATE] Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day related to UNSPECIFIED ATRIAL FIBRILLATION (I48.91);TYPICAL ATRIAL FLUTTER (I48.3) hold if apical pulse less than 60 Pharmacy Active [DATE] 13:00 [DATE] Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) hold for SBP less than 100 or pulse less than 60 Pharmacy Active [DATE] 19:00 [DATE] Milk of Magnesia Suspension 7.75 % (Magnesium Hydroxide) Give 30 ml by mouth every 24 hours as needed for constipation Pharmacy Active [DATE] 19:00 [DATE] Tylenol Extra Strength Tablet 500 MG (Acetaminophen) (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give 1 tablet by mouth every 6 hours as needed for Pain;Elevated Temperature Pharmacy Active [DATE] 11:15 [DATE] Antacid & Antigas Suspension [DATE] MG/5ML (Alum & Mag Hydroxide-Simeth) Give 20 ml by mouth every 2 hours as needed for gas/bloating;Indigestion Pharmacy Active [DATE] 14:30 [DATE] traZODone HCl Tablet 50 MG Give 1 tablet by mouth at bedtime related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES (F33.2) Pharmacy Active [DATE] 20:00 [DATE] Melatonin Tablet 5 MG Give 2 tablet by mouth at bedtime related to INSOMNIA, UNSPECIFIED (G47.00) Give two tabs to = 10mg Pharmacy Active [DATE] 20:00 [DATE] Zofran Tablet 8 MG (Ondansetron HCl) Give 1 tablet by mouth every 8 hours as needed for Nausea and Vomiting Pharmacy Active [DATE] 15:45 [DATE] Colace Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth two times a day related to CONSTIPATION, UNSPECIFIED (K59.00) Pharmacy Active [DATE] 19:00 [DATE] Meclizine HCl Tablet 25 MG Give 1 tablet by mouth three times a day related to DIZZINESS AND GIDDINESS (R42) Pharmacy Active [DATE] 13:00 [DATE] Tums Tablet Chewable 500 MG (Calcium Carbonate Antacid) Give 1 tablet orally three times a day for Indigestion Pharmacy Active [DATE] 19:00 [DATE] (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Paxil Tablet 20 MG (PARoxetine HCl) Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, SEVERE WITH PSYCHOTIC SYMPTOMS (F33.3) Pharmacy Active [DATE] 07:00 [DATE] SEROquel Tablet 100 MG (QUEtiapine Fumarate) Give 1 tablet by mouth at bedtime related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOLOGICAL CONDITION (F29) Take 1 tablet by mouth nightly Pharmacy Active [DATE] 20:00 [DATE] LORazepam Tablet 0.5 MG Give 1 tablet by mouth two times a day related to ANXIETY DISORDER, UNSPECIFIED (F41.9) Pharmacy Active [DATE] 19:00 [DATE] busPIRone HCl Tablet 10 MG Give 1 tablet by mouth three times a day related to ANXIETY DISORDER, UNSPECIFIED (F41.9) Pharmacy Active [DATE] 13:00 [DATE] Benadryl Allergy Capsule 25 MG (diphenhydrAMINE HCl) Give 1 capsule by mouth every 24 hours as needed for Redness/irritation Pharmacy Active [DATE] 02:45 Ocean Nasal Spray Solution 0.65 % (Saline) 2 spray in both nostrils every 6 hours as needed for Nasal Dryness Pharmacy Active [DATE] 17:15 ********** ORDERS: FULL CODE No directions specified for order. Other Active [DATE] (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain VS weekly one time a day every Thu Other Active [DATE] 06:00 [DATE] MAY HAVE COVID 19 TESTING No directions specified for order. Other Active [DATE] DIGOXIN VALPORIC ACID AND KEPPRA LEVEL Q 3 MONTHS DUE IN APRIL JULY OCT JAN one time a day every 3 month(s) starting on the 1st for 1 day(s) related to CEREBRAL INFARCTION, UNSPECIFIED (I63.9);UNSPECIFIED CONVULSIONS (R56.9);METABOLIC ENCEPHALOPATHY (G93.41);UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE (F03.90);LONG TERM (CURRENT) USE OF ANTICOAGULANTS (Z79.01) Laboratory Active [DATE] 06:00 [DATE] [DATE] Keppra level was done 14 (,d+[DATE]) normal [DATE] Digoxin 0.85 (0XXX,d+[DATE].00) normal [DATE] VPA <12.5 Resident was changed to Keppra [DATE]. CMP CBC Q 6 MONTHS IN APRIL OCT one time a day every 6 month(s) starting on the 1st for 1 day(s) related to CEREBRAL INFARCTION, UNSPECIFIED (I63.9);UNSPECIFIED ATRIAL FIBRILLATION (I48.91);ESSENTIAL (PRIMARY) HYPERTENSION (I10);METABOLIC ENCEPHALOPATHY (G93.41) Laboratory Active [DATE] 06:00 [DATE] Lab obtained [DATE] normal TSH LIPIDS VIT D YEARLY IN APRIL one time a day every 12 month(s) starting on the 1st for 1 day(s) related to CEREBRAL INFARCTION, UNSPECIFIED (I63.9);UNSPECIFIED ATRIAL FIBRILLATION (I48.91);ESSENTIAL (PRIMARY) HYPERTENSION (I10);METABOLIC ENCEPHALOPATHY (G93.41);TYPICAL ATRIAL FLUTTER (I48.3);HYPERLIPIDEMIA, UNSPECIFIED (E78.5) Laboratory Active [DATE] 06:00 Lab obtained for CMP, CBC [DATE] normal Lipid Panel HDL 49 low range >60, Triglycerides 157 high range is <150 (continued on next page)

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MDS:

[DATE] Annual [DATE] Quarterly

BIMS 10 07

Mood 01 01

Behaviors - none Physical & verbal behaviors 1to3 days

Bed mobility ,d+[DATE] ,d+[DATE]

Transfer ,d+[DATE] ,d+[DATE]

Walk in room/corridor ,d+[DATE] ,d+[DATE]

Locomotion on/off unit ,d+[DATE] ,d+[DATE]

Dressing ,d+[DATE] ,d+[DATE]

Eating ,d+[DATE] ,d+[DATE]

Toilet use ,d+[DATE] ,d+[DATE]

Personal hygiene ,d+[DATE] ,d+[DATE]

Bathing ,d+[DATE] ,d+[DATE]

Urinary always continent always continent

Bowel - not rated always continent

Pain - no scheduled pain medication/ PRN pain meds/no pain has not received PRN pain medications.

Medications:

Antipsychotic 7 days 7 days

Antianxiety 7 days 7 days

Antidepressant 7 days 7 days

Anticoagulant 7 days 7 days

Med review: No- anti were not received - routine YES

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	GDR - NO SP TX: none none ********** Care Plan: [DATE] Labile Emotional Control. Diagnosis of PSEUDOBULBAR EFFECT. I have a chemical imbalance in the brain that effects my emotions secondary to diagnosis of SIGNS AND SYMPTOMS INVOLVING COGNITIVE FUNCTIONING FOLLOWING CEREBRAL INFARCTION. I have a reduced stress threshold secondary to VASCULAR DEMENTIA, CVA. I have diminished mental capacity secondary to DEMENTIA, CVA. I have feelings of anxiety, fear, confusion associated with DEMENTIA, CVA, ALTERED MENTAL STATUS. H [Behavior] Resident will have behavioral problems identified and preventive measures implemented to minimize labile emotions by the review date. H Resident will experience improved emotional control or maintain current level of emotional control through the review date. H Resident will have safe, stable environment with routine scheduling of activities to decrease anxiety and confusion through the review date. H Administer medications as prescribed. ANAFRANIL CAPSULE 50mg. [CMA/T,LPN,RN] H Allow the resident the freedom to sit in a chair new the window or nurse station, etc., utilize books, magazines or diversion activities as desired/appropriate. [CNA,RNA,LPN,RN] H Allow wandering in a controlled environment as appropriate or within acceptable limitations. This increases the resident's security and decreases hostile and agitated behaviors within the confines of a safe, supervised environment. [CNA,RNA,LPN,RN] H Approach the resident in a consistent manner in all interactions. A consistent approach to resident interaction enhances feelings of security and provides structure. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[LPN,RN,SS,CNA,ACTD] H Assess and document ability to cope with events, interests in surroundings and activity in surroundings every shift. [LPN,RN,CNA,SS,RNA] H Assist with establishing cues and reminders for resident assistance. [CNA,RNA,ACTD,LPN,RN] H Avoid or terminate emotionally charged situations or conversations. Avoid anger and expectation of resident to remember or follow instructions. Do not expect more than the resident is capable of doing. [CNA,LPN,RN,RNA,ACTD] H Guard against personal feelings of frustration and lack of progress. [RN,LPN,SS,CNA,RNA] H If labile emotional control is demonstrated, provide a calm, quiet environment with minimal sensory stimuli for the resident. Speak calmly, clearly in a soothing voice. Provide reassurance. Provide appropriate diversion activity as needed. [CNA,RNA,LPN,RN,SS] H Limit decisions the resident makes. Be supportive and convey warmth and concern when communicating with the resident. [CNA,CMA/T,RNA,LPN,RN] H Maintain consistent scheduling with allowances for resident's specific needs. Avoid situations that may lead to overstimulation. [CNA,LPN,RN,RNA,ACTD] H Orient to person and environment as needed. Utilize calendars, radios, newspapers, television, etc. as appropriate. [CNA,RNA,LPN,RN,SS] H Provide time for reminiscing if resident desires to do so. [ACTD,CNA,RNA] H Refer to psych. to treat and evaluate as ordered. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[RN,LPN,SS] H Altered Thought Processes Risk. I have damage to cerebral tissues associated with cerebral ischemia secondary to CVA, DEMENTIA. H [Behavior][Psychotropics] Resident will demonstrate improvement in thought processes evidenced by improved level of orientation by the review date. H Resident will reduce the frequency of inappropriate responses/behaviors through the review date. H Administer medications as prescribed. Monitor effectiveness of medications and s/s adverse drug reactions. [CMA/T,LPN,RN] H Assess/monitor/document s/s altered thought processes (e.g., shortened attention span, impaired memory, decreased ability to problem solve, confusion, inappropriate responses, inappropriate behaviors). [LPN,RN,SS] H Assist resident to problem solve as necessary. [CNA,RNA,LPN,RN,SS] H Consult physician/appropriate health care provider if altered thought processes continue and/or worsen. [LPN,RN,SS] H Discuss physiological basis for altered thought processes with resident and significant others; inform them that cognitive and emotional functioning may improve. Encourage/support in methods of dealing with resident's altered thought processes. [LPN,RN,SS] H Implement measure to minimize emotional outbursts and inappropriate responses/behaviors if they occur (e. g., provide distraction, redirect, use calm, quiet language/approach, don't argue/confront, turn on music/television, give familiar object, etc.). [CNA,RNA,LPN,RN] H Keep environmental stimuli to a minimum but avoid sensory deprivation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Care & Rehab Center	1622 East Broadway Muskogee, OK 74403

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[CNA,RNA,LPN,RN,ACTD] H Maintain a consistent and regular, structured routine. Maintain onsistent caregivers when possible. [CNA,LPN,RN] H Place familiar objects, clock and calendar within the resident's view. [ACTD,SS,RNA,CNA,LPN] H Reorient to person, place and time as indicated/necessary. [CNA,RNA,LPN,RN] H Repeat instructions as necessary using clear, simple language and short sentences. Allow ample time for communication. [CNA,RNA,LPN,RN,SS] H ANTIDEPRESSANTS. Disturbed Thought Process/Risk. I am exhibiting decreased problem-solving capability, hypovigilance, impaired interpretation of environment, inappropriate behaviors associated with DEPRESSION, ANXIETY, PSEUDOBULBAR AFFECT. I am experiencing changes in sleep habits, loss of appetite, decreased energy level, inability to concentrate associated with DEPRESSION, INSOMNIA, ANXIETY, MIGRAINE. H [Behavior][Psychotropics] Resident will be free from SE and/or adverse drug reaction from use of antidepressant medications PAXIL, SEROQUIL, TRAZADONE through the review date. H Resident will demonstrate improved mood evidenced by absence of crying, decreased anxiety, improved sleep pattern, participation in preferred activities by the review date. H Resident will demonstrate improved sleep pattern and interest in self-care, preferred activities by the review date. H Administer medications as prescribed. Monitor for effectiveness, side effects and adverse drug reactions. PAXIL 20mg. TRAZADONE 50mg. [CMA/T,LPN,RN,PHARM] H (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADVERSE REACTIONS: Monitor for s/s CNS effects that may increase the risk for falls: dizziness, nausea, diarrhea, anxiety, nervousness, insomnia, somnolence, weight gain, anorexia, increased appetite. [RN,LPN,CMA/T,CNA,SS] H Allow ample time to finish ADLs, activities, eating, routines. Understand that demands to hurry only increase anxiety and slow down ability to think and respond clearly. [CNA,CMA/T,RNA,LPN,RN] H Allow plenty of time to think and frame responses. [CNA,CMA/T,LPN,RN,SS] H DOSAGE: Use of two or more antidepressants simultaneously may increase risk of SE. Provide documentation of expected benefits that outweigh the associated risks and monitoring for increase in SE with use of two or more antidepressants simultaneously. [RN,LPN,CMA/T,PHARM,SS] H Move the resident to a quiet area with minimal stimulus, dim lighting, small area, relaxing music, comfort items with s/s anxious behavior and/or escalating behavior. [LPN,RN,CNA,CMA/T,SS] H Observe for increasing anxiety. Assume a calm manner. Decrease environmental stimulation, Provide temporary isolated environment as indicated. Early detection and intervention facilitates a method of minimizing the escalation of anxiety/behaviors. [SS,RN,LPN,CNA,ACTD] H Provide reassurance and comfort measures to relieve s/s anxiety. [RN,LPN,CNA,CMA/T,SS] H SIDE EFFECTS: MENTAL STATUS CHANGE: Monitor s/s, SE mental status changes: mood changes, sensorium, suicidal tendency, increase in psychiatric symptoms, depression, panic, flat affect. Report new onset SE to physician. [CMA/T,LPN,RN,PHARM,SS] H SIDE EFFECTS: SEROTONIN SYNDROME: Monitor for s/s, SE of serotonin syndrome: increased heart rate, sweating, dilated pupils, tremors, twitching, hyperthermia, agitation, hyperreflexia, nausea, vomiting, diarrhea, hallucinations, coma (SSRIs, SNRIs, TRIPTANS). [LPN,RN,CMA/T] H (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident will be continent during daytime through the review date. H Administer medications as prescribed. [CMA/T,LPN,RN] H Assess and document risk factors and history for bowel incontinence. [LPN,RN,CNA] H Assess and document s/s and frequency of bowel incontinence. [CNA,LPN,RN] H Check resident every two hours and assist with toileting as needed [CNA] H Observe pattern of incontinence, and initiate toileting schedule if indicated. H Provide bedpan/bedside commode [CNA] H Provide loose fitting, easy to remove clothing [CNA] H Provide pericare after each incontinent episode Constipation Risk Chronic Perceived. I have decreased peristalsis secondary to impaired mobility, activity intolerance. I have inadequate food and fluid intake secondary to diminished appetite. H will pass soft, formed stool at the preferred frequency of every third day through the review date. H Resident will have a normal bowel movement at least every third day through the review date. H Administer medication as prescribed. Colace 100mg CAPSULE BID. MILK OF MAGNESIA 30ml PRN. H Assess/monitor/document bowel sounds. Report pattern of diminishing sounds or sounds that do not return to normal when expected. [LPN,RN] H (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist me to the bathroom or bedside commode. Pace me in high Fowler's position on bedpan for bowel movements unless contraindicated. Provide privacy. [CNA] H Encourage resident to defecate whenever the urge is felt. [CNA,LPN,RN] H Encourage resident to sit on toilet to evacuate bowels if possible. [CNA] H Establish a regular time for bowel movements, preferably one hour after meals. [CNA] H Follow facility bowel protocol for bowel management. H Monitor medications for side effects of constipation. Keep physician informed of any problems. H Record bowel movement pattern each day. Describe amount, color and consistency. [CNA] H Decision-Making. I am experiencing inadequate preparation for stressors secondary to DEPRESSION, AXIETY, CONFUSION, IMPAIRED MEMORY, PAIN, DEBILITY. I experience confusion in appraisal of threat associated with FATIGUE, DEBILITY, ANXIETY, DEPRESSION. H [Advance Directive] Resident will verbalize feelings related to emotional state by the review date. H Resident will communicate needs and negotiate with others to meet needs through the review date. H Convey feelings of acceptance and understanding. Avoid false reassurances. [SS,DON,LPN,RN] H Determine the resident's understanding of the stressful situation. [SS,LPN,RN] H (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Evaluate resources and support systems available to the resident. [SS] H Identify specific stressors. [SS,LPN,RN,CNA] H Observe for causes of ineffective coping such as poor self-concept, grief, lack of problem-solving skills, lack of support, or recent change in life situation. [SS,LPN,RN,CNA] H Observe for strengths such as the ability to relate the facts and to acknowledge the source of stressors. [SS,LPN,RN,CNA] H Provide diversion activities. Encourage use of cognitive behavioral relaxation. [SS,LPN,RN] H Provide information the resident wants and needs. Do not give more than the resident can handle. Decreased Cardiac Output Risk. Resident has a pre-existing compromise in cardiac function associated with HYPERLIPIDEMIA, HTN. Resident has an alteration in heart rate, rhythm and conduction secondary to AFIB, ATRIAL FLUTTER. H Resident will remains free of side effects from medications used to achieve adequate cardiac output through the review date. H Resident will maintain adequate cardiac output as evidenced by urine output at least 30ml/hour through the review date. H Resident will demonstrate adequate cardiac output evidenced by BP, pulse rate and rhythm WNL, strong peripheral pulses and ability to tolerate activity without symptoms of dyspnea, syncope or chest pain through the review date. H Administer medications as prescribed. Monitor for side effects and toxicity. [CMA/T,LPN,RN] H Assess monitor/document peripheral pulses and capillary refill. Report s/s decreased cardiac output: weak pulses, capillary refill >3seconds or absent refill to the physician. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[LPN,RN] H Assess/monitor/document bowel function. Provide stool softeners as prescribed. Teach/instruct resident to avoid straining with BM. [CNA,CMA/T,LPN,RN] H Assess/monitor/document complaints of fatigue and reduced activity tolerance. Report abnormal findings and/or changes from baseline to physician. [LPN,RN] H Assess/monitor/document heart sounds. Auscultate apical pulse, assess heart rate, rhythm. [LPN,RN] H Assess/monitor/document oxygen saturation with pulse oximetry both at rest and during activity. Report s/s hypoxemia and/or SPO2 <90% to physician. [RN,LPN] H Assess/monitor/document respiratory rate, rhythm and breath sounds. Report s/s decreased cardiac output to physician: shallow, rapid respirations, crackles, paroxysmal nocturnal dyspnea, orthopnea, SOB. [LPN,RN] H Assess/monitor/document/report to MD PRN any s/sx of altered cardiac output or pacemaker malfunction: dizziness, syncope, difficulty breathing (Dyspnea), pulse rate lower than programmed rate, lower than baseline B/P. [LPN,RN] H HYPERTENSION: Perform actions to prevent or treat HTN. Implement measures to warm client (increase room temperature, apply warm blankets) if he/she is hypothermic, reduce stress (initiate pain relief, reduce fear/anxiety), administer medications as prescribed. [LPN,RN] H Identify emergency plan to include resident's desire for CPR and established advance directives [SS,LPN,RN] H Obtain and monitor lab as ordered. Falls/High/Moderate/Low Risk I am experiencing altered sensory perception secondary to progression of DEMENTIA, CVA. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I have immobility/impaired mobility secondary to ATAXIA, CVA, AMS, CONVULSIONS. I may improperly use assistive devices, forget to call for assistance secondary to CVA, DEMENTIA, AMS. H [Falls] Resident will be free from significant injury associated with falls through the review date. H Resident will be free of falls through the review date. H [DATE]. Resident reported that she bumped her head on her dresser. No obvious injury. Intervention-Resident educated on getting out of bed slowly. H [DATE]. Resident lying in floor on the left side. No obvious injury. Intervention-Staff instructed to keep resident room clutter free. H [DATE]-13:40 PM. Laying on floor by bed. No injuries. H [DATE]-Observed sitting on floor-No change in plan of care at this time. H [DATE]. Resident lying on the floor right side. X-ray was benign for injury-bilateral hip. Intervention-Instructed staff to ensure resident is wearing non-skid socks. H [DATE] 1830 PM. CNA ENTERED ROOM AND OBSERVED MS [NAME] LYING ON THE FLOOR. ASSISTED TO BED BY NURSING STAFF. NO INJURIES. INTERVENTION. STAFF TO ENSURE PROPER FOOTWEAR. H CONFUSION: Use memory trigger devices to remind resident to get up slowly and carefully, use assistive devices, etc. [CNA,RNA,LPN,RN,SS] H Do not rush resident. Allow adequate time for ambulation to the bathroom, activities, meals and in the hallway. [CNA,RN,LPN,PT] H ENVIRONMENT: Create a home-like environment with familiar items/objects to personalize resident room. [ACTD,SS,CNA,RNA,LPN] H ENVIRONMENT: Move resident to a calm, different, more quiet environment, more familiar environment as needed/indicated/with s/s sensory overload. [CNA,RNA,ACTD,LPN,RN] H FALL PROTOCOL: Follow facility fall protocol. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[CNA] H FALL RISK: Communicate fall risk and fall prevention interventions to all caregivers every shift. H FALL RISK: Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. [RN] H FOOTWEAR: Assess/monitor/document footwear fit and in good condition. [CNA,RNA,PT,OT,LPN] H FOOTWEAR: Encourage socks with non-slip, non-skid surfaces. [CNA,RNA,PT,OT,LPN] H HYDRATION: Promote adequate hydration. [LPN,RN,CMA/T,CNA,Diet] H HYGIENE: Maintain toenails neatly trimmed. [CNA,RNA,LPN,RN] H INFECTION: Assess/monitor/document s/s infection, confusion, unmet n [TRUNCATED]

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, and record review, it was determined the facility failed to complete a significant change assessment for one (#53) of 24 sampled residents who experienced declines in two or more areas of activities of daily living. This had the potential to affect 64 residents who resided at the facility. Findings: Resident #53 was admitted to the facility on [DATE] with diagnoses that included respiratory failure, anxiety, vascular dementia, and adult failure to thrive. A quarterly assessment, dated 04/05/21, documented the resident: ~ required limited assistance with bed mobility; ~ required limited assistance with transfers; ~ required limited assistance with locomotion both on and off the unit; and ~ was occasionally incontinent of bowel and bladder. A quarterly assessment, dated 07/06/21 documented the resident: ~ required extensive assistance with bed mobility; ~ required extensive assistance with transfers; ~ was dependent on staff for locomotion both on and off the unit; and ~ was frequently incontinent of bowel and bladder. A comparison of the two quarterly assessments revealed the resident had experienced a decline in four areas of activities of daily living. This indicated a significant change assessment should have been completed for the resident. Review of the resident's clinical record revealed no significant change assessment. Review of the resident's clinical record revealed the resident suffered seven falls between 02/11/21 and 08/09/21 when she was attempting to transfer herself. On 08/16/21 at 3:30 p.m., the assessment coordinator was asked what dictated when a significant change assessment should be completed. She stated two changes in the areas of activities of daily living would require a significant change assessment. She stated a significant change assessment should have been completed for the resident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation, interview, and record review, it was determined the facility failed to provide complete and accurate assessments for five (#8, #16, #19, #56, and #68) of 24 sampled residents whose assessments were reviewed. This had the potential to affect 64 residents who resided at the facility. Findings: 1. Resident #16 was admitted to the facility on [DATE] with diagnoses that included periodontal disease. An admission assessment, dated 11/10/20, documented the resident did not have any problems with his teeth. The assessment also documented the resident had limited range of motion only to one upper side. A physician's order, dated 03/11/21, documented the resident was to receive peridex oral solution to his gums twice daily related to periodontal disease. A quarterly assessment, dated 05/24/21, documented the resident did not have any broken teeth or /pain. The assessment also documented the resident had limited range of motion only to one upper side. On 08/04/21 at 2:59 p.m., the resident was observed to have missing and rotted teeth. On 08/12/21 at 3:22 p.m., the resident was asked if he could straighten out his hands. The resident tried and was not able to. The resident could move his left thumb and first finger, and his right hand was contracted at the knuckles. On 08/16/21 at 3:43 p.m., the minimum data set (MDS) assessment coordinator stated she probably should have marked the assessment for cavities on the admission. She stated she did not remember the resident complaining of any pain in the look back period for the quarterly assessment. She stated she did not put his contractures for both hands in the range of motion field. 2. Resident #19 was admitted to the facility on [DATE] with diagnoses that included unspecified psychosis, major depressive disorder, anxiety disorder, pseudobulbar affect, dementia without behavioral disturbances, and vascular dementia with behavioral disturbances. A physician's order, dated 06/12/20, documented the resident was to receive Seroquel, an antipsychotic medication, 100 milligrams daily. An annual assessment, dated 02/24/21, documented the resident did not receive antipsychotic medications regularly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/16/21 at 3:37 p.m., the MDS coordinator stated she either missed that area or hit the wrong area. She stated either way, when the resident was on an antipsychotic medication routinely, that area on the MDS should be marked. 3. Resident #56 was admitted to the facility on [DATE] and had diagnoses that included dementia and Parkinson's disease. A physician's order, dated 06/28/21, documented the resident was to be admitted to hospice services. A significant change assessment, dated 07/12/21, documented the resident was severely impaired with cognition. It did not document the resident was receiving hospice services. On 08/17/21 at 10:50 a.m., the MDS coordinator stated she did a significant change for the resident because the resident went on hospice, and one was required. She reviewed the assessment and stated she missed marking hospice on the assessment. 25225 4. Resident #8 was admitted to the facility on [DATE] with diagnoses that included chronic pain, depressive disorder, and fluid overload. A quarterly assessment, dated 05/11/21, documented the resident had received an opioid pain medication on seven of the preceding seven days. Review of the resident's clinical record revealed no documentation the resident received a opioid during 05/2021. On 08/16/21 at 3:23 p.m., the assessment coordinator was asked what opioid had been administered to the resident. She reviewed the clinical record and stated she did not see where an opioid had been administered. 5. Resident #68 was admitted to the facility on [DATE] with diagnoses that included atrial flutter, deep vein embolism and thrombosis. Physician orders, dated 05/13/21, documented the resident was to receive Eliquis, an anticoagulant, 5 milligrams (mgs) twice daily. Medication administration records, dated 05/16/21 through 05/25/21, documented the resident received Eliquis each day, for a total of 10 days. An admission assessment, dated 05/25/21, documented the resident had not received an anticoagulant during the seven day look back period.

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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** 41810 Based on interview and record review, it was determined the facility failed to develop a comprehensive care plan related to hospice services for one (#43) of two sampled residents who were reviewed for hospice services. The facility identified 20 residents as receiving hospice services. Findings: Resident #43 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, congestive heart failure, and cancer of the lips and oral cavity. Review of the resident's clinical record revealed the resident was admitted to hospice services on 06/08/21. Review of the resident's care plan revealed the care plan did not address hospice as a problem. There was no goal. There were no interventions. On 08/09/21 at 2:46 p.m., the care plan coordinator stated hospice services had not been added to the care plan as a problem, and it should have been.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation, interview, and record review, it was determined the facility failed to provide assistance with nail care for two (#4 and #16) of three sampled residents who were reviewed for activities of daily living. The facility identified 39 residents as requiring assistance with activities of daily living. Findings: 1. Resident #4 was admitted to the facility on [DATE] with diagnoses that included a contracture of the right hand, chronic pain syndrome, and Parkinson's disease. A quarterly assessment, dated 07/30/21, documented the resident was severely impaired with cognition and required extensive to total assistance with activities of daily living (ADLs). The resident's care plan, dated 08/04/21, documented the resident required extensive assistance with ADLs. On 08/04/21 at 10:09 a.m., the resident was observed in his bed. The resident was unshaven, his eyes were matted, and his face was not washed. There was food on the resident's shirt, and his fingernails were long. On 08/09/21 at 3:56 p.m., the resident was observed in the dining room in a geriatric chair. The resident was clean, shaved, and he had glasses on. The resident's fingernails were still long. On 08/12/21 at 8:49 a.m., the resident was observed in bed with food on his face and chest. The resident's hair was not combed, and he had not been shaved. The resident's fingernails were long. On 08/12/21 at 9:00 a.m., certified nurse aide (CNA) #1 was observed assisting the resident with his ADL needs. The CNA dressed the resident and obtained assistance to get the resident to the geriatric chair using the lift. The CNA then used a wash cloth and washed the resident's face and ears. The CNA placed a pillow on the resident's right side for positioning. CNA #1 then brushed the resident's hair. CNA #1 asked the resident if he wanted shaved this morning and went to get shaving supplies. On 08/12/21 at 09:21 a.m., CNA #1 stated the CNAs did not clip nails. He stated the nurses did. On 08/12/21 at 2:02 p.m., licensed practical nurse (LPN)#1 stated nails were cut as needed for the residents. LPN #1 stated CNAs and medication aides were able to cut nails for the residents who are not diabetic. The LPN stated the facility had a restorative aide who did fingernail care for the residents and painted the ladies' fingernails if they wanted. LPN #1 stated the resident should have had his nails cut by the CNAs by now. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/12/21 at 2:57 p.m., LPN #2 stated she did nail care for the residents. She stated all nurses could, and the CNAs could also perform nail care for residents who were not diabetic. LPN #2 stated the CNAs did not feel comfortable doing nail care for resident #4 because of the way his right hand was contracted. She stated the resident's nails grew very fast. She stated she did not keep a record of when she cuts nails. On 08/12/21 at 3:15 p.m., LPN #2 looked at the residents's fingernails and stated they were long but his nails grew fast. She stated the resident's nails would be trimmed before she left on this day. 2. Resident #16 was admitted to the facility on [DATE] with diagnoses that included cerebral artery occlusion and stenosis, fetal alcohol syndrome, and epilepsy. A quarterly assessment, dated 05/24/21, documented the resident was severely impaired with cognition and required extensive assistance with most activities of daily living. The resident's care plan, dated 06/04/21, documented, . Keep fingernails short . On 08/09/21 at 8:45 a.m., the resident was observed in the hall in his wheel chair. The resident's fingernails were long and dirty. On 08/12/21 at 3:22 p.m., the resident's fingernails were observed by LPN #2. She stated the resident's nails were long and needed to be cut. She stated his nails grew fast, and she would cut them on this day.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist when the facility failed to assess and monitor a resident with a significant change in condition. Resident #68 was admitted to the facility on [DATE] with diagnoses that included a history of deep vein thrombosis, atrial fibrillation, atrial flutter, multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, and acute intraoperative massive pulmonary embolism. On [DATE], [DATE], and [DATE], the resident exhibited signs of symptoms of a change in her respiratory status. Staff did not assess for the cause of the change in respiratory status. The staff did not monitor the resident after showing signs of a change in condition. On [DATE], the resident was found unresponsive. Cardiopulmonary resuscitation was started but was unsuccessful. The resident expired on [DATE]. At 11:46 a.m., the Oklahoma State Department of Health verified the existence of the IJ situation. At 11:49 a.m., the administration, director of nursing, and corporate administrator were notified of the IJ situation related to the facility's failure to assess and monitor the resident. On [DATE] at 3:57 p.m., an acceptable plan of removal was provided. The plan of removal documented, . 1. All residents in the facility who currently have oxygen will be reassessed by a Licensed Nurse to ensure that the oxygen liter flow being delivered matches the physician order for oxygen administration. Pulse Ox [pulse oximetry] will be obtained for all residents currently receiving oxygen. All findings will be documented in their medical record. [Physician name withheld] will be notified of any abnormal findings . " 2. In-services will be initiated immediately for all Licensed Nurses concerning respiratory assessment. These in-services will be continued/conducted for Licensed Nurses as they report to work for their shifts to ensure all Licensed Staff receive training. This will include: ~ Symptoms of low O2 sats [oxygen saturation] and high O2 sats, ~ Following treatment orders for breathing treatments such as nebulizers which will include checking MD order for the treatment and documentation on the MARS/TARS [medication administration sheets/treatment administration sheets] after the treatment is administered. ~ Ensuring all oxygen flow is delivered per physician order ~ Notifying the physician for any abnormal pulse ox reading, changes in mental status complaints of SOB [shortness of breath], cough, and abnormal lung sounds . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. In-service will be initiated immediately for all Licensed Nurses concerning notification of physician for any resident change in condition. This will include any new resident complaints, any subtle changes in resident's ADL [activities of daily living] abilities, subtle changes in resident's level of consciousness or cognition, changes in vital signs, increased SOB, etc. This in-service will also include notification of physician if any medication is not available for administration - Nurse may not 'hold' a medication without a physician order . 4. In-service will be initiated immediately for all Licensed Nurses concerning addressing O2 flow rates . 5. Pharmacy will conduct medication audit for all residents in the facility to ensure that all ordered medications are present for administration. These audits will be initiated this afternoon . 6. Direct Care Nursing staff to be in-serviced immediately concerning notification to Charge Nurse any changes noted in a resident's condition. This will include any resident complaint of discomfort, changes in resident's ability to perform ADLs, changes in resident's cognition, changes in resident's level of alertness, changes in resident's communication, noted increased weakness or balance issues . 7. Direct Care staff will be questioned upon completion of the above in-service, if they have any resident that has had changes in condition. Any resident noted will be reassessed by a Licensed Nurse with the assessment documented in the resident's medical record and notification of the changes, if noted, to the physician . 8. Nurse Managers will check the Oxygen Administration for all residents receiving oxygen daily x the next week to ensure that the oxygen flow rates are being administered according to physician orders . 9. Facility has posted the INTERACT Care Path for symptoms of SOB and the INTERACT Care Path for Acute Mental Status Change . 10. Any employee who was unable to come to facility for in service will be taken off of the schedule until they can be in services . The immediate jeopardy was removed on [DATE] at 10:20 p.m. when all components of the plan of removal were carried out. The deficient practice remained at a pattern of actual harm. Based on interview and record review, it was determined the facility failed to assess and monitor one (#68) of 24 sampled residents reviewed for change in condition after the resident exhibited signs of a change in respiratory status. This had the potential to affect 64 of 64 residents who resided at the facility. Findings: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A hospital history and physical report for resident #68, dated [DATE] and located in the facility's scanned documents, documented, . PMH [past medical history] of . atrial fibrillation previously on Eliquis who presents . with CC [chief complaint] of numbness and tingling to her left lower leg . intermittent numbness and tingling to left lower leg and occasionally similar symptoms to the right lower leg and bilateral wrists. Her symptoms have been progressive. Over the last month, she has had more constant numbness and tingling to the left lower leg and foot. She now reports a cold feeling to the limb. She had not previously sought medical attention after losing her job and health insurance . No chest pain or shortness of breath . palpitation intermittently. She stopped taking her Eliquis about 3 to 5 days ago after running out of medication . Hospital discharge documentation, dated [DATE] and located in the facility's scanned documents, documented, . Your Diagnosis[:] Atrial Flutter, physical deconditioning, right leg deep vein thrombosis (DVT) . multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, acute intraoperative massive pulmonary embolism - s/p [status post] catheter direct TPA [tissue plasminogen activator, used to dissolve blood clots] thrombolysis, subacute thrombotic occlusion of the left iliac artery and left femoral-popliteal trifurcation vessels, acute kidney injury, anemia, hypertension, hypertension, hypokalemia,, moderate aortic regurgitation, ventricular septal defect, multiple fractures of ribs . Home needs: oxygen; 'Contact physician for: increased swelling, chest pain' 'Contact physician for: increased shortness of breath . ' Education: . Atrial Flutter . get help right away if you have: . shortness of breath . Peripheral Vascular Disease . get help right away if: . you have chest pain or trouble breathing . Deep Vein Thrombosis . get help right away if: . you have . shortness of breath . Cardiogenic shock . what are the signs or symptoms . shallow, quick breathing, or shortness of breath . Get help right away if you: . Have shortness of breath . Discharge physician orders documented the resident was to receive Apixaban (Eliquis, an anticoagulant) 5 milligrams (mgs) twice daily for the prevention of blood clots. Resident #68 was admitted to the facility on [DATE] with diagnoses that included atrial flutter, chronic embolism, and deep vein thrombosis. A medication administration note, dated [DATE] at 8:23 p.m., documented, . waiting on pharmacy . A medication administration note, dated [DATE] at 9:10 a.m., documented, . Apixaban Tablet 5 MG Give 1 tablet by mouth two times a day related to chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A medication administration note, dated [DATE] at 9:44 a.m., documented, . Pharmacy notified that medication Apixaban has not made it to facility, pharmacist stated the medication needed insurance approval and he would be sending a form over to the facility to fill out. Apixaban Tablet 5 MG placed on hold until paperwork can be submitted to insurance . Review of facility medication administration records revealed the resident did not receive Eliquis, as ordered by the physician from admission on [DATE] until 8:00 p.m. on [DATE]. The resident's care plan, dated [DATE], documented the resident had a problem related to an imbalance between oxygen supply and demand. The goal was the resident would maintain blood pressure, pulse, and respirations within prescribed limits during activity through the review date. Interventions included to administer medications as prescribed; assess for signs and symptoms of activity intolerance such as statements of fatigue and weakness, exertional dyspnea, and chest pain; and to report decreased activity tolerance to the physician. An admission assessment, dated [DATE], documented the resident was moderately impaired in cognitive skills for daily decision making; required limited assistance for most activities of daily living; had diagnoses that included blood clots and heart failure; and was receiving oxygen therapy. The assessment documented the resident was not receiving an anticoagulant medication. A progress note, dated [DATE] at 4:34 p.m., documented, . Resident arrived in facility . No acute distress or discomfort noted . One person limited assist is required for transfers and ambulation due to general weakness. Continent of bowel and bladder with occasional episodes of incontinence requiring extensive assist. Staff strive to keep call light and fluids within easy reach. A progress note, dated [DATE] at 1:40 a.m., documented, . respirations unlabored via nasal cannula, in place and patent . A health status note, dated [DATE] at 7:13 a.m., documented, . Respirations are even and unlabored, clear to auscultation . Resident uses oxygen via nasal cannula, respirations unlabored . O2 at 2LPM [two liters per minute] via nasal cannula . for Shortness of Breath related to acute respiratory failure with hypoxia . A health status note, dated [DATE] at 7:45 a.m., documented, . respirations easy on room air 02 off for awhile giving nose a rest continues with good 02 Sat on room air . A health status note, dated [DATE] at 9:57 a.m., documented, . Respiration with ease 02 flowing at 2LPM via NC. [nasal cannula] . A health status note, dated [DATE] at 11:40 a.m., documented, . focused assessment r/t [related to] resident requesting breathing treatment. no orders for breathing treatment. [physician name withheld] office notified with a request of breathing treatments . Review of the resident's clinical record revealed no documentation the resident's respiratory status was assessed and monitored. There was no documentation the physician's office was notified of the resident's request for a breathing treatment. There was no documentation an order was received for a breathing treatment or that one was provided. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A health status note, dated [DATE] at 1:48 p.m., documented, . focused assessment r/t resident continues to tell staff she can't breath, 02 sat 99%. 02 bumped up to 3L/NC. resident setting on side of bed leaning forward, nurse spoke with resident about trying to relax and breath in through her nose out through her mouth . Review of the resident's clinical documentation reveals no documentation the resident's physician was notified after the resident complained of being unable to breath on [DATE]. There was no documentation the facility assessed and monitored the resident for a change in condition except checking her blood oxygen level. There was no documentation the facility notified the physician of the increase in the oxygen flow rate. There was no documentation of any previous reports that the resident was unable to breath. A health status note, dated [DATE] at 11:10 a.m., documented, . focused assessment r/t residents breathing pattern. Resident is breathing with her mouth open and her oxygen in her mouth. Residents O2 sat 94 on 3L . Review of the resident's clinical record revealed no documentation the resident's physician was notified of the resident's decreased blood oxygenation level and continued difficulties with breathing on [DATE]. There was no documentation the facility assessed and monitored the resident for a change in condition except for checking her blood oxygen level. A health status note, dated [DATE] at 1:49 a.m., documented, . [12:50 a.m.] entered resident room and noted resident wasn't breathing. Resident assisted to floor with assist of 3 staff CPR [cardiopulmonary resuscitation] started nurse from back nurses station called EMS [Emergency Medical Services]. EMS here at 1 am CPR stopped at that time. EMT's [emergency medical technicians] received order to stop CPR at that time . On [DATE] at 9:59 a.m., licensed practical nurse (LPN) #5, who was the resident's nurse, was asked what the resident's admitting diagnoses were. She stated atypical atrial flutter, chronic embolism of the deep veins of the lower extremities, hypertension, anemia, heart failure at one time, acute kidney failure, and acute respiratory failure with hypoxia. LPN #5 was asked what things were monitored for with these diagnoses. She stated, Pulse ox [blood saturation level], breathing, color of the skin, if diaphoretic. LPN #5 was asked what the facility did when the resident requested a breathing treatment on [DATE]. She stated, I guess I should have followed up with that. She stated she had notified the physician, received an order, and then started with the breathing treatment he had ordered. She was asked where the order was documented. She reviewed the clinical record and stated, I don't see it do I. I don't see one. She stated there was no documentation a breathing treatment had been given. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LPN #5 was asked what the facility did after the resident complained of being unable to breath on [DATE]. She stated, I made sure the head of the bed was raised and repositioned her. She stated, With mouth breathing, I put the oxygen in her mouth and turned it up to make sure she was breathing it in. She stated the resident's blood oxygen saturation levels were in the middle 90's. She stated, I didn't do very good charting. LPN #5 was asked if she notified the physician. She stated, I always fax him. She was asked where it was documented the physician was notified of the resident's complaint of being unable to breath and that she had turned the oxygen flow rate up. She stated, Should be in the chart. LPN #5 was asked how the resident was assessed and monitored following the change in condition. She stated, I just kept watching her, making sure she did not turn blue, that her O2 sats were in the 90s. She stated she tried to do some relaxing with the resident and tried to get her to breath through her mouth and not her nose. LPN #5 was asked how the resident was assessed and monitored on [DATE] after she was noted to have a change in her breathing pattern and continued with mouth breathing and using the oxygen nasal cannula in her mouth and where it was documented. She stated, Clearly, it's not there. She was asked if the physician was notified on [DATE] and how he was notified. She stated, We have to fax him every time. She was asked if she faxed him on this date. She shook her head in a yes motion and stated it should be on the chart. LPN #5 was asked what the facility did after the resident continued to have a change in her breathing patterns on [DATE]. She stated, She [the resident] wouldn't let me send her to the hospital. I just kept monitoring her O2 sats. She was asked where that was documented. She stated, I didn't chart that either. LPN #5 was asked if there was any other place the information might be documented. She stated, Everything I would have charted would be in this area right here [pointed at the progress note section of the electronic medical record]. Other than me doing it, it it's not charted, it's not done. On [DATE] at 10:18 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were asked where the physician's order was for a breathing treatment on [DATE]. They reviewed the clinical record, and the ADON stated, I don't see an order. The DON stated, I don't either. They were asked where the documentation was the resident received a breathing treatment. The ADON stated, I don't see it on any MAR [medication administration sheet]. The DON and ADON were asked what the staff did when the resident began to have complaints of being unable to breath on [DATE]. The ADON stated, It looks like they did the deep breathing and breathing through her mouth for that day. They were asked where it was documented the physician was notified. They reviewed the clinical record, and the ADON stated, I did not see any in the notes. They were asked where it was documented the staff assessed and monitored the resident after complaining of being unable to breathe. The ADON stated, I don't see that. The DON and ADON were asked how the staff assessed and monitor the resident on [DATE] after she was noted to have a change in her breathing pattern, breathing with her mouth open, and her oxygen in her mouth. The ADON stated, I don't see any assessments. They were asked what the resident's diagnoses were. The ADON stated atypical atrial flutter, chronic embolism of DVT (deep vein thrombosis), hypertension, anemia, hyperlipidemia, heart failure, atrial fibrillation, acute kidney failure, rib fractures, respiratory failure with hypoxia. They were asked what the staff should have been monitoring for in relation to the resident's diagnoses. The ADON stated, All the respiratory stuff, shortness of breath, fluid overload. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON and ADON were asked how often the resident's oxygen saturation levels were monitored. They reviewed the clinical record and stated the levels were being checked once to twice daily through [DATE]. The ADON stated when a resident was admitted on Intermediate Care, their levels were usually charted for 72 hours and then stopped, but if there was a change in condition, staff should chart on them for that length of care again. They were asked if the resident was exhibiting signs of a condition change. The ADON stated, Yes, she was with the breathing problems. They were asked what happened to the resident. The ADON stated, She expired after she coded. The DON and ADON were asked how the physician was notified of the resident's continued difficulties with breathing. The ADON stated the staff would have notified him via fax. She was asked where that information was. She stated it should be on the chart. The surveyor informed her there was no documentation the physician was notified. They were asked why the staff did not notify the physician. The ADON stated, I can't answer that. I'm not the nurse. They were asked why the staff did not assess and monitor the resident after she began to have difficulties breathing. The ADON stated, I can't answer that either. I don't know what else to say other than they didn't do it. The DON and ADON were asked how they ensured the nursing staff was competent to care for the residents with cardiac issues. They stated competency checks were done yearly. They were asked if the staff was assessed for competency related to cardiac and respiratory concerns. The ADON stated it was added into their evaluations. They were asked if, in their professional opinion, the staff acted with competency with the resident's care. The ADON stated, I don't think they did. The DON stated, I have to agree with that. On [DATE] at 11:09 a.m., the resident's physician was asked if the facility had notified him the resident had missed dosage of Eliquis from admission on [DATE] until 8:00 p.m. on [DATE]. He stated he did not recall it, but they may have. He stated sometimes they had trouble getting insurance companies to pay for Eliquis. He was asked what the dangers were of a resident not receiving their Eliquis. He stated they could certainly have a pulmonary embolis or stroke. He stated he would normally place a resident on Lovenox (an anticoagulant) until a resident was able to get their Eliquis. The physician was asked what the staff should have been monitoring the resident for. He stated oxygen levels, normal vitals signs, and respiratory status. He was asked if the facility notified him on [DATE] when the resident stated she was have difficulty breathing. He stated he could remember being called on her, but he could not state what days or for what reason. He was asked if staff had notified him they had increased her oxygen flow rate. He stated he did not specifically remember the conversation. He was asked if the facility notified him on [DATE] when the resident continued to have difficulties breathing. He stated he did not remember. He was asked what his expectation was if a resident began to have a change in condition or began to show signs and symptoms of distress. He stated he expected to be notified.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Care & Rehab Center	1622 East Broadway Muskogee, OK 74403

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation, interview and record review, it was determined the facility failed to ensure a resident with limited range of motion (ROM) received services to improve or prevent potential decline in ROM for one (#16) of two sampled residents reviewed for mobility. The facility failed to provide restorative services for a resident who had impairment in both of his hands. The facility identified six residents with limited range of motion. Findings: Resident #16 was admitted to the facility on [DATE] with diagnoses that included cerebral artery occlusion and stenosis, fetal alcohol syndrome, epilepsy, and contractures. A nursing assessment, dated 10/30/20, documented the resident had a contracture, but the location of the contracture was not noted. An admission assessment, dated 11/10/20, documented the resident was severely impaired with cognition, required extensive assistance with most activities of daily living, and had impaired mobility on one side of the upper body. A care plan, dated 06/04/21, documented . I have diagnosis of joint contracture . Resident will improve muscle strength and joint ROM by the review date . Progress from passive to active ROM as tolerated to prevent joint contractures and muscle atrophy . On 08/04/21 at 2:59 p.m., the resident was observed with contractures to both his hands. No splints were in use. On 08/12/21 at 3:22 p.m., licensed practical nurse (LPN) #2 observed the resident's hands. The resident was asked if he could straighten out his hands. The resident tried and was not able to. The resident moved the thumb and first finger on his left hand. The resident's right hand was contracted at the knuckles. The resident was able to squeeze the LPN's fingers with both hands. The LPN stated the resident had contractures to both of his hands. On 08/16/21 at 12:52 p.m., the assistant director of nursing (ADON) stated the nursing assessment, dated 10/30/20, documented the resident had contracture but the assessment did not document where the contracture was. She stated she was aware a couple of his fingers were contracted. The ADON stated the resident had not received restorative care. On 08/16/21 at 4:20 p.m., the ADON was asked why the resident was not on a restorative program. She stated she had not asked therapy to do an evaluation for the resident. The ADON stated she believed the resident would benefit from the restorative program.

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, and record review, it was determined the facility failed to ensure two (#42 and #53) of three sampled residents who were reviewed for falls were provided supervision to prevent accidents when the facility did not identify and implement interventions to aid in the prevention of falls. Resident #42 suffered repeated falls without appropriate intervention with one fall resulting in a left femoral neck fracture. Resident #53 suffered repeated falls without appropriate intervention with one fall resulting in a left ulna fracture. The facility identified five residents with falls and major injury in the last six months. Findings: The facility's guideline on accident/incident monthly log and follow-up, dated 12/2018, documented, . Track and trend all unusual occurrences (accidents/incidents), investigations, and the necessary follow-up action taken . Identify a particular resident and/or patient who is having repeated accidents/incidents . Analyze the data collected and calculated to determine how to reduce/prevent accidents/incidents from occurring . Attempt to identify trends and/or consistency to types, times, location, etc. of incidents . 1. Resident #42 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, Lewy body dementia, and gait/mobility abnormalities. A quarterly assessment, dated 03/11/21, documented the resident was severely impaired in cognitive skills for daily decision making. It was documented the resident required extensive assistance with bed mobility and transfers, had no functional impairments to the upper or lower extremities, and had no falls. An incident note, dated 04/13/21 at 5:27 p.m., documented, . CNA [certified nurse aide] reported to this nurse that resident was on fall mat beside bed. Upon entering room resident was observed lying on left side on fall mat wrapped up in blankets . No obvious s/s [signs or symptoms] injury noted . Resident assisted to bed x [by] 2 staff. New intervention for bed alarm to alert staff to needs . A facility accident/incident report, dated 04/14/31, documented, . resident to [sic] close to edge of bed rolled off . was reasonable cause of occurrence established . [marked yes] . state cause . resident rolled out of bed . place resident away from edge of bed while lying down . An incident note, dated 04/20/21 at 5:04 p.m., documented, . Resident observed on floor beside bed . What safety interventions were in place at the time of the occurrence: Fall mat in place, bed in low position, call light within reach, room well lit and clutter free . New interventions . Bed bolsters . A facility accident/incident report, dated 04/21/21, documented, . res observed on floor beside bed . AA [alert and oriented] x1 . was fall observed . no . resident room . lying in bed . slid out of bed . new interventions: bed bolsters . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	An incident note, dated 04/22/21 at 4:42 a.m., documented, . resident lying on left side beside bed with pillow under head and blankets on her body . What safety interventions were in place at the time of the occurrence: bed in lowest position, fall mat in place, call light within reach . New interventions added at time of incident to prevent re-occurrence: hourly safety checks . A facility accident/incident report, dated 04/22/21, documented, . rolled out of bed . new intervention - hourly checks . An incident note, dated 05/08/21, documented, . Describe occurrence in resident's words: I don't know how I fell . Resident lying on floor with blankets under her and pillow under her head . Factors that could have contributed to incident . Resident placed to [sic] close to edge of bed when turning on side . New interventions . Place resident in center of bed and to make sure she is not on the edge of the bed . New order received to x-ray left hip . A facility accident/incident report, dated 05/08/21, documented, . Summoned to room by CNA Resident lying on floor on fall matt [sic] c [with] blankets and under her and pillow. Resident slipe [sic] out of bed to floor r/t [related to] being placed to [sic] close to edge of bed . describe immediate action taken: to place resident in center of bed to prevent sliding out . A radiology report, dated 05/09/21, documented, . There is clear evidence of a fracture of the left femoral neck, with severe cephalad [towards the head] displacement of the distal fragment . A progress note, dated 05/13/21 at 9:30 a.m., documented, . return from hospital after left hip fracture . physicians have decided to left the fracture heal naturally . reconstruction was not possible . Staff will continue to monitor . An incident note, dated 05/16/21 at 10:30 p.m., documented, . Resident lying in floor at bed side. Lying on blankets and sheet . Fall matt [sic]. Call light in easy reach. Bolster placed in air mattress. Bed in lowest position. Bed locked . Continue checking on resident q [every] 1 [one] hour . The resident's care plan, dated 05/16/21, documented a problem related to being at moderate to high risk of falls. The goals included the resident would be free of falls through the review date. Interventions included bed bolsters, bed alarm, anticipate needs, to answer the call light promptly, simplify the environment, minimize environmental hazards, low bed, and to communicate fall risk and interventions to caregivers on every shift. A facility accident/incident report, dated 05/16/21, documented, . when nurse entered room found resident on floor with blanket [and] pillow; sheets under resident c/o [complain of] stomach hurting. when removed to side noted large hard stool on chuck [incontinent pad] . Was the fall observed . [marked no] . Outcome of interview with staff: Resident using the side of bed to strain to have bowel movement pulled self off in floor . Resident was placed in bed on [left] side facing wall . On 08/12/21 at 2:44 p.m., CNA #2 stated the resident was at risk for falls. She stated the resident tried to move and scoot in the bed. She stated the resident had not suffered any falls on her shift. She stated they placed a long pillow behind her back to help prevent falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 08/12/21 at 2:53 p.m., CNA #3 stated the resident could be at risk for falls if she was too close to the edge of the bed. She stated the resident could pull herself out of bed. She stated the resident had a fall mat and bed alarm and they kept her bed in the low position, but those things did not prevent falls. She stated at the facility she learned about fall interventions through inservices and report. On 08/12/21 at 3:04 p.m., CNA #4 stated the resident was at high risk for falls and had fallen. She stated the facility used a floor mat, did hourly checks, and turned and repositioned the resident. She stated she knew residents were at risk for falls when they had a fall mat. She stated the nurses let them know what interventions were in place to prevent falls. On 08/12/21 at 3:08 p.m., licensed practical nurse (LPN) #4 stated the resident was at high risk for falls. She stated the interventions that were in place were using a bed alarm because the resident could not verbalize her needs, keeping the call light within reach, a fall mat to prevent injury, keeping the bed in the lowest position, and bolsters on the bed. On 08/12/21 at 3:31 p.m., the director of nursing (DON) and assistant director of nursing (ADON) were asked what the resident could do for herself. The ADON stated it depended on the side on which the resident was lying. She stated the resident moved one side better than the other. She stated the resident could move one of her upper extremities pretty good. She stated the resident could pull herself to the side of the mattress; however, her legs were pretty much contracted. They were asked if the resident could reposition herself in bed. The ADON stated the resident could grab onto the grab bar or the side of the bed with the arm she had the most strength in. They were asked what caused the resident's fall on 04/13/21. The ADON reviewed the clinical record and stated the resident had been too close to the edge of the bed and rolled off. She stated the intervention of repositioning the resident away from the side of the bed was implemented. They were asked what caused the fall on 04/20/21. The ADON stated the resident slid out of the bed. She stated bed bolsters were put into place. She stated it was a concave mattress with bolsters at the top and the bottom of the mattress, with a gap between the bolsters. The DON and ADON were asked what caused the resident's fall on 04/22/21. The ADON stated the resident rolled out of bed. She stated the intervention put into place to prevent future falls were hourly checks. The ADON was asked if the bed bolsters were being used that were supposed to be put into place on 04/20/21, how did the resident roll out of the bed on this fall. She stated there was a gap in the bolsters that was not raised, and the resident slipped between the bolsters. The DON and ADON were asked what caused the resident's fall on 05/08/21. The ADON stated the resident rolled out of bed again onto the fall mat. She stated the resident was placed too close to the edge of the bed. The ADON was asked if the resident suffered an injury at that time. She stated yes, a hip fracture. The ADON was asked what interventions were put into place after the fall on 05/08/21. She stated it was to place the resident in the center of the bed to prevent her from sliding out. She was asked if that was a new intervention. She stated no. The ADON was asked if the resident had already suffered a fall due to being placed too close to the edge of the bed. She stated yes, from what the documentation showed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The DON and ADON were asked what caused the fall on 05/16/21. The ADON stated the resident slid out of the bed while she was trying to have a bowel movement. She was asked how the nurse knew that since the fall was unwitnessed. The DON stated the nurse probably deduced that from seeing the bowel movement. The DON and ADON asked how long the resident had gone without having a bowel movement. The ADON reviewed the clinical record and stated it was five days. The DON and ADON were asked if they had determined the bolster was not an effective intervention. The ADON stated she had not determined that. She stated the resident had more strength on her right side than on the left. She stated the bolsters needed to be the length of the bed, instead of just at the top and bottom. The ADON stated if the bolsters were the whole length of the bed, that would maybe help prevent her from going through the gap between the bolsters. The ADON stated the resident's head was kept elevated due to receiving a tube feeding, and with her head up she had a tendency to slide down, and then she could pull herself through the gap between the bolsters. The ADON was asked why she did not implement a full length bolster after the fall on 04/22/21. She stated she had figured it out while having the interview with the surveyors. The DON and ADON were asked what the facility's process was for conducting a root cause analysis of falls. The ADON stated they found out what the problem was and then what interventions should be implemented. They were asked if the facility conducted a root cause analysis of the resident's falls. The ADON stated, No. They were asked if they conducted root cause analysis of any falls in the facility. The ADON stated, I haven't in a while. The DON stated, No, I have not. The DON and ADON were asked what kind of training had been provided to the staff in regards to fall interventions. The ADON stated most of the time, the resident's falls occurred on the evening and night shift, so she hoped the nurses had educated the staff at the time of the falls. She stated the nurses had been instructed to provide the education. 2. Resident #53 was admitted to the facility with diagnoses that included vascular dementia, restlessness, agitation, anxiety, and adult failure to thrive. An admission assessment, dated 01/04/21, documented the resident was severely impaired in cognitive skills for daily decision making, required limited assistance with bed mobility, extensive assistance with transfers, and was frequently incontinent of bladder and bowel. It was documented the resident had a history of falls prior to admission to the facility. An incident note, dated 02/11/21 at 6:09 p.m., documented, . Called to residents room by CNA where resident was found laying in floor between bed and Tv . A facility accident/incident report form, dated 02/12/21 at 3:30 p.m., documented, . Called to resident's room by CNA where resident was found sitting in floor . staff educated on resident wearing proper footwear . An incident note, dated 02/18/21 at 4:39 p.m., documented, . Called to residents room by CNA where resident was found sitting on her bottom next to bed. No obvious injury noted . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	An initial incident note, dated 03/06/21 at 6:36 p.m., documented, . Describe occurrence in resident's words: I was transferring from my wheelchair to my bed and got weak and fell down . resident sitting on buttocks with knees pulled up to chest in between wheelchair and bed . New interventions added at time of incident to prevent re-occurrence: directed to use call light for assistance to transfer . An incident note, dated 03/31/21 at 1:45 p.m., documented, . This nurse was called to the room by cma [certified medication aide], cna. Resident was sitting on the pad beside her bed. Resident states she was trying to reach her milk cup when she slid out of her wheelchair onto her right knee then when [sic] on and sat down on the padded mat by her bed . An initial incident note, dated 04/04/21 at 7:10 p.m., documented, . Describe occurrence in resident's words: I was trying to go to bathroom and sat down . when cna's entered the room resident was sitting on tilted trash can beside chair. staff assisted resident to lower to floor while removing trash can. called nurse to room. resident sitting on buttock . Factors that could have contributed to incident . resident trying to transfer self to bsc, incont of urine, briefs utilized, floor dry . call light in easy reach but not on at time of event . New interventions added at time of incident to prevent re-occurrence: encourage resident to utilize assist w/ brp's [bathroom priviledges] . continue to remind resident to seek assistance w/ [with] transfers . An incident note, dated 04/22/21 at 9:20 a.m., documented, . Nurse was called to the room by cna. Resident was laying on her stomach beside her bed. Resident has a skin tear on left forehead, some bleeding noted, initial treatment cleansed with sterile normal saline, patted dry, applied steri strips . An initial incident note, dated 04/24/21 at 11:32 a.m., documented, . Describe occurrence in resident's words: I was trying to help my friend (points to her roommate). Describe scene as observed by staff: Resident was sitting on the pad beside the bed . Resident noncompliant with using call light. The bed alarm was covered with blankets and was not heard by staff. What safety interventions were in place at the time of the occurrence: Bed in low position, pad on floor, call light in reach, bed alarm attached to resident and operating properly . New interventions added at time of incident to prevent re-occurrence: Monitor closely, keep alarm on and functioning properly, remind resident to call for help, pad remains on the floor by the bed . The resident's care plan, dated 04/29/21, documented the resident was a moderate fall risk. The goals included the resident would be free of falls through the review date. Interventions included to provide a shepard's hook for assistance with reposition, anticipate and meet needs, keep needed items within reach at all time, ensure call light is within reach and encourage use, implement fall prevention protocol, and encourage socks with non-slip, non-skid surfaces. A health status note, dated 05/29/21 at 6:20 a.m., documented, . CNA found the resident sitting on the floor leaned up against her bed. Resident had a dime size [sic] to her forehead between her eyes. Resident was awake and alert and had turned her light on for help after she fell . There was a 12 inch puddle of blood on the floor by the end table. Resident stated she had tried to get up and reach her robe that was on her wheelchair but when she stood up she fell forward hitting her head on the table . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A health status note, dated 05/29/21 at 12:50 p.m., documented, . Resident returned from the emergency room . Resident has 3 dissolvable stitches in the forehead muscle and 3 stitches in the outer layer of tissue that will need to be removed in a couple of weeks. Resident has a pressure dressing intact to forehead . A radiology report, dated 05/31/21, documented, . Acute nondisplaced oblique fracture of the distal diaphysis of the [left] ulna . A health status note, dated 05/31/21 at 9:27 p.m., documented, . x ray results received of patients of [sic] left arm showing a impression of fracture of left ulna . transfer resident to [hospital name withheld] . A health status note, dated 07/25/21 at 3:41 p.m., documented, . She is no longer weight bearing. She is not ambulatory . She is able to make needs some needs known [sic] . Bed is kept low for safety. She has a personal alarm as fall precaution. Bedside mat in place. Observed often. Will continue to monitor and address needs . An initial incident note, dated 08/06/21 at 9:52 p.m., documented, . resident observed to be sitting on floor in bed . What safety interventions were in place at the time of the occurrence: call light within easy reach . New interventions added at time of incident to prevent re-occurrence: room light on . On 08/09/21 at 1:15 p.m., the resident was observed in her room, sitting in her wheelchair. She had socks on. The socks were not gripper socks. The resident was attempting to propel her wheelchair, without success. An initial incident note, dated 08/09/21 at 11:08 p.m., documented, . Resident . states 'I was headed to the bathroom' . This Nurse and Staff on hall across resident's room overheard a trash bin knocked down. Upon entering room. resident noted sitting on floor next to roommate's bed . asking to be picked up and stating 'I was headed to the bathroom' . Resident AOX2 [alert and oriented to person and place] with unsteady gait out of bed transferring self without use of staff assistance nor assistive device (wheelchair). What safety interventions were in place at the time of the occurrence: call light within reach, room lit, bed at lowest position with bed locks in place and patent. assistive device at bedside with wheelchair locks in place . New interventions added at time of incident to prevent re-occurrence: Educate/encourage/reinforce/remind resident to call for/request assistance/use call light for assistance with transfers, toileting, repositioning . On 08/10/21 at 3:00 p.m., the resident was observed sitting up in her bed. Her fall mat was behind the door to her room. On 08/12/21 at 8:45 a.m. and 1:35 p.m., the resident was observed in bed with her eyes closed. Each time, the resident's fall mat was observed behind the door to the resident's room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A behavior note, dated 08/13/21 at 3:44 a.m., documented, . Noise coming from resident room is overheard from BNS [back nurses' station]. CNA on hall is in resident's room and notifies this Nurse that resident was noted transferring self back to bed after transferring self to bedside commode. This Nurse in room with resident. Resident noted sitting in bed . Resident stating What?, am I wrong? Resident educated that she is not wrong for trying to do more for self but that resident is still in need of staff assistance r/t [related to] unsteady gait balance and history of falls. Resident also educated that is also to uses assistive device of which is at bedside with locks in place . verbalizes agreement to utilize call light for staff assistance. c/l [call light] and fluids within reach . On 08/13/21 at 12:15 p.m., the DON and ADON were asked what interventions were implemented following the fall on 02/11/21. The ADON stated the staff was educated on reducing clutter in the room. She was asked what the cause of the fall was. She stated it was an unwitnessed fall, but the resident was unsteady when she ambulated. The DON and ADON were asked what intervention was implemented after the fall on 02/12/21. The ADON stated the staff was educated to make sure the resident had proper footwear on. She was asked what the cause of the fall was. She stated it was an unwitnessed fall. The DON and ADON were asked if the resident was alert and oriented. The ADON stated she was oriented to her name. They were asked what the resident's memory was like. The DON stated it varied throughout the day. He stated her long term memory was better than her short term memory. They were asked if the resident was always capable of knowing when to use her call light. The ADON stated, No. They were asked what the cause of the fall was on 02/18/21. The ADON stated it was unwitnessed. She was asked what interventions were implemented after the fall. She stated staff educated the resident on wearing proper footwear. The DON and ADON were asked what interventions were implemented after the resident fell on [DATE]. The ADON stated the resident was directed to use her call light for assistance. The DON and ADON were asked what interventions were implemented after the fall on 03/31/21. The ADON stated to remind the resident to lock the wheelchair wheels and call for assistance. The DON and ADON were asked what interventions were implemented after the fall on 04/04/21. The ADON stated, Assist with transfers. The DON and ADON were asked what interventions were put into place after the fall on 04/22/21. The ADON reviewed the documentation and stated, I don't see an intervention. The DON and ADON were asked what interventions were implemented after the fall on 04/24/21. The ADON stated, I don't see another intervention other than the call light. The DON and ADON were asked what interventions were put into place after the resident fell and suffered the laceration to her forehead and fracture to her left ulna on 05/29/21. The ADON reviewed the clinical record and stated, I don't see anything. The DON and ADON were asked what interventions were put into place after the fall on 08/06/21. The ADON reviewed the documentation and stated she did not see any interventions. (continued on next page)

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	375146	A. Building B. Wing	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Care & Rehab Center	1622 East Broadway Muskogee, OK 74403

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The DON and ADON were asked what interventions were put into place after the resident's fall on 08/09/21. The ADON stated, Use call light for assist. The DON and ADON were asked if they had conducted root cause analysis on the resident's falls. The ADON stated, No. She stated the resident required assistance when going to the bathroom to keep her from falling. The ADON was asked if the resident was supposed to have a fall mat in place when she was in bed. The ADON stated, Yes. She was asked what kind of socks the resident was to wear. She stated, Nonskid.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation, interview, and record review, it was determined the facility failed to ensure a resident with a gastrostomy tube received the appropriate treatment and services for one (#16) of one sampled residents reviewed for tube feedings. The facility identified seven residents as receiving tube feedings. Findings: Resident #16 was admitted to the facility on [DATE] with diagnoses that included fetal alcohol syndrome, epilepsy, and a gastrostomy tube. A nursing admission assessment, dated 10/30/20, documented the resident was to receive a tube feeding diet of Isosource HN 50 cc/hr (cubic centimeters per hour) with 50cc/hr water flush. It was documented the resident did not receive any nutrition by mouth. A quarterly assessment, dated 05/24/21, documented the resident was severely impaired with cognition and required extensive assistance with most activities of daily living. The assessment documented the resident had a feeding tube. The resident's care plan, dated 06/04/21, documented, . I have a PEG [percutaneous endoscopic gastrostomy] tube . Feeding: Keep HOB [head of bed] elevated at 45 degrees at all times. Maintaining HOB may help decrease risk of aspiration . Enteral Feeding: Stop/hold continual feeding temporarily when turning, repositioning, or moving the resident . A physicians order, dated 06/28/21, documented the resident was to receive Isosource HN 50 cc/hr with 50 cc/hr water flush via his PEG tube three times a day. On 08/04/21 at 9:38 a.m., the resident was observed in bed with the enteral feeding running through a pump at 35 cc/hr and a water flush at 40 cc/hr. On 08/04/21 at 2:55 p.m., the resident was observed in his wheelchair in the hallway. The resident did not have his continuous tube feeding. A dietary note, dated 08/06/21, documented, . 113# [pounds], BMI [body mass index]=18 (UW) [underweight]; Reg [regular] diet/puree/honey/ in addition to Isosource HN 50cc with 50cc flush provides 1440 kcal; + [increase] 13# in one month which was needed; Resident has had several teeth pulled and continues to have more teeth pulled; Mouth sores make feeding difficult; Currently meeting needs with TF [tube feeding] and PO [by mouth] diet; Gastronomy . feeding difficulties; Continue to monitor weight gain and adjust TF as necessary . On 08/09/21 at 8:45 a.m., the resident was observed in his wheelchair in the hallway. The resident did not have his continuous tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/09/21 at 3:54 p.m., the resident was observed in bed with his eyes closed. His tube feeding was running at 50 cc/hr with a 40 cc/hr water flush. On 08/12/21 at 8:43 a.m., the resident was observed in his wheelchair in the hallway. The resident did not have his continuous tube feeding. On 08/12/21 at 1:40 p.m., certified nurse aide (CNA) #1 stated the resident was on a continuous tube feeding except when he was up to eat. The CNA stated the resident went back on his tube feeding after his meals. On 08/12/21 at 1:44 p.m., registered nurse #2 stated the resident was on a continuous tube feeding and he also ate very well by mouth. She stated the tube feeding was stopped for his meals, and he ate almost 100% of all meals. She stated he likes to wheel around in his wheelchair for a little while before going back on his tube feeding. On 08/16/21 at 9:50 a.m., licensed practical nurse (LPN) #3 reviewed the resident's diet order and stated the tube feeding was supposed to be continuous. She stated he received the tube feeding and a puree diet by mouth. She stated she was not taking the resident off of his tube feeding or decreasing the feeding. She stated if the resident was full or if he was having issues like vomiting, she would check the residual and call the physician on what needed to be done. On 08/16/21 at 12:45 p.m., the ADON stated the resident's tube feeding was continuous and that meant it was not supposed to be unplugged. She stated it should be running while he ate. She was asked why his tube feeding had been turned down to 35 cc/hr. She reviewed the clinical record and stated she did not see a nurse's note stating why it was turned down. She stated there was not an order for the resident's feedings to be stopped. The ADON stated staff should have brought the feeding pump with the resident when he came to the dining room or in the common areas.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on observation, interview, and record review, it was determined the facility failed to provide oxygen therapy as ordered by the physician and/or change oxygen tubing per current standards of practice for three (#41, #51 and #53) of three sampled residents reviewed for respiratory concerns. The facility identified eight residents as receiving respiratory treatments. Findings: 1. Resident #51 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD). The resident's physician order, dated 01/30/19, documented the resident was to receive oxygen at a flow rate of two liters per minute via nasal cannula at night. It was documented the oxygen was to be off in the mornings. The resident's care plan, dated 04/20/21, documented a problem related to impaired gas exchange risk related to COPD. A goal was documented, . resident will be free from s/s [signs and symptoms] of respiratory distress through the review date with interventions of administer humidified oxygen . Monitor for evidence of hypoventilation by increased somnolence after initiating or increasing oxygen therapy . Avoid high concentration of oxygen in patients with COPD unless otherwise ordered . The resident's health status note, dated 08/05/21 at 11:57, documented, . 115/62 [blood pressure] 68 [heart rate] 16 [respirations] 97.0 [temperature] 97% [oxygen saturation] 02 [oxygen] 2L [two liters] Resident resting quietly, respirations even and unlabored. Resident has no complaints of not feeling well today . On 08/05/21 at 1:05 p.m., the resident was observed in bed wearing her oxygen nasal cannula. The concentrator was set at a flow rate of seven liters, and the tubing was undated and not connected to the water bottle for humidification. The resident was asked how many liters of oxygen she was on. She stated she was on two liters. She was asked if she knew it was on seven liters. She stated no, the nurse must have turned it up. She was asked if she was to have humidified oxygen. She stated she did not like it connected to the water because the water got in her nose through the tubing. A nurse's note, dated 08/06/21 at 2:16 a.m., documented, . Alert and oriented . with confusion noted. Resp [respirations] with ease. LCTA [lungs clear to auscultation]. O2 [oxygen] @ [at] 3L/M [three liters per minute] in use via NC [nasal cannula] . On 08/10/21 at 9:29 a.m., the resident was observed in her bed, lying flat on her back, and wearing her nasal cannula. The tubing was undated and not connected to the water bottle. The concentrator was observed to be set to a flow rate of seven liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/10/21 at 9:37 a.m., LPN #1 was asked how many liters of oxygen the resident was to receive. He stated two liters. He was asked if she had the oxygen on now. He said he did not know. He entered the resident's room and observed her to be wearing her oxygen cannula and observed her concentrator. He stated, She has it on, and it is set to seven liters. He then turned off the concentrator. The resident stated, Hey, I need that on. The nurse turned it back on and turned the flow rate down to two liters. He did not assess the resident or ask any questions. He was asked when her blood oxygen saturation was last checked. He stated, Well, not today, and left the room. He returned with a blood oxygen saturation meter. He obtained a reading and stated it was 96%. At 9:47 a.m., he was asked what the diagnosis was for her oxygen orders. He stated one order was for comfort and respiratory distress, and the other was for COPD. He was asked if there were risks or dangers associated for a resident with COPD to be on high levels of oxygen. He stated, Yes, I'm going to contact the doctor or nurse practitioner. 25225 2. Resident #53 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and chronic respiratory failure. A physician's order, dated 12/29/20, documented the resident was to have oxygen at 2 liters/minute per nasal cannula continuously. Review of physician orders and treatment sheets, dated 05/2021 through 07/2021, revealed no order to change the resident's oxygen tubing or documentation the tubing had been changed. On 08/04/21 at 3:35 p.m., 08/09/21 at 1:51 p.m., and 08/10/21 at 3:00 p.m., the resident was observed in her room. Her oxygen tubing was not dated. On 08/16/21 at 4:25 p.m., the assistant director of nursing (ADON) stated the facility's policy on changing oxygen tubing was to change it weekly. She stated the tubing should be labeled with the date, time, and initials of the person changing it. 3. Resident #41 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease. Physician orders, dated 06/07/21, documented to change the resident's oxygen tubing on the 10th and 25th of every month; however, there were no orders for oxygen therapy. Treatment sheets, dated 06/2021 and 07/2021, documented the oxygen tubing was changed as ordered by the physician. On 08/04/21 at 9:51 a.m., the resident was observed in his room. An oxygen concentrator was noted, with oxygen tubing dated 05/10/21. A physician's order, dated 08/10/21, documented the resident was to receive oxygen at 2 liters per minute, as needed, for shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/16/21 at 4:41 p.m., the ADON stated she did not know why staff had documented the oxygen tubing had been changed when it was not. She stated the facility's policy was to change the tubing weekly.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist when the facility failed to ensure staff competency related to assessing and monitoring and physician notification. Resident #68 was admitted to the facility on [DATE] with diagnoses that included a history of deep vein thrombosis, atrial fibrillation, atrial flutter, multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, and acute intraoperative massive pulmonary embolism. On [DATE], [DATE], and [DATE], the resident exhibited signs of symptoms of a change in her respiratory status. Staff did not assess for the cause of the change in respiratory status. The staff did not monitor the resident after showing signs of a change in condition. The staff did not notify the physician of a significant change in the resident's condition. On [DATE], the resident was found unresponsive. Cardiopulmonary resuscitation was started but was unsuccessful. The resident expired on [DATE]. At 11:46 a.m., the Oklahoma State Department of Health verified the existence of the IJ situation. At 11:49 a.m., the administration, director of nursing, and corporate administrator were notified of the IJ situation related to the facility's failure to ensure competency of staff related to assessing and monitoring and physician notification of a significant change in condition. On [DATE] at 3:57 p.m., an acceptable plan of removal was provided. The plan of removal documented, . 1. All residents in the facility who currently have oxygen will be reassessed by a Licensed Nurse to ensure that the oxygen liter flow being delivered matches the physician order for oxygen administration. Pulse Ox [pulse oximetry] will be obtained for all residents currently receiving oxygen. All findings will be documented in their medical record. [Physician name withheld] will be notified of any abnormal findings . " 2. In-services will be initiated immediately for all Licensed Nurses concerning respiratory assessment. These in-services will be continued/conducted for Licensed Nurses as they report to work for their shifts to ensure all Licensed Staff receive training. This will include: ~ Symptoms of low O2 [oxygen] sats [saturation] and high O2 sats, ~ Following treatment orders for breathing treatments such as nebulizers which will include checking MD order for the treatment and documentation on the MARS/TARS [medication administration sheets/treatment administraton sheets] after the treatment is administered. ~ Ensuring all oxygen flow is delivered per physician order ~ Notifying the physician for any abnormal pulse ox reading, changes in mental status complaints of SOB [shortness of breath], cough, and abnormal lung sounds . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. In-service will be initiated immediately for all Licensed Nurses concerning notification of physician for any resident change in condition. This will include any new resident complaints, any subtle changes in resident's ADL [activities of daily living] abilities, subtle changes in resident's level of consciousness or cognition, changes in vital signs, increased SOB, etc. This in-service will also include notification of physician if any medication is not available for administration - Nurse may not 'hold' a medication without a physician order . 4. In-service will be initiated immediately for all Licensed Nurses concerning addressing O2 flow rates . 5. Pharmacy will conduct medication audit for all residents in the facility to ensure that all ordered medications are present for administration. These audits will be initiated this afternoon . 6. Direct Care Nursing staff to be in-serviced immediately concerning notification to Charge Nurse any changes noted in a resident's condition. This will include any resident complaint of discomfort, changes in resident's ability to perform ADLs, changes in resident's cognition, changes in resident's level of alertness, changes in resident's communication, noted increased weakness or balance issues . 7. Direct Care staff will be questioned upon completion of the above in-service, if they have any resident that has had changes in condition. Any resident noted will be reassessed by a Licensed Nurse with the assessment documented in the resident's medical record and notification of the changes, if noted, to the physician . 8. Nurse Managers will check the Oxygen Administration for all residents receiving oxygen daily x the next week to ensure that the oxygen flow rates are being administered according to physician orders . 9. Facility has posted the INTERACT Care Path for symptoms of SOB and the INTERACT Care Path for Acute Mental Status Change . 10. Any employee who was unable to come to facility for in service will be taken off of the schedule until they can be in services . The immediate jeopardy was removed on [DATE] at 10:20 p.m. when all components of the plan of removal were carried out. The deficient practice remained at a pattern of actual harm. Based on interview and record review, it was determined the facility failed to ensure staff competency related to assessing and monitoring and physician notification of a significant change in condition for one (#68) of 24 sampled residents reviewed for change in condition after the resident exhibited signs of a change in respiratory status. This had the potential to affect 64 of 64 residents who resided at the facility. Findings: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A hospital history and physical report for resident #68, dated [DATE] and located in the facility's scanned documents, documented, . PMH [past medical history] of . atrial fibrillation previously on Eliquis who presents . with CC [chief complaint] of numbness and tingling to her left lower leg . intermittent numbness and tingling to left lower leg and occasionally similar symptoms to the right lower leg and bilateral wrists. Her symptoms have been progressive. Over the last month, she has had more constant numbness and tingling to the left lower leg and foot. She now reports a cold feeling to the limb. She had not previously sought medical attention after losing her job and health insurance . No chest pain or shortness of breath . palpitation intermittently. She stopped taking her Eliquis about 3 to 5 days ago after running out of medication . Hospital discharge documentation, dated [DATE] and located in the facility's scanned documents, documented, . Your Diagnosis[:] Atrial Flutter, physical deconditioning, right leg deep vein thrombosis (DVT) . multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, acute intraoperative massive pulmonary embolism - s/p [status post] catheter direct TPA [tissue plasminogen activator, used to dissolve blood clots] thrombolysis, subacute thrombotic occlusion of the left iliac artery and left femoral-popliteal trifurcation vessels, acute kidney injury, anemia, hypertension, hypertension, hypokalemia,, moderate aortic regurgitation, ventricular septal defect, multiple fractures of ribs . Home needs: oxygen; 'Contact physician for: increased swelling, chest pain' 'Contact physician for: increased shortness of breath . ' Education: . Atrial Flutter . get help right away if you have: . shortness of breath . Peripheral Vascular Disease . get help right away if: . you have chest pain or trouble breathing . Deep Vein Thrombosis . get help right away if: . you have . shortness of breath . Cardiogenic shock . what are the signs or symptoms . shallow, quick breathing, or shortness of breath . Get help right away if you: . Have shortness of breath . Discharge physician orders documented the resident was to receive Apixaban (Eliquis, an anticoagulant) 5 milligrams (mgs) twice daily for the prevention of blood clots. Resident #68 was admitted to the facility on [DATE] with diagnoses that included atrial flutter, chronic embolism, and deep vein thrombosis. A medication administration note, dated [DATE] at 8:23 p.m., documented, . waiting on pharmacy . A medication administration note, dated [DATE] at 9:10 a.m., documented, . Apixaban Tablet 5 MG Give 1 tablet by mouth two times a day related to chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A medication administration note, dated [DATE] at 9:44 a.m., documented, . Pharmacy notified that medication Apixaban has not made it to facility, pharmacist stated the medication needed insurance approval and he would be sending a form over to the facility to fill out. Apixaban Tablet 5 MG placed on hold until paperwork can be submitted to insurance . Review of facility medication administration records revealed the resident did not receive Eliquis, as ordered by the physician from admission on [DATE] until 8:00 p.m. on [DATE]. The resident's care plan, dated [DATE], documented the resident had a problem related to an imbalance between oxygen supply and demand. The goal was the resident would maintain blood pressure, pulse, and respirations within prescribed limits during activity through the review date. Interventions included to administer medications as prescribed; assess for signs and symptoms of activity intolerance such as statements of fatigue and weakness, exertional dyspnea, and chest pain; and to report decreased activity tolerance to the physician. An admission assessment, dated [DATE], documented the resident was moderately impaired in cognitive skills for daily decision making; required limited assistance for most activities of daily living; had diagnoses that included blood clots and heart failure; and was receiving oxygen therapy. The assessment documented the resident was not receiving an anticoagulant medication. A progress note, dated [DATE] at 4:34 p.m., documented, . Resident arrived in facility . No acute distress or discomfort noted . One person limited assist is required for transfers and ambulation due to general weakness. Continent of bowel and bladder with occasional episodes of incontinence requiring extensive assist. Staff strive to keep call light and fluids within easy reach. A progress note, dated [DATE] at 1:40 a.m., documented, . respirations unlabored via nasal cannula, in place and patent . A health status note, dated [DATE] at 7:13 a.m., documented, . Respirations are even and unlabored, clear to auscultation . Resident uses oxygen via nasal cannula, respirations unlabored . O2 at 2LPM [two liters per minute] via nasal cannula . for Shortness of Breath related to acute respiratory failure with hypoxia . A health status note, dated [DATE] at 7:45 a.m., documented, . respirations easy on room air 02 off for awhile giving nose a rest continues with good 02 Sat on room air . A health status note, dated [DATE] at 9:57 a.m., documented, . Respiration with ease 02 flowing at 2LPM via NC. [nasal cannula] . A health status note, dated [DATE] at 11:40 a.m., documented, . focused assessment r/t [related to] resident requesting breathing treatment. no orders for breathing treatment. [physician name withheld] office notified with a request of breathing treatments . Review of the resident's clinical record revealed no documentation the resident's respiratory status was assessed and monitored. There was no documentation the physician's office was notified of the resident's request for a breathing treatment. There was no documentation an order was received for a breathing treatment or that one was provided. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A health status note, dated [DATE] at 1:48 p.m., documented, . focused assessment r/t resident continues to tell staff she can't breath, 02 sat 99%. 02 bumped up to 3L/NC. resident setting on side of bed leaning forward, nurse spoke with resident about trying to relax and breath in through her nose out through her mouth . Review of the resident's clinical documentation reveals no documentation the resident's physician was notified after the resident complained of being unable to breath on [DATE]. There was no documentation the facility assessed and monitored the resident for a change in condition except checking her blood oxygen level. There was no documentation the facility notified the physician of the increase in the oxygen flow rate. There was no documentation of any previous reports that the resident was unable to breath. A health status note, dated [DATE] at 11:10 a.m., documented, . focused assessment r/t residents breathing pattern. Resident is breathing with her mouth open and her oxygen in her mouth. Residents O2 sat 94 on 3L . Review of the resident's clinical record revealed no documentation the resident's physician was notified of the resident's decreased blood oxygenation level and continued difficulties with breathing on [DATE]. There was no documentation the facility assessed and monitored the resident for a change in condition except for checking her blood oxygen level. A health status note, dated [DATE] at 1:49 a.m., documented, . [12:50 a.m.] entered resident room and noted resident wasn't breathing. Resident assisted to floor with assist of 3 staff CPR [cardiopulmonary resuscitation] started nurse from back nurses station called EMS [Emergency Medical Services]. EMS here at 1 am CPR stopped at that time. EMT's [emergency medical technicians] received order to stop CPR at that time . On [DATE] at 9:59 a.m., licensed practical nurse (LPN) #5, who was the resident's nurse, was asked what the resident's admitting diagnoses were. She stated atypical atrial flutter, chronic embolism of the deep veins of the lower extremities, hypertension, anemia, heart failure at one time, acute kidney failure, and acute respiratory failure with hypoxia. LPN #5 was asked what things were monitored for with these diagnoses. She stated, Pulse ox [blood saturation level], breathing, color of the skin, if diaphoretic. LPN #5 was asked what the facility did when the resident requested a breathing treatment on [DATE]. She stated, I guess I should have followed up with that. She stated she had notified the physician, received an order, and then started with the breathing treatment he had ordered. She was asked where the order was documented. She reviewed the clinical record and stated, I don't see it do I. I don't see one. She stated there was no documentation a breathing treatment had been given. (continued on next page)

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	375146	A. Building B. Wing	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Care & Rehab Center	1622 East Broadway Muskogee, OK 74403

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LPN #5 was asked what the facility did after the resident complained of being unable to breath on [DATE]. She stated, I made sure the head of the bed was raised and repositioned her. She stated, With mouth breathing, I put the oxygen in her mouth and turned it up to make sure she was breathing it in. She stated the resident's blood oxygen saturation levels were in the middle 90's. She stated, I didn't do very good charting. LPN #5 was asked if she notified the physician. She stated, I always fax him. She was asked where it was documented the physician was notified of the resident's complaint of being unable to breath and that she had turned the oxygen flow rate up. She stated, Should be in the chart. LPN #5 was asked how the resident was assessed and monitored following the change in condition. She stated, I just kept watching her, making sure she did not turn blue, that her O2 sats were in the 90s. She stated she tried to do some relaxing with the resident and tried to get her to breath through her mouth and not her nose. LPN #5 was asked how the resident was assessed and monitored on [DATE] after she was noted to have a change in her breathing pattern and continued with mouth breathing and using the oxygen nasal cannula in her mouth and where it was documented. She stated, Clearly, it's not there. She was asked if the physician was notified on [DATE] and how he was notified. She stated, We have to fax him every time. She was asked if she faxed him on this date. She shook her head in a yes motion and stated it should be on the chart. LPN #5 was asked what the facility did after the resident continued to have a change in her breathing patterns on [DATE]. She stated, She [the resident] wouldn't let me send her to the hospital. I just kept monitoring her O2 sats. She was asked where that was documented. She stated, I didn't chart that either. LPN #5 was asked if there was any other place the information might be documented. She stated, Everything I would have charted would be in this area right here [pointed at the progress note section of the electronic medical record]. Other than me doing it, it it's not charted, it's not done. On [DATE] at 10:18 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were asked where the physician's order was for a breathing treatment on [DATE]. They reviewed the clinical record, and the ADON stated, I don't see an order. The DON stated, I don't either. They were asked where the documentation was the resident received a breathing treatment. The ADON stated, I don't see it on any MAR [medication administration sheet]. The DON and ADON were asked what the staff did when the resident began to have complaints of being unable to breath on [DATE]. The ADON stated, It looks like they did the deep breathing and breathing through her mouth for that day. They were asked where it was documented the physician was notified. They reviewed the clinical record, and the ADON stated, I did not see any in the notes. They were asked where it was documented the staff assessed and monitored the resident after complaining of being unable to breathe. The ADON stated, I don't see that. The DON and ADON were asked how the staff assessed and monitor the resident on [DATE] after she was noted to have a change in her breathing pattern, breathing with her mouth open, and her oxygen in her mouth. The ADON stated, I don't see any assessments. They were asked what the resident's diagnoses were. The ADON stated atypical atrial flutter, chronic embolism of DVT (deep vein thrombosis), hypertension, anemia, hyperlipidemia, heart failure, atrial fibrillation, acute kidney failure, rib fractures, respiratory failure with hypoxia. They were asked what the staff should have been monitoring for in relation to the resident's diagnoses. The ADON stated, All the respiratory stuff, shortness of breath, fluid overload. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON and ADON were asked how often the resident's oxygen saturation levels were monitored. They reviewed the clinical record and stated the levels were being checked once to twice daily through [DATE]. The ADON stated when a resident was admitted on Intermediate Care, their levels were usually charted for 72 hours and then stopped, but if there was a change in condition, staff should chart on them for that length of care again. They were asked if the resident was exhibiting signs of a condition change. The ADON stated, Yes, she was with the breathing problems. They were asked what happened to the resident. The ADON stated, She expired after she coded. The DON and ADON were asked how the physician was notified of the resident's continued difficulties with breathing. The ADON stated the staff would have notified him via fax. She was asked where that information was. She stated it should be on the chart. The surveyor informed her there was no documentation the physician was notified. They were asked why the staff did not notify the physician. The ADON stated, I can't answer that. I'm not the nurse. They were asked why the staff did not assess and monitor the resident after she began to have difficulties breathing. The ADON stated, I can't answer that either. I don't know what else to say other than they didn't do it. The DON and ADON were asked how they ensured the nursing staff was competent to care for the residents with cardiac issues. They stated competency checks were done yearly. They were asked if the staff was assessed for competency related to cardiac and respiratory concerns. The ADON stated it was added into their evaluations. They were asked if, in their professional opinion, the staff acted with competency with the resident's care. The ADON stated, I don't think they did. The DON stated, I have to agree with that. On [DATE] at 11:09 a.m., the resident's physician was asked if the facility had notified him the resident had missed dosage of Eliquis from admission on [DATE] until 8:00 p.m. on [DATE]. He stated he did not recall it, but they may have. He stated sometimes they had trouble getting insurance companies to pay for Eliquis. He was asked what the dangers were of a resident not receiving their Eliquis. He stated they could certainly have a pulmonary embolis or stroke. He stated he would normally place a resident on Lovenox (an anticoagulant) until a resident was able to get their Eliquis. The physician was asked what the staff should have been monitoring the resident for. He stated oxygen levels, normal vitals signs, and respiratory status. He was asked if the facility notified him on [DATE] when the resident stated she was have difficulty breathing. He stated he could remember being called on her, but he could not state what days or for what reason. He was asked if staff had notified him they had increased her oxygen flow rate. He stated he did not specifically remember the conversation. He was asked if the facility notified him on [DATE] when the resident continued to have difficulties breathing. He stated he did not remember. He was asked what his expectation was if a resident began to have a change in condition or began to show signs and symptoms of distress. He stated he expected to be notified.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation, interview, and record review, it was determined the facility failed to provide resident-centered dementia care to one (#19) of five sampled residents who were reviewed for unnecessary medications received care and services. The facility identified 12 residents as having a dementia diagnosis. Findings: The facility policy and procedure, dated [DATE], documented . Dementia Management . when a person with dementia behaves differently, this is often mistakenly seen as a direct result of dementia or simply as another symptom of the condition. However, this is often not the case. The behavior (such as memory loss, language or orientation problems), but also mental and physical health, habits, personality, interactions with others and the environment. Dementia can make the word a confusing and frightening place as the person struggles to understand what is going on around them. Though it may confuse the caregiver, the behavior will have meaning to the person with dementia . The person with dementia may be influenced by an environment that is unable to support or meet their needs. Disorientation is common feature of dementia, so an environment that is difficult to navigate and confusing can increase distress .Behavior may be an attempt to meet a need . When managing a situation where a person with dementia is behaving out of character, it is important not to see the behavior as just another symptom that needs treating. A problem-solving approach is needed to try to work out why the person's behavior has changed . It used to be that antipsychotic drugs were frequently prescribed to people with challenging behavior. while these may be appropriate and helpful in some situations they can suppress behavior without addressing the cause, and may add to the person's confusion . Resident #19 was admitted to the facility on [DATE] with diagnoses that included unspecified psychosis, major depressive disorder, anxiety disorder, pseudobulbar affect, dementia without behavioral disturbances, and vascular dementia with behavioral disturbances. A nurse's note, dated [DATE] at 9:48 p.m., documented, . alert, oriented to name, speech clear, denies pain at this time, repetitive w/ [with] requests for help/assistance to bathroom, continues to turn call light on within only minutes of staff leaving room asking to be assisted with going to the bathroom and back to bed, does not void or have bm [bowel movement] with each trip to bathroom. staff strives to offer comfort and reassurance . staff strives to keep call light and personal items w/i [within] easy reach . A physician's order, dated [DATE], documented the resident was to receive Seroquel, an antipsychotic medication, 12.5 milligrams (mgs) by mouth at bedtime for dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated [DATE] at 2:03 a.m., documented, . Resident AOX2 [alert and oriented to person and place] anxious, noted constantly for the past 2 nights ambulating from room to BNS [back nurses' station] every 5 minutes or so to ask this Nurse and staff if she can go back to bed and sleep, resident denies pain or needs, speech is clear, no s/s [signs or symptoms] of grimacing, distress, pain noted, resident noted confused, resident constantly redirected and encouraged, resident educated that she does not [sic] permission to get into her own bed and sleep, resident has been offered to sit at BNS lobby to watch TV to which she refuses stating she needs to go to bed- resident does go to room only to come back in approximate every 5 minutes to ask the same question of if she's allowed to go to bed and sleep . A physician order, dated [DATE], documented the resident was to receive Seroquel 25 mg by mouth at bedtime for dementia. A physician order, dated [DATE], documented the resident was to receive Buspar, an antianxiety medication, 10 mgs twice daily for anxiety. Review of the resident's clinical record revealed no documentation the facility attempted to identify or implement any resident specific, non-pharmalogical interventions before requesting an increase in the resident's Seroquel dose or the addition of Buspar. A behavior note, dated [DATE] at 2:30 a.m., documented, . Resident noted anxious coming from her room and up C -hall awakening several residents and up to BNS several times throughout the night, repeating 'can you help me' 'can you help me' 'I cant find my room' 'I get confused' resident has been assisted and oriented to room, resident insists staff to help her back in bed of which she got up from several times on her own, resident has been encouraged to do for herself while supervising by this Nurse and staff through the night, once resident is in bed, resident does not remain in bed and once again is noted in hallway coming up to staff keeping staff and this Nurse from working while invading their personal space, resident has been educated about personal space and to utilize c/l [call light]for staff assistance with little effect as resident again noted in hallway keeping this Nurse from moving nurse cart to perform job duties and resident care. several residents have complained stating 'that woman is keeping me up' resident c/o [complain of] shoulder pain of which prn [as needed] pain relief was administered, resident educated and encouraged to get rest as prn pain relief will not work if resident continues using shoulder- education and encouragement unsuccessful . Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax, dated [DATE], documented, . resident has been up all night noted anxious repeatedly at BNS stating she needs finding her room & needing help back into bed of which she has gotten up from by herself - resident does not rest - has been keeping residents up this night-attached - behavior note current meds - buspirone [Buspar] 10 mg Seroquil [sic] 25 mg at HS, melatonin 5 mg 1 tab at HS Lexapro 10 mg at HS . A physician's order, dated [DATE], documented to increase the resident's Buspar to 15 mgs twice daily for anxiety. Review of the resident's clinical record revealed no documentation the facility attempted to identify or implement any resident specific, non-pharmalogical interventions before requesting an increase in the resident's Buspar dosage. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated [DATE] at 3:02 a.m., documented, . Resident noted to be following staff around interrupting them and also following staff into other residents' rooms while staff is attempting to provide care. Denies pain/discomfort, no grimacing or guarding noted at this time. Skin clean and dry, brief is clean and dry and resident doesn't require any assistance to the restroom as she is ambulatory and continent of bowel and bladder and denies offer for help to restroom. Staff frequently assists resident back to own room and resident continues to come up to nurses station and to interrupt staff attempting to work. Difficult to redirect . A health status note, dated [DATE] at 5:27 a.m., documented, . Faxed [physician name withheld] r/t [related to] increased anxiety and resident request for new medication . Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax, dated [DATE], documented, . Resident c/o anxiety and restlessness. Asks if there is something she can take for her anxiety and insomnia. Resident noted to be up all hours of the night multiple nights a week. Resident is inconsolable. Any suggestions ??? . A physician's order, dated [DATE], documented the resident was to receive Trazodone, an antidepressant, 50 mgs at bedtime for depression and to increase the resident's Buspar dosage to 10 mg every six hours for anxiety. Review of the resident's clinical record revealed no documentation the facility attempted to identify or implement any resident specific, non-pharmalogical interventions before requesting pharmalogical intervention. A behavior note, dated [DATE] at 12:15 a.m., documented, . Resident noted restless and pacing up and down the hallways asking for help, staff assists resident and within 10 minutes resident is interrupting staff while they are working to ask for help in same area. E.G. Staff makes bed for resident, resident comes back to nurses station insisting bed has no linens, however bed has fresh clean linens, recently placed by staff. Argues with staff about assistance provided. Inconsolable. Staff strives to assist resident with needs, resident is continent, has a clean brief on. No s/s of pain and verbally denies pain. Staff will continue to monitor . A physician's order, dated [DATE], documented the resident was ordered Vistaril (hydroxyzine), an antihistamine medication, 25 mgs one every six hours to treat anxiety. A health status note, dated [DATE] at 5:03 a.m., documented, . Focused assessment r/t COVID 19 ISOLATION. Resident noted to be noncompliant with isolation, repeatedly comes off of unit to ask for assistance with simple things such as pulling blankets back up, resident demonstrated to this nurse that she can, in fact, pull her own blankets up, despite constant requests to staff . Skin warm and dry, afebrile. Fresh fluids and call light within easy reach . Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax dated [DATE], documented, . [resident name withheld] . 605 Am Telling staff she fell in the floor. Discoloration to knees light purple. Raised area to back of head . unsure if this is new . (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated [DATE] at 8:41 a.m., documented, . Resident unable to stay in her room, she is in contact isolation. Following nurseing [sic] staff around from room to room. States that she needs to lay down and that she needs help. Staff provide assistance, however before staff can make it out of the room resident uncovers herself and walks out of the room following staff. Resident has been out of the isolation unit multiple times. [Nurse practitioner name withheld] notified and stated that as soon as the facility can the resident needed to go to geri psych [geriatric psychiatric] for eval [evaluation]. Also gave verbal orders for hydroxyzine HCl Tablet 25 MG Give 2 tablet by mouth every 6 hours related to anxiety disorder . Resident redirected as much as possible to say [sic] in her room . An activities progress note, dated [DATE] at 9:05 a.m., documented, . [nurse practitioner name withheld] called facility to have this nurse call pharmacy for recommendation [sic] on medication changes. Pharmacy [name withheld] notified of residents anxiety and behaviors. Stated to left [sic] [nursing practitioner name withheld] know that she can increase Buspar to 15 mg and/or increase his [sic] Trazodone to 100 mg. [Nurse practitioner name withheld] stated to just increase the Buspar for right now and we can see how she does . A physician order, dated [DATE], documented to increase the resident's Buspar dosage to 15 mgs every six hours for anxiety. Review of the resident's clinical record revealed no documentation the facility attempted to identify or implement any resident specific, non-pharmalogical interventions before requesting pharmalogical intervention for the resident's behaviors. A behavior note, dated [DATE] at 3:24 a.m., documented, . resident noted coming out of isolation room and out of isolation hall (E unit) into D hall hallway 9 times this night, despite being oriented and educated that resident must remain in contact isolation as precautions r/t global pandemic COVID-19, resident alert, oriented X 3 with ongoing episodes of restlessness and anxiety nods head in 'Yes' goes back into isolation hallway only to come out again stating she needs help to get back into room of which she has been taken to by staff and this nurse various times, resident has been educated to utilize call light for staff assistance of which resident has demonstrated to use prior, resident again educated and reoriented to remain in isolation as per order without success . Review of the residents clinical record, documented the resident was hospitalized to a psychiatric hospital from [DATE] to [DATE]. A physician's order, dated [DATE], documented the resident was to receive lorazepam, an antianxiety medication, 0.5 mgs three times daily for anxiety and Seroquel 100 mg every day for major depressive disorder. The lorazepam was an additional medication to the resident's medication regimen. The diagnosis for the use of Seroquel was changed from dementia to major depressive disorder, and the time of administration was changed from bedtime to daily. A health status note, dated [DATE] at 8:18 p.m., documented, . Res up and down the hallway repetitively, asking staff to put her to bed, after being assisted to bed resident gets up and finds someone to put her to bed again. Resident was put to bed multiple times without success. CMA [certified medication aide] gave medication for the night, then CNA [certified nurse aide] assisted resident. Ambulated outside facility with CNA supervision for some fresh air and re-direction away from being put to bed. CNA provided one on one for 15 min and resident then assist back to bed . (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A health status note, dated [DATE] at 7:34 pm., documented, . One on one sitter for part of this ,d+[DATE] shift, sitting in sun room for evening meal, denies pain, tolerated well. Stayed with the sitter without complaints . A behavior note, dated [DATE] at 6:39 p.m., documented, . Resident up and down the hallways following staff. [Nurse practitioner name withheld] notified of residents behaviors and that resident often has a sitter. New orders for Lorazepam Tablet 0.5 MG Give 1 tablet by mouth every 24 hours as needed for anxiety related to anxiety disorder . CMA notified and PRN to be given. [Nurse practitioner name withheld] stated that she can still have her routine Lorazepam when it is due and that there is no need to wait to give the medication . A physician's order, dated [DATE], documented the resident was to receive Lorazepam, 0.5 mg one tab every 24 hours as needed for anxiety, in addition to her routine dosages. Review of the resident's clinical record revealed when the resident specific intervention of one on one with staff was implemented, the resident had a decrease in behaviors. There was no documentation to show any resident specific, non-pharmalogical interventions were in place when the staff notified the nurse practitioner on [DATE]. There was no documentation to show any other resident specific, non-pharmalogical interventions were identified or implemented for the resident. A pharmacy medication regimen review, dated [DATE], documented the resident received the following medications: ~ Trazodone - 50 mg at bed time; ~ Buspar - 15 mg four times daily; ~ Hydroxyzine 50 mg every six hours; ~ Lorazepam 0.5 mg three times daily; and ~ Seroquel 100 mg nightly. The medication regimen review documented, . This resident is at risk for falls based on the current medication profile. Please consider reducing one of the following meds which are being administered at bedtime . Facility inservice records, dated [DATE], documented the facility held an educational session on pain and dementia. Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax dated [DATE], documented, . Res with increasing anxiety, restlessness Res is following staff into other patients room. Res with repetitive questions/statements about anxiety, restlessness, stomach c/o prn meds given with minimal effectiveness. Staff attempts to do redirect unsuccessful. Unwilling to do any activities is staying in her room. Only comes out of room when she hears staff in the hallway. Please Advise . (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], the nurse practitioner responded to the pharmacist's request on [DATE] with an order to decrease the resident's Buspar to 10 mgs four times daily. Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax dated [DATE], documented, . Resident has shown increased agitation, has been following staff into other resident rooms, and yelling at staff to assist her to bed. Multiple attempts have been made to redirect resident -w no success. Resident was found jogging down the hall in attempt to catch up to a staff member. Resident has been flailing arms around causing resident to lose balance, and has been grabbing staff members by the arm. I've attached a medication list to review. Thanks . The physician responded . 1/ DC [discontinue]Trazodone 2/ increase Anafranil [antidepressant] to 50 mg at HS [hour of sleep] . A health status note, dated [DATE] at 12:38 p.m., documented, . Agitated. Resident is concerned her room mate is being harmed. Refuses to go back to her room at the moment. Is not tolerating room change well. Staff will continue to monitor . An initial behavior progress note, dated [DATE] at 3:07 p.m., documented, . Resident pacing and screaming at staff that she can not stay there and live the way she does. Very argumentative upon trying to redirect. Non-medication Interventions attempted: Redirection, distraction with activities painting nails and listening to music . Response to intervention: As long as activity was going on no behaviors, as soon as activity was over became very argumentative and very defensive . [nurse practitioner name withheld] notified . A physician's order, dated [DATE], documented the resident was to receive Lorazepam, 0.5 mg one time only. A health status note, dated [DATE] at 1:40 a.m., documented, . Lying in bed with eyes closed easily aroused with verbal stimuli. Alert and oriented x 2. Speech clear. Resident stated 'one of my dx [diagnosis] has come back I have diarrhea I'm sorry.' No c/o's [complaints] voiced r/t room change. staff strives to keep call light and water in easy reach . A behavior note, dated [DATE] at 8:15 a.m., documented, . resident keeps putting on call light and complaining about breakfast and not being able to eat it. observed that resident had eaten all of her cereal and part of boiled egg. States that the cereal is too mushy and the milk is sour. milk is not expired and attempted to show resident and she got hatful [sic] and started getting loud. asked if she would like something else and she stated 'no, just take this away' . A health status note, dated [DATE] at 9:56 a.m., documented, . continuously agitated this shift and demands anxiety medication. was given anxiety medication routinely as prescribed this morning by CMA [certified medication aide] already and was informed that she can only have it as it is prescribed . A health status note, dated [DATE] at 10:57 a.m., documented, . Resident demanding to go to hospital for her head. she states that she is having a stroke. resident has had a stroke in the past and ever since has been very worried that she is having another one. Nurse does not observe any s/s of stroke at this time . have redirected resident to dining room for lunch after calling her [family member] and calming down a little . (continued on next page)

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	375146	A. Building B. Wing	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Care & Rehab Center	1622 East Broadway Muskogee, OK 74403

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated [DATE] at 11:06 a.m., documented, . resident stated that she has not been given a bath in 3 wks [weeks] or been taken care of at all. demands to go to the hospital so she can get a bath. have redirected numerous times that there is not a reason for her to go to the hospital right now. she is now demanding that she starts therapy today or she is going to find another place to live . A behavior note, dated [DATE] at 11:33 a.m., documented, . focused assessment r/t residents behavior. resident kept coming to the desk stating she needed to go to the hospital because her stomach hurt, just like it did when she had her stroke. resident medicated for upset stomach, she then stated she hadn't had a BM in a couple of days, and she needed to go to the hospital. resident medicated for constipation. residents room mate keeping resident stirred up . An annual assessment, dated [DATE], documented the resident was moderately impaired with cognition and required limited assistance with activities of daily living (ADLs). The assessment documented the resident had no behaviors during the assessment period. The assessment documented the resident received an antipsychotic, antianxiety, and an antidepressant medication on seven days out of the seven day look back period. The assessment documented the resident had following diagnoses: cerebrovascular accident, dementia, anxiety disorder, depression, insomnia, and pseudobulbar affect. A social services progress note, dated [DATE] at 2:43 p.m., documented, . res [resident] enjoys coloring & doing word puzzles as tolerated, at times confused & needs much redirecting but carries good conversation, ambulates well, this SSD [social services director] offers water/snacks, assists with phone calls to [family member] & carries casual conversation with res in room, SS [social services] will monitor for social depression during this time of social distancing & continue to provide one on one visits . A physician's order, dated [DATE], documented the resident was to receive Seroquel 100 mg at bedtime for psychosis. This was a change in diagnosis for the use of the medication from depressive disorder. A behavior note, dated [DATE] at 7:31, documented, . resident yelling at staff to, 'send me out, I don't wanna be here.' resident then yelled at nearby aide, 'i don't know why you don't put me in bed.' encouraged resident that she is capable enough to help herself to bed as she is independent enough to do so. resident became frustrated and began crying demanding that she be released. resident states, 'Do you want me to break down that door,' while holding up both fists. this nurse asked resident to take a walk until she can calm down. resident has already received all medication. continues to cry and states, 'I didn't do anything.' . A quarterly assessment, dated [DATE], documented the resident was severely impaired with cognition and required limited assistance with activities of daily living. The assessment documented the resident had physical and verbal behaviors on one to three days during the assessment period. The assessment documented the resident received an antipsychotic, antianxiety, and an antidepressant medication on seven days out of the seven day look back period. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated [DATE] at 5:48 p.m., documented, . resident following staff and yelling, 'I need a shower.' explained to resident that she'll have to wait until a staff member is available to assist her. allowed resident to make outgoing call to her [family member]. resident hung up phone and walked away from desk. resident noted to be stopping aides that were assisting other residents and asking them to take her to her room. when told that she is independent enough to take herself back to her room, she began to cry. this nurse stepped away from desk to assist another resident, reported by nearby aide that resident was at the phone making another outgoing call but hung up quickly when she was approached. received call from Muskogee Police Department shortly after that resident had made a call with the statement, 'I'm lost, I need help back to my room.' and hung up. when asked about the situation, resident raised hand and said, 'yes, I guess that was me that did it.' . A physician order, dated [DATE], documented Lorazepam, 0.5 mg twice daily for anxiety and Buspar, 10 mg three times daily for anxiety. This was a reduction in dosages for both medications even though the resident was continuing with the same behaviors the medications were originally prescribed for. Facility inservice records, dated [DATE], documented the facility held an educational session on pain and dementia. The resident's care plan, dated [DATE], documented a problem related to the resident having feelings of anxiety, fear, confusion associated with dementia, cerebrovascular accident (CVA), and altered mental status. The care plan documented the resident will have behavioral problems identified and preventive measures implemented to minimize labile emotions by the review date. The care plan documented to administer medications as prescribed, monitor for effectiveness, side effects and adverse drug reactions. The care plan documented a problem related to the diagnosis of pseudobulbar effect. It was documented, I have a chemical imbalance in the brain that effects my emotions . The goals included the resident would experience improved emotional control through the review date. Interventions included to administer medications as ordered, allow the resident the freedom to sit in a chair near the window or nurses' station, allow wandering in a controlled environment, approach the resident in a consistent manner, avoid or terminate emotionally charged situation or conversations, and avoid the expectation of the resident to remember or follow instructions. Another problem was documented as altered thought processes. It was documented, . I am experiencing confusion, inappropriate behaviors . The goal was the resident would be free from side effects and/or adverse reactions from antipsychotics through the review date. Interventions included to administer medications as prescribed and to monitor for adverse drug reactions. Review of the resident's clinical record revealed no psychotropic medication side effect monitoring for , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], or ,d+[DATE]. From ,d+[DATE] through ,d+[DATE], the only month when side effect monitoring occurred was ,d+[DATE]. Review of the resident's clinical record revealed from ,d+[DATE] through ,d+[DATE], revealed no resident specific, non-pharmalogical interventions had been identified or implemented to help the resident with her behaviors, except for two instances when the resident was provided one on one interaction with the staff. Each time, it was documented the intervention was successful. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated [DATE] at 4:27 a.m., documented, . this Nurse in process of passing routine medication. resident again in hallway asking assistance into bed and with blankets of which resident has proven to do with no issue when encouraged and watched while she does so. this time resident has been following this Nurse and has been standing behind Nurse while this Nurse is pulling medication out while resident continues to ask assistance into bed again. resident educated that staff is not to be interrupted while in process of meds/giving meds with no success as resident continues to follow event stopping at other roommates doorway to stand there. doors of other resident's closed for privacy as per procedure. resident once again assisted into bed only to note resident out in hallway in search of staff to ask assistance with getting into bed. at this time, encouragement, education, orientation all unsuccessful as resident continues with said behavior . A behavior note, dated [DATE] at 3:37 a.m., documented, . [3:35 a.m.] resident noted walking in hallway from FNS [front nurses' station] desk to BNS. resident AOX2, calm with no s/s if [sic] pain, needs or distress noted is now stating 'I can't sleep, my blankets are all twisted up, I'm just not sleepy. resident encouraged to sit at BNS where TV was turned on for entertainment, resident reluctantly agreed but for only a brief moment stating she wanted to go back to bed. resident now in bed being assisted with blankets but encouraged to help as resident AOX2, ambulatory is able to so with no issue. resident's roommate again noted annoyed stating she would like to rest. roommate again apologized to for continuously need to entering room and use of call light. resident's c/l and fluids within reach. 0335 and 0338 resident again noted in hallway, call light room not on, resident again stating her blankets are all twisted up 0351 resident again encouraged and welcomed to sit BNS, only to sit for a very short brief moment, stating I'm going back to my room, can you help me? resident assisted to room X 3 times and encouraged to get some rest as well as to allow roommate some rest. c/l and fluids within reach. [linked] Nursing (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated [DATE] at 2:14 a.m., documented, . Since the beginning of shift change, resident AOX2, has been noted on call light, each time call light is answered, resident is noted stating to either forger [sic] reason for call light or is noted thinking of a reason then. Each time that call light is answered resident denies pain/discomfort, no s/s of pain, grimacing, distress noted each time. this Nurse in room to answer call light after CNA notified this Nurse that resident stated she was wanting more 'Tums'. resident stated she had went to the restroom but only has a small bowel movement and so she needed tums. resident educated/oriented that order for tums of which she has is routine and that last dose was at [7:00 p.m.]. resident also educated that tums were not for her bowel movements. resident was asked if she was experiencing s/s of constipation of which she denied. [12:42 a.m.] this Nurse in room to pass medication for resident's roommate. upon assessment of roommate's VS, resident is over heard in bed calm AOX2, 'can I ask you a question', 'can I ask you a question' resident notified by this Nurse that once done with roommate's assessment and medication pass, this Nurse would be over to her side of the room to address question/needs. this Nurse now over to resident's room side. resident in bed AOX2, calm, stating 'uh, uh, oh! I'm feeling feverish and I don't know what to do' speech is clear. denies pain at this time. skin is warm and dry with no s/s of excess skin warmth . resident notified of current temp and VS, resident then stating she would now be getting some rest, c/l and fluids within reach. [2:15 a.m.] this Nurse answers call light, notes resident in bed stating 'oh that's me hun, I pressed the call light' resident then states 'I don't know what's wrong with me' speech is clear. denies pain but states 'maybe I can have some that milk of mag' resident asked if she is straining to have an bowel movement, to which resident states 'well I haven't gone to the restroom since last time' resident educated that milk of magnesium is a laxative and should only be taken for constipation. resident encouraged to voice s/s of constipation; straining. c/l and fluids within reach. [2:45 a.m.] resident's call light noted just on and then resident walking inti [sic] hallway towards Nurse's station. resident educated that call light would promptly be answered. resident AOX2 at Nurses' station rubbing at stomach, arms and looking down at feet. resident asked if she was in pain anywhere, resident then states 'ugh I don't know, I just can't relax' resident offered and welcomed to come at BNS lobby to watch TV if she is not sleepy, resident refused. resident then asked to bed assisted back to room by CNA. c/l and fluids within reach . On [DATE] at 8:46 a.m., the resident was laying on her bed under the blanket facing the wall. She stated she was tired and would rather take her nap this morning than do an interview. On [DATE] at 2:09 p.m., the resident was observed in the hallway. She asked, Do I go wait for dinner? The surveyor informed the resident it was not time for dinner. The resident asked if the surveyor could get her back to bed. She stated she needed help with her bed. At this time, a CNA approached the resident and asked her if she wanted to have her nails painted. The resident walked to her room, and the CNA began to paint her nails. At 3:01 p.m., the resident walked out

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, and record review, it was determined the facility failed to: ~ obtain anticoagulant medications for administration as ordered by the physician for one (#68) of six residents whose medications were reviewed. The facility identified 61 residents as receiving medications; ~ ensure unlabeled medications were not administered for one (#33) of 10 sampled residents who were observed receiving medications. The facility identified 61 residents as receiving medications; and ~ ensure insulin was administered using safe medication practices for one (#33) of four sampled residents who were observed receiving fingerstick blood sugar checks. The facility identified 17 residents as receiving fingerstick blood sugar checks. Findings: The Institute for Safe Medication Practices [Guidelines for Optimizing Safe Subcutaneous Insulin Use in Adults. Institute for Safe Medication Practices. (2017, [DATE]). http://www.ismp.org.] website documented, . The manufacturers do not recommend the withdrawal of medication from the pen, except in an emergency with a malfunctioning pen. In these instances, the pen should then be discarded, even if insulin remains in the pen . Large pockets of air have been observed in cartridges of insulin pen injectors after aspirating some of the drug with a needle. If the pen injector or cartridge is not discarded, and the air is not eliminated before delivering a subsequent dose, the patient could receive less than the desired dose of insulin as well as a subcutaneous injection of air . 1. Resident #68 was admitted to the facility on [DATE] with diagnoses that included atrial flutter, chronic embolism, and deep vein thrombosis. A hospital history and physical report, dated [DATE] and located in the facility's scanned documents, documented, . PMH [past medical history] of . atrial fibrillation previously on Eliquis who presents . with CC [chief complaint] of numbness and tingling to her left lower leg . intermittent numbness and tingling to left lower leg and occasionally similar symptoms to the right lower leg and bilateral wrists. Her symptoms have been progressive. Over the last month, she has had more constant numbness and tingling to the left lower leg and foot. She now reports a cold feeling to the limb. She had not previously sought medical attention after losing her job and health insurance . No chest pain or shortness of breath . palpitation intermittently. She stopped taking her Eliquis about 3 to 5 days ago after running out of medication . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A hospital discharge documentation, dated [DATE] and located in the facility's scanned documents, documented, . Your Diagnosis[:] Atrial Flutter, physical deconditioning, right leg deep vein thrombosis (DVT) . multiple rib fractures due to CPR, pneumonia, acute hypoxemic respiratory failure, cardiogenic shock, acute intraoperative massive pulmonary embolism - s/p [status post] catheter direct TPA [tissue plasminogen activator, used to dissolve blood clots] thrombolysis, subacute thrombotic occlusion of the left iliac artery and left femoral-popliteal trifurcation vessels, acute kidney injury, anemia, hypertension, hypertension, hypokalemia,, moderate aortic regurgitation, ventricular septal defect, multiple fractures of ribs . Discharge physician orders documented the resident was to receive Apixaban (Eliquis, an anticoagulant) 5 milligrams (mgs) twice daily for the prevention of blood clots. A medication administration note, dated 05//,d+[DATE] at 8:23 p.m., documented, . waiting on pharmacy . A medication administration note, dated [DATE] at 9:10 a.m., documented, . Apixaban Tablet 5 MG Give 1 tablet by mouth two times a day related to chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity . A medication administration note, dated [DATE] at 9:44 a.m., documented, . Pharmacy notified that medication Apixaban has not made it to facility, pharmacist stated the medication needed insurance approval and he would be sending a form over to the facility to fill out. Apixaban Tablet 5 MG placed on hold until paperwork can be submitted to insurance . Review of facility medication administration records revealed the resident did not receive Eliquis, as ordered by the physician from admission on [DATE] until 8:00 p.m. on [DATE]. On [DATE] at 10:36 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were asked when the resident received her first dose of Eliquis. The ADON stated, The number 5 means it wasn't here. She stated the resident received the first dose of Eliquis at 8:00 p.m. on [DATE]. They were asked why the resident had physician orders for Eliquis. The ADON stated, DVT [deep vein thrombosis]. They were asked what kind of consequences could occur if a resident did not receive the ordered Eliquis. The ADON stated a blood clot could to go the brain, the heart, or cause a stroke. On [DATE] at 11:09 a.m., the resident's physician was asked if the facility notified him the pharmacy had not delivered the resident's Eliquis and that the resident had missed dosages from admission until the 8:00 p.m. dose on [DATE]. He stated he did not recall, but they may have. He was asked what the dangers were of the resident not receiving her Eliquis. He stated, They certainly could have a PE [pulmonary embolism] or stroke. On [DATE] at 11:21 a.m., the administrator stated the pharmacy would generally call her and inform her if a medication was not approved by insurance, and she would authorize them to send the medication, and the facility would absorb the cost. She stated she always approved a medication, and had never let cost or anything else prevent her from giving the authorization. She was asked if the staff had informed her the resident did not have her Eliquis. She stated, Not that I recall. 41809 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #33 was admitted to the facility on [DATE] with diagnoses that included constipation. A physician order, dated [DATE], documented to administer one suppository of biscodyl 10 milligrams (mg) every four hours as needed for constipation. On [DATE] at 8:52 a.m., registered nurse (RN) #1/care plan coordinator, was at a treatment cart next to the resident's room. She was asked if she had any medications to administer. She stated yes, she had a suppository to administer and picked it up off the cart to show. She was asked to provide the bag for the suppository, with its' labeling. She checked the refrigerator in the medication room and did not locate a bag for the resident. She was asked where she had gotten the suppository. She stated it was loose in the refrigerator. She was asked if she was going to administer the medication to the resident. She stated, Yes, but I didn't. On [DATE] at 9:28 a.m., the assistant director of nursing (ADON) was asked when the resident had last received a biscodyl suppository. She reviewed the resident's medication administration records (MARs) and stated, He has never received the medication. It must have come from the hospital. She was asked when it was last ordered. She stated [DATE]. She was asked what should happen to loose medications. She stated, It should have been destroyed. She was asked what happened if an as needed (PRN) medication had not been administered over a period of time. She stated usually the pharmacist will recommend to discontinue them. She was asked if the resident's order was active. She stated yes. She was informed that RN #1 had obtained a suppository that was loose in the medication refrigerator and had it on her cart to administer to resident #33. She was asked if the nurse was going to administer it. She stated she hoped not. She was asked if the care plan coordinator nurse had received any training on the floor. She stated, She had one day of one on one training and I've tried to help her as I could today. 3. Resident #7 was admitted to the facility on [DATE] with diagnoses that included diabetes type two. A physician's order, dated [DATE], documented the resident was to administer 25 units of Novolog solution three times a day subcutaneously related to diabetes type two. A physician's order, dated [DATE], documented to administer Novolog solution per a sliding scale subcutaneously before meals and at bedtime related to diabetes type two. On [DATE] at 11:22 a.m., RN #1/Care Plan Coordinator asked resident #7 if she had already had lunch. The resident stated she had. The nurse proceeded to check the resident's blood sugar level. RN #1 stated the blood sugar level was 431. She stated, This resident has a Flex pen, they use it for both the sliding scale and her routine insulin. RN #1 stated the resident was to receive a total of 37 units of insulin, according the her blood sugar reading, sliding scale, and routine order. She stated, I don't like using the Flex pen, I don't feel they [the resident] get the correct dose. She cleaned the tip of the pen with an alcohol wipe, and used an insulin syringe to pierce the end of the pen. She injected air from the insulin syringe into the Flex pen, and withdrew up 37 units of insulin from the pen. She then administered the medication to the resident. She recapped the flex pen and placed it back in the drawer next to another resident's pen. It was not placed into an individual bag. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 1:00 p.m., the director of nursing (DON) was informed of the nurse drawing insulin out of an insulin pen instead of using the pen to inject the resident with the insulin. He stated he was unaware the practice was not acceptable. He stated he had done the same in the past.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation, interview, and record review, it was determined the facility failed to identify and implement non-pharmalogical interventions before initiating psychotropic medications and/or failed to monitor for adverse consequences of psychotropic medications for two (#19 and #53) of five sampled residents reviewed for unnecessary medications. The facility identified 62 residents as receiving psychotropic medications. Findings: 1. Resident #19 was admitted to the facility on [DATE] with diagnoses that included unspecified psychosis, major depressive disorder, anxiety disorder, pseudobulbar affect, dementia without behavioral disturbances, and vascular dementia with behavioral disturbances. A nurse's note, dated [DATE] at 9:48 p.m., documented, . alert, oriented to name, speech clear, denies pain at this time, repetitive w/ [with] requests for help/assistance to bathroom, continues to turn call light on within only minutes of staff leaving room asking to be assisted with going to the bathroom and back to bed, does not void or have bm [bowel movement] with each trip to bathroom. staff strives to offer comfort and reassurance . staff strives to keep call light and personal items w/i [within] easy reach . A physician's order, dated [DATE], documented the resident was to receive Seroquel, an antipsychotic medication, 12.5 milligrams (mgs) by mouth at bedtime for dementia. A behavior note, dated [DATE] at 2:03 a.m., documented, . Resident AOX2 [alert and oriented to person and place] anxious, noted constantly for the past 2 nights ambulating from room to BNS [back nurses' station] every 5 minutes or so to ask this Nurse and staff if she can go back to bed and sleep, resident denies pain or needs, speech is clear, no s/s [signs or symptoms] of grimacing, distress, pain noted, resident noted confused, resident constantly redirected and encouraged, resident educated that she does not [sic] permission to get into her own bed and sleep, resident has been offered to sit at BNS lobby to watch TV to which she refuses stating she needs to go to bed- resident does go to room only to come back in approximate every 5 minutes to ask the same question of if she's allowed to go to bed and sleep . A physician order, dated [DATE], documented the resident was to receive Seroquel 25 mg by mouth at bedtime for dementia. A physician order, dated [DATE], documented the resident was to receive Buspar, an antianxiety medication, 10 mgs twice daily for anxiety. Review of the resident's clinical record revealed no documentation the facility attempted to identify or implement any resident specific, non-pharmalogical interventions before requesting an increase in the resident's Seroquel dose or the addition of Buspar. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated [DATE] at 2:30 a.m., documented, . Resident noted anxious coming from her room and up C -hall awakening several residents and up to BNS several times throughout the night, repeating 'can you help me' 'can you help me' 'I cant find my room' 'I get confused' resident has been assisted and oriented to room, resident insists staff to help her back in bed of which she got up from several times on her own, resident has been encouraged to do for herself while supervising by this Nurse and staff through the night, once resident is in bed, resident does not remain in bed and once again is noted in hallway coming up to staff keeping staff and this Nurse from working while invading their personal space, resident has been educated about personal space and to utilize c/l [call light]for staff assistance with little effect as resident again noted in hallway keeping this Nurse from moving nurse cart to perform job duties and resident care. several residents have complained stating 'that woman is keeping me up' resident c/o [complain of] shoulder pain of which prn [as needed] pain relief was administered, resident educated and encouraged to get rest as prn pain relief will not work if resident continues using shoulder- education and encouragement unsuccessful . Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax, dated [DATE], documented, . resident has been up all night noted anxious repeatedly at BNS stating she needs finding her room & needing help back into bed of which she has gotten up from by herself - resident does not rest - has been keeping residents up this night-attached - behavior note current meds - buspirone [Buspar] 10 mg Seroquil [sic] 25 mg at HS, melatonin 5 mg 1 tab at HS Lexapro 10 mg at HS . A physician's order, dated [DATE], documented to increase the resident's Buspar to 15 mgs twice daily for anxiety. Review of the resident's clinical record revealed no documentation the facility attempted to identify or implement any resident specific, non-pharmalogical interventions before requesting an increase in the resident's Buspar dosage. A behavior note, dated [DATE] at 3:02 a.m., documented, . Resident noted to be following staff around interrupting them and also following staff into other residents' rooms while staff is attempting to provide care. Denies pain/discomfort, no grimacing or guarding noted at this time. Skin clean and dry, brief is clean and dry and resident doesn't require any assistance to the restroom as she is ambulatory and continent of bowel and bladder and denies offer for help to restroom. Staff frequently assists resident back to own room and resident continues to come up to nurses station and to interrupt staff attempting to work. Difficult to redirect . A health status note, dated [DATE] at 5:27 a.m., documented, . Faxed [physician name withheld] r/t [related to] increased anxiety and resident request for new medication . Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax, dated [DATE], documented, . Resident c/o anxiety and restlessness. Asks if there is something she can take for her anxiety and insomnia. Resident noted to be up all hours of the night multiple nights a week. Resident is inconsolable. Any suggestions ??? . A physician's order, dated [DATE], documented the resident was to receive Trazodone, an antidepressant, 50 mgs at bedtime for depression and to increase the resident's Buspar dosage to 10 mg every six hours for anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's clinical record revealed no documentation the facility attempted to identify or implement any resident specific, non-pharmalogical interventions before requesting pharmalogical intervention. A behavior note, dated [DATE] at 12:15 a.m., documented, . Resident noted restless and pacing up and down the hallways asking for help, staff assists resident and within 10 minutes resident is interrupting staff while they are working to ask for help in same area. E.G. Staff makes bed for resident, resident comes back to nurses station insisting bed has no linens, however bed has fresh clean linens, recently placed by staff. Argues with staff about assistance provided. Inconsolable. Staff strives to assist resident with needs, resident is continent, has a clean brief on. No s/s of pain and verbally denies pain. Staff will continue to monitor . A physician's order, dated [DATE], documented the resident was ordered Vistaril (hydroxyzine), an antihistamine medication, 25 mgs one every six hours to treat anxiety. A health status note, dated [DATE] at 5:03 a.m., documented, . Focused assessment r/t COVID 19 ISOLATION. Resident noted to be noncompliant with isolation, repeatedly comes off of unit to ask for assistance with simple things such as pulling blankets back up, resident demonstrated to this nurse that she can, in fact, pull her own blankets up, despite constant requests to staff . Skin warm and dry, afebrile. Fresh fluids and call light within easy reach . Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax dated [DATE], documented, . [resident name withheld] . 605 Am Telling staff she fell in the floor. Discoloration to knees light purple. Raised area to back of head . unsure if this is new . A behavior note, dated [DATE] at 8:41 a.m., documented, . Resident unable to stay in her room, she is in contact isolation. Following nurseing [sic] staff around from room to room. States that she needs to lay down and that she needs help. Staff provide assistance, however before staff can make it out of the room resident uncovers herself and walks out of the room following staff. Resident has been out of the isolation unit multiple times. [Nurse practitioner name withheld] notified and stated that as soon as the facility can the resident needed to go to geri psych [geriatric psychiatric] for eval [evaluation]. Also gave verbal orders for hydroxyzine HCl Tablet 25 MG Give 2 tablet by mouth every 6 hours related to anxiety disorder . Resident redirected as much as possible to say [sic] in her room . An activities progress note, dated [DATE] at 9:05 a.m., documented, . [nurse practitioner name withheld] called facility to have this nurse call pharmacy for recommendation [sic] on medication changes. Pharmacy [name withheld] notified of residents anxiety and behaviors. Stated to left [sic] [nursing practitioner name withheld] know that she can increase Buspar to 15 mg and/or increase his [sic] Trazodone to 100 mg. [Nurse practitioner name withheld] stated to just increase the Buspar for right now and we can see how she does . A physician order, dated [DATE], documented to increase the resident's Buspar dosage to 15 mgs every six hours for anxiety. Review of the resident's clinical record revealed no documentation the facility attempted to identify or implement any resident specific, non-pharmalogical interventions before requesting pharmalogical intervention for the resident's behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated [DATE] at 3:24 a.m., documented, . resident noted coming out of isolation room and out of isolation hall (E unit) into D hall hallway 9 times this night, despite being oriented and educated that resident must remain in contact isolation as precautions r/t global pandemic COVID-19, resident alert, oriented X 3 with ongoing episodes of restlessness and anxiety nods head in 'Yes' goes back into isolation hallway only to come out again stating she needs help to get back into room of which she has been taken to by staff and this nurse various times, resident has been educated to utilize call light for staff assistance of which resident has demonstrated to use prior, resident again educated and reoriented to remain in isolation as per order without success . Review of the residents clinical record, documented the resident was hospitalized to a psychiatric hospital from [DATE] to [DATE]. A physician's order, dated [DATE], documented the resident was to receive lorazepam, an antianxiety medication, 0.5 mgs three times daily for anxiety and Seroquel 100 mg every day for major depressive disorder. The lorazepam was an additional medication to the resident's medication regimen. The diagnosis for the use of Seroquel was changed from dementia to major depressive disorder, and the time of administration was changed from bedtime to daily. A health status note, dated [DATE] at 8:18 p.m., documented, . Res up and down the hallway repetitively, asking staff to put her to bed, after being assisted to bed resident gets up and finds someone to put her to bed again. Resident was put to bed multiple times without success. CMA [certified medication aide] gave medication for the night, then CNA [certified nurse aide] assisted resident. Ambulated outside facility with CNA supervision for some fresh air and re-direction away from being put to bed. CNA provided one on one for 15 min and resident then assist back to bed . A health status note, dated [DATE] at 7:34 pm., documented, . One on one sitter for part of this ,d+[DATE] shift, sitting in sun room for evening meal, denies pain, tolerated well. Stayed with the sitter without complaints . A behavior note, dated [DATE] at 6:39 p.m., documented, . Resident up and down the hallways following staff. [Nurse practitioner name withheld] notified of residents behaviors and that resident often has a sitter. New orders for Lorazepam Tablet 0.5 MG Give 1 tablet by mouth every 24 hours as needed for anxiety related to anxiety disorder . CMA notified and PRN to be given. [Nurse practitioner name withheld] stated that she can still have her routine Lorazepam when it is due and that there is no need to wait to give the medication . A physician's order, dated [DATE], documented the resident was to receive Lorazepam, 0.5 mg one tab every 24 hours as needed for anxiety, in addition to her routine dosages. Review of the resident's clinical record revealed when the resident specific intervention of one on one with staff was implemented, the resident had a decrease in behaviors. There was no documentation to show any resident specific, non-pharmalogical interventions were in place when the staff notified the nurse practitioner on [DATE]. There was no documentation to show any other resident specific, non-pharmalogical interventions were identified or implemented for the resident. A pharmacy medication regimen review, dated [DATE], documented the resident received the following medications: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Trazodone - 50 mg at bed time; ~ Buspar - 15 mg four times daily; ~ Hydroxyzine 50 mg every six hours; ~ Lorazepam 0.5 mg three times daily; and ~ Seroquel 100 mg nightly. The medication regimen review documented, . This resident is at risk for falls based on the current medication profile. Please consider reducing one of the following meds which are being administered at bedtime . Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax dated [DATE], documented, . Res with increasing anxiety, restlessness Res is following staff into other patients room. Res with repetitive questions/statements about anxiety, restlessness, stomach c/o prn meds given with minimal effectiveness. Staff attempts to do redirect unsuccessful. Unwilling to do any activities is staying in her room. Only comes out of room when she hears staff in the hallway. Please Advise . On [DATE], the nurse practitioner responded to the pharmacist's request on [DATE] with an order to decrease the resident's Buspar to 10 mgs four times daily. Review of the resident's clinical record revealed a faxed communication to the resident's physician. The fax dated [DATE], documented, . Resident has shown increased agitation, has been following staff into other resident rooms, and yelling at staff to assist her to bed. Multiple attempts have been made to redirect resident -w no success. Resident was found jogging down the hall in attempt to catch up to a staff member. Resident has been flailing arms around causing resident to lose balance, and has been grabbing staff members by the arm. I've attached a medication list to review. Thanks . The physician responded . 1/ DC [discontinue]Trazodone 2/ increase Anafranil [antidepressant] to 50 mg at HS [hour of sleep] . A health status note, dated [DATE] at 12:38 p.m., documented, . Agitated. Resident is concerned her room mate is being harmed. Refuses to go back to her room at the moment. Is not tolerating room change well. Staff will continue to monitor . An initial behavior progress note, dated [DATE] at 3:07 p.m., documented, . Resident pacing and screaming at staff that she can not stay there and live the way she does. Very argumentative upon trying to redirect. Non-medication Interventions attempted: Redirection, distraction with activities painting nails and listening to music . Response to intervention: As long as activity was going on no behaviors, as soon as activity was over became very argumentative and very defensive . [nurse practitioner name withheld] notified . A physician's order, dated [DATE], documented the resident was to receive Lorazepam, 0.5 mg one time only. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A health status note, dated [DATE] at 1:40 a.m., documented, . Lying in bed with eyes closed easily aroused with verbal stimuli. Alert and oriented x 2. Speech clear. Resident stated 'one of my dx [diagnosis] has come back I have diarrhea I'm sorry.' No c/o's [complaints] voiced r/t room change. staff strives to keep call light and water in easy reach . A behavior note, dated [DATE] at 8:15 a.m., documented, . resident keeps putting on call light and complaining about breakfast and not being able to eat it. observed that resident had eaten all of her cereal and part of boiled egg. States that the cereal is too mushy and the milk is sour. milk is not expired and attempted to show resident and she got hatful [sic] and started getting loud. asked if she would like something else and she stated 'no, just take this away' . A health status note, dated [DATE] at 9:56 a.m., documented, . continuously agitated this shift and demands anxiety medication. was given anxiety medication routinely as prescribed this morning by CMA [certified medication aide] already and was informed that she can only have it as it is prescribed . A health status note, dated [DATE] at 10:57 a.m., documented, . Resident demanding to go to hospital for her head. she states that she is having a stroke. resident has had a stroke in the past and ever since has been very worried that she is having another one. Nurse does not observe any s/s of stroke at this time . have redirected resident to dining room for lunch after calling her [family member] and calming down a little . A behavior note, dated [DATE] at 11:06 a.m., documented, . resident stated that she has not been given a bath in 3 wks [weeks] or been taken care of at all. demands to go to the hospital so she can get a bath. have redirected numerous times that there is not a reason for her to go to the hospital right now. she is now demanding that she starts therapy today or she is going to find another place to live . A behavior note, dated [DATE] at 11:33 a.m., documented, . focused assessment r/t residents behavior. resident kept coming to the desk stating she needed to go to the hospital because her stomach hurt, just like it did when she had her stroke. resident medicated for upset stomach, she then stated she hadn't had a BM in a couple of days, and she needed to go to the hospital. resident medicated for constipation. residents room mate keeping resident stirred up . An annual assessment, dated [DATE], documented the resident was moderately impaired with cognition and required limited assistance with activities of daily living (ADLs). The assessment documented the resident had no behaviors during the assessment period. The assessment documented the resident received an antipsychotic, antianxiety, and an antidepressant medication on seven days out of the seven day look back period. The assessment documented the resident had following diagnoses: cerebrovascular accident, dementia, anxiety disorder, depression, insomnia, and pseudobulbar affect. A social services progress note, dated [DATE] at 2:43 p.m., documented, . res [resident] enjoys coloring & doing word puzzles as tolerated, at times confused & needs much redirecting but carries good conversation, ambulates well, this SSD [social services director] offers water/snacks, assists with phone calls to [family member] & carries casual conversation with res in room, SS [social services] will monitor for social depression during this time of social distancing & continue to provide one on one visits . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated [DATE], documented the resident was to receive Seroquel 100 mg at bedtime for psychosis. This was a change in diagnosis for the use of the medication from depressive disorder. A behavior note, dated [DATE] at 7:31, documented, . resident yelling at staff to, 'send me out, I don't wanna be here.' resident then yelled at nearby aide, 'i don't know why you don't put me in bed.' encouraged resident that she is capable enough to help herself to bed as she is independent enough to do so. resident became frustrated and began crying demanding that she be released. resident states, 'Do you want me to break down that door,' while holding up both fists. this nurse asked resident to take a walk until she can calm down. resident has already received all medication. continues to cry and states, 'I didn't do anything.' . A quarterly assessment, dated [DATE], documented the resident was severely impaired with cognition and required limited assistance with activities of daily living. The assessment documented the resident had physical and verbal behaviors on one to three days during the assessment period. The assessment documented the resident received an antipsychotic, antianxiety, and an antidepressant medication on seven days out of the seven day look back period. A behavior note, dated [DATE] at 5:48 p.m., documented, . resident following staff and yelling, 'I need a shower.' explained to resident that she'll have to wait until a staff member is available to assist her. allowed resident to make outgoing call to her [family member]. resident hung up phone and walked away from desk. resident noted to be stopping aides that were assisting other residents and asking them to take her to her room. when told that she is independent enough to take herself back to her room, she began to cry. this nurse stepped away from desk to assist another resident, reported by nearby aide that resident was at the phone making another outgoing call but hung up quickly when she was approached. received call from Muskogee Police Department shortly after that resident had made a call with the statement, 'I'm lost, I need help back to my room.' and hung up. when asked about the situation, resident raised hand and said, 'yes, I guess that was me that did it.' . A physician order, dated [DATE], documented Lorazepam, 0.5 mg twice daily for anxiety and Buspar, 10 mg three times daily for anxiety. This was a reduction in dosages for both medications even though the resident was continuing with the same behaviors the medications were originally prescribed for. The resident's care plan, dated [DATE], documented a problem related to the resident having feelings of anxiety, fear, confusion associated with dementia, cerebrovascular accident (CVA), and altered mental status. The care plan documented the resident will have behavioral problems identified and preventive measures implemented to minimize labile emotions by the review date. The care plan documented to administer medications as prescribed, monitor for effectiveness, side effects and adverse drug reactions. The care plan documented a problem related to the diagnosis of pseudobulbar effect. It was documented, I have a chemical imbalance in the brain that effects my emotions . The goals included the resident would experience improved emotional control through the review date. Interventions included to administer medications as ordered, allow the resident the freedom to sit in a chair near the window or nurses' station, allow wandering in a controlled environment, approach the resident in a consistent manner, avoid or terminate emotionally charged situation or conversations, and avoid the expectation of the resident to remember or follow instructions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another problem was documented as altered thought processes. It was documented, . I am experiencing confusion, inappropriate behaviors . The goal was the resident would be free from side effects and/or adverse reactions from antipsychotics through the review date. Interventions included to administer medications as prescribed and to monitor for adverse drug reactions. Review of the resident's clinical record revealed no psychotropic medication side effect monitoring for , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], or ,d+[DATE]. From ,d+[DATE] through ,d+[DATE], the only month when side effect monitoring occurred was ,d+[DATE]. Review of the resident's clinical record revealed from ,d+[DATE] through ,d+[DATE], revealed no resident specific, non-pharmalogical interventions had been identified or implemented to help the resident with her behaviors, except for two instances when the resident was provided one on one interaction with the staff. Each time, it was documented the intervention was successful. On [DATE] at 8:46 a.m., the resident was laying on her bed under the blanket facing the wall. She stated she was tired and would rather take her nap this morning than do an interview. On [DATE] at 2:09 p.m., the resident was observed in the hallway. She asked, Do I go wait for dinner? The surveyor informed the resident it was not time for dinner. The resident asked if the surveyor could get her back to bed. She stated she needed help with her bed. At this time, a CNA approached the resident and asked her if she wanted to have her nails painted. The resident walked to her room, and the CNA began to paint her nails. At 3:01 p.m., the resident walked out of her room and showed the surveyor her fingernails. She stated she liked the color. On [DATE] at 1:55 p.m., CNA #1 stated staff walked the resident to lunch and helped her with a shower. CNA #1 stated the resident would tell staff when she went to the bathroom and when she had a bowel movement. CNA #1 stated there resident really did not have behaviors but had anxiety, getting up and down out of bed. CNA #1 stated the resident would ask for help to lie back down, and he would assist her, and she was good. On [DATE] at 2:01 p.m., licensed practical nurse (LPN) #3 stated the resident got agitated and anxious. She stated the resident was attention seeking and acted out. LPN #3 stated the resident like [NAME] and having her hair braided. She stated the resident was up and down and hard to console. On [DATE] at 2:07 p.m., the activities director (AD) stated the resident loved music, dancing, and one on one conversations, if staff would sit and interact with her. She stated the resident had a short attention span and needed a lot of praise. The AD stated the resident had chose to have her nails done on the previous day. On [DATE] at 3:06 p.m., the director of nursing (DON) and assistant director of nursing (ADON) were asked what non-pharmalogical interventions had been identified and implemented for the resident. The ADON stated the resident attended quite a few activities, and the staff had done some one on one with the resident. They were asked what they were doing to determine the source of the resident's behaviors. The DON stated she had a mental disease. The ADON stated it was due to a stroke affecting her brain. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON and ADON were asked what they had done to find the root cause of the resident's behaviors regarding her bed linens. The ADON stated the resident was in and out of the bed several times a night, and the aides would go and straighten the bed linens five to six times per night. The ADON stated they would try distraction and redirection for the resident. She was asked how they communicated their findings to all staff members, including the night shift. She stated, We pass it on from one shift to the next. She stated the resident got up during the night and had the same behaviors. The ADON was asked if the resident could help her behaviors. She stated, No. She stated the resident's family member reported she had the same behaviors when at home. The DON and ADON was asked what training the staff received on dementia care. The ADON stated, We have in-services at least two times a year for dementia. They were asked why the resident was receiving psychotropic medications. The DON stated, Because the doctor ordered it. They were asked who had requested the resident have the medications. The ADON stated the nurses called to get the medications because of the behaviors the resident was having. The DON and ADON were asked if the staff had exhibited a level of frustration with the resident. The ADON stated not that she knew of. She stated, I know they redirect her. They were asked who monitored for adverse consequences to the medications. The ADON stated the nurses did. She stated the monitoring would be documented in the behavior notes and in the assessments. The DON and ADON were asked why the staff consistently instructed the resident to go take care of something herself and why they did not attempt any non-pharmalogical interventions before asking for an increase in her medications. The ADON stated the staff did not tell her that. She stated she would not ask for an increase in medications when it could cause the resident to fall. The DON stated he did not think they had called for an increase in her medications for a while. The ADON stated the resident needed encouragement. She stated she had good long term memory, but her short term memory was around 45 minutes to an hour. The DON stated her behaviors got worse the later it got, like sundowners. Details of nursing notes were shared with the DON and ADON. The ADON stated the staff was not properly taking care of a resident with dementia. They were asked again what specific non-pharmalogical interventions had been attempted with the resident. The ADON stated one on one with a staff member and the resident liked to take walks. The ADON stated, She liked to sing. The DON and ADON were asked what their expectation was for the staff and this resident. The ADON stated, The staff is not meeting the resident's needs. She stated the resident should have been assisted every time she asked. On [DATE] at 8:35 a.m., the resident was observed in bed with covers up to her neck facing the wall, her breakfast tray was on the overbed table. The resident's roommate stated the resident had already eaten her breakfast. The roommate was asked if the resident received help from staff to go back to bed when she asked. The roommate stated, At times she does. She stated the resident would not go back to bed if the linens on the resident's bed were messed up. The roommate stated she straightened the resident's bed linens at least five to six times a day. (continued on next page)

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	375146	A. Building B. Wing	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Care & Rehab Center	1622 East Broadway Muskogee, OK 74403

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:01 p.m., the director of nursing (DON) stated the side effect monitoring was done monthly. The assistant director of nursing (ADON) stated she would expect her staff to perform side effect monitoring once a month. The DON stated their electronic charting system was not generating the form for side effect monitoring to be completed monthly. The DON was asked who was responsible for ensuring side effect monitoring was being completed. The DON stated the administrative nursing staff. 25225 2. Resident #53 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, restlessness, and anxiety. A physician's order, dated [DATE], documented the resident was to received Lorazepam, 0.5 mg, every two hours as needed for anxiety. An admission assessment, dated [DATE], documented the resident had received an anxiolytic medication on one of the preceding seven days. Medication administration records (MARs), dated ,d+[DATE], documented the resident received Lorazepam on [DATE] and [DATE]. The resident's care plan, initiated on [DATE], documented a problem related to the diagnosis of anxiety. Interventions included to administer medications as ordered and to monitor for side effects. MARs, dated [DATE], documented the resident received an as needed dose of Lorazepam. A behavior evaluation form, dated [DATE], docume [TRUNCATED]

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on observation, interview, and record review, it was determined the facility failed to have a medication error rate of less than 5% for two (#7 and #23) of 10 residents observed during the medication passes. Two errors out of 35 opportunities were observed, resulting in a medication error rate of 5.71%. The facility identified 61 residents as receiving medications. Findings: The facility's eye drop administration policy, dated 04/2018, documented, . To administer ophthalmic solution/suspension into the eye in a safe, accurate, and effective manner . If the eye drop is a suspension (read label), shake well . 1. Resident #23 was admitted to the facility on [DATE] with diagnoses that included dry eyes. A physician's order dated 10/07/20, documented to administer one drop in both eyes two times a day of LiquiTears Solution 1.4 %. On 08/11/21 at 9:00 a.m., licensed practical nurse (LPN) #2 was observed to administer eye drops to the resident. She administered three drops in the left eye. 2. Resident #7 was admitted to the facility on [DATE] with diagnoses that included allergies. A physician's order, dated 03/24/21, documented to administer one drop in both eyes two times a day of Artificial Tears Solution 1.4 % (Polyvinyl Alcohol), for allergies. On 08/11/21 at 9:46 a.m., LPN #2 was observed to administer eye drops to the resident. She administered three drops in the left eye and two drops in the right eye. On 08/12/21 at approximately 1:00 p.m., LPN #2 stated she messed up and gave too many drops.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on observation, interview, and record review, it was determined the facility failed to ensure: ~ one of four medications carts was secure when unattended; and ~ failed to ensure medications were stored at safe temperatures in one (B Hall) of two medication rooms. The facility identified 61 residents as receiving medications. Findings: The website https://www.helmerinc. com/articles/usp-chapter-outlines-good-drug-storage-and-shipping-practices which contained an article from [NAME] Scientific titled, USP CHAPTER <1079> OUTLINES GOOD DRUG STORAGE AND SHIPPING PRACTICES, documented, . The United States Pharmacopoeia (USP) chapter 1079 from 2016 . temperature ranges for drugs stored at the following requirements: Room Temperature Storage: 20 C - 25 C [68 degrees Fahrenheit - 77 degrees Fahrenheit] (Excursions permitted between 15 C and 30 C [59 degrees Fahrenheit - 86 degrees Fahrenheit]) . 1. On 08/11/21, from 10:54 through at 11:09 a.m., registered nurse (RN) #1/Care Plan Coordinator was observed to check the blood sugar and inject insulin for residents #23, #41, and #45. Each time she would enter a resident room, she would leave the cart unlocked and out of her sight. At 11:17 a.m., RN #1 pushed the medication cart from A Hall to the walkway in front of the back nurses' station. She left the cart unlocked and unattended and walked into the dining room. The director of nursing (DON) walked past the cart, locked it, and pushed it against the nurses' station wall. At 11:22 a.m., RN #1 entered the room of resident #7 to check her blood sugar. She left the medication cart unlocked and unattended. At 11:39 a.m., she went into resident #25's room to check his intravenous (IV) antibiotic and left the medication cart unlocked and unattended. At 11:45 a.m., RN #1 entered the room of resident #58 to check her blood sugar. She left the medication cart unlocked and unattended. 2. On 08/12/21 at 4:34 p.m., the temperature in the medication room on hall B was observed to be 82 degrees Fahrenheit. Two fans were observed on the counter. A sign titled Recommended minimum medication storage parameters was on the wall under the thermostat. It documented a recommended temperature of 77 degrees Fahrenheit with some medications to have excursions up to 86 degrees Fahrenheit. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/12/21 at 4:45 p.m., licensed practical nurse (LPN) #4 stated she checked the temperatures first thing in the morning, but she had not checked them on this day. She stated the medication room temperature was not checked in the evenings or afternoons. She was asked if she knew what the temperature was at that time. She stated no. She was asked what the temperature should be for a medication storage room. She stated no higher than 75 or 76 degrees. She was informed the temperature was 82 degrees. She stated that was too hot.

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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. 41810 Based on observation and interview it was determined the facility failed to store food in a sanitary manner. This had the potential to affect 59 of 59 residents who ate food from the kitchen. Findings: On 08/04/21 at 9:16 a.m., during an initial tour of the kitchen, scoops, with their handles touching the food, were observed in the cornmeal, flour, bread crumbs, sugar, and rice crisp cereal containers. At 9:27 a.m., the dietary manager stated the scoops should not be left in the containers and removed them. She stated it was an infection control concern.

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F 0835 Level of Harm - Actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 25225 Based on observation, interview, and record review, it was determined the facility failed to have an effective administration who ensured: a. there was sufficient competent licensed nursing staff to ensure physicians were notified when there was a significant change in a resident's respiratory status and assessed and monitored a resident with changes in respiratory status; b. nursing staff identified and implemented non-pharmalogical interventions before initiating psychotropic medications and monitored for adverse consequences of psychotropic medications; and c. nursing staff identified and implemented interventions to aid in the prevention of falls. This had the potential to affect 64 of 64 residents who resided at the facility. Findings: 1. The facility failed to notify the physician of a significant change in condition for one (#3) of 24 sampled residents reviewed for change in condition after the resident exhibited signs of a change in respiratory status. This had the potential to affect 64 of 64 residents who resided at the facility. The findings at F580 are incorporated here by reference. 2. The facility failed to assess and monitor one (#3) of 24 sampled residents reviewed for change in condition after the resident exhibited signs of a change in respiratory status. This had the potential to affect 64 of 64 residents who resided at the facility. The findings at F684 are incorporated here by reference. 3. The facility failed to identify and implement non-pharmalogical interventions before initiating psychotropic medications and/or failed to monitor for adverse consequences of psychotropic medications for two (#19 and #53) of five sampled residents reviewed for unnecessary medications. The facility identified 62 residents as receiving psychotropic medications. The findings at F758 are incorporated here by reference. 4. The facility failed to ensure two (#42 and #53) of three sampled residents who were reviewed for falls were provided supervision to prevent accidents when the facility did not identify and implement interventions to aid in the prevention of falls. Resident #42 suffered repeated falls without appropriate intervention with one fall resulting in a left femoral neck fracture. Resident #53 suffered repeated falls without appropriate intervention with one fall resulting in a left ulna fracture. The facility identified five residents with falls and major injury in the last six months. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	The findings at F689 are incorporated here by reference. On 08/17/21 at 12:32 p.m., the administrator, director of nursing (DON), and assistant director of nursing (ADON) were asked how they thought the harm level deficiency in falls and immediate jeopardy deficiencies related to physician notification and assessing and monitoring came to be. The administrator stated the immediate jeopardy situations came to be because of failure to follow up on concerns. She stated the harm level deficiency was because of ineffective interventions. She was asked how she would know there was a problem related to physician notification, assessing and monitoring, and fall interventions. She stated by someone telling her and reviewing the incident reports. The DON and ADON were asked how they identified concerns that needed to be brought to the administrator. The ADON stated by reviewing the production of the nurse, determining what they are lacking, documentation reviews, and reviewing physician orders. She was asked when she reviewed the clinical documentation. She stated she reviewed the physician orders daily. She stated reviewing clinical documentation was hit and miss, when I have the time.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 38495 Based on observation and interview, it was determined the facility failed to ensure the facility's emergency suction machine was in a safe operating condition. This had the potential to affect 64 of 64 residents who resided at the facility. Findings: The facility's policy and procedure regarding emergency medical equipment, dated March 2019, documented, . Emergency Medical Equipment/Cart . will include suction machine . Emergency cart will be stored in a central location so it can be accessed quickly by staff in the event of an emergency . The Emergency cat will be checked daily by Licensed Staff daily to ensure equipment is clean and available for immediate use. (Suction machine clean/oxygen cylinder set up etc) . On 08/16/21 at 9:45 a.m., the crash cart was observed on D hall in the supply closet. The suction machine was observed sitting on the top of the crash cart. The dial on the machine was broken and there was no top to the suction canister. Licensed practical nurse (#3) was asked if the suction machine worked. She stated she did not know. On 08/16/21 at 12:59 p.m., the assistant director of nursing (ADON) looked at the crash cart. The ADON stated, Oh yeah, that's broke. The suction machine dial is broken and missing the cap to the suction bottle. She was asked what the staff would do if they had an emergency and needed the suction machine. The ADON stated the staff would probably get another suction machine. She stated she could get another suction machine for it now. The ADON tried to open the storage closet, but it was locked. The ADON asked the nurse working that hall to open the storage closet door. The nurse did not have a key to open the door. She stated if there was an emergency, they would have had to get a suction machine from another hall. On 08/16/21 at 1:12 p.m., LPN #2 brought a different suction machine from another hall for the crash cart. On 08/17/21 at 12:03 p.m., the administrator stated the crash cart should be inspected every shift. She stated she thought there was a check off list in the drawer of the cart.