Printed: 12/22/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022	
NAME OF PROVIDER OR SUPPLII  Jan Frances Care Center	ER	STREET ADDRESS, CITY, STATE, ZI 815 North Country Club Road Ada, OK 74820	P CODE	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)	
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	and neglect by anybody.  **NOTE- TERMS IN BRACKETS II  On [DATE], an Immediate Jeopard ensure residents were free from ne skilled nursing services. Res #152' services progress notes, ADL doct record, vital signs, or ongoing asse admission.  On [DATE] at 1:13 p.m., the Oklah the IJ situation.  On [DATE] at 1:19 p.m., the admin On [DATE] at 1:19 p.m., an accept Health. The plan of removal docum [DATE]  Jan [NAME] Care Center  Plan of Removal for 4 IJs Completication All education will be done by the Residual contents.	ion Date [DATE] 11:00 p.m. legional Nurse, [name deleted], and [na dures. Identify types of abuse and neg	ONFIDENTIALITY** 46387  It related to the facility's failure to refrom the hospital on [DATE] for admission assessment, skilled eted medication administration expired in the facility four days after notified and verified the existence of related to neglect for Res #152.  The Oklahoma State Department of ether of the order of the	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 375243

If continuation sheet Page 1 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER: 375243  STREET ADDRESS, CITY, STATE, ZIP CODE 815 North Country Club Road Ada, DK 74362  For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES [Sach deficiency must be preceded by full regulatory or 1.50 identifying information) Level of Harm - Immediate jacopardy to resident health or safety and resident nealth or safety Alfacted - Few  Medication Administration Policy & Procedure. Discussed medication availability, timely administration of all medications, resident refusal of medications, resident indications, resident nealth or safety And resident assessments and skilled documentation when required.  Residents Affected - Few  Resident Assessments Angle of Condition/flavened the process for significant medication errors.  Vital Sign Documentation Reviewed the importance of obtaining vitals signs for the surveillance monitoring daily, and resident assessments and skilled documentation when required.  Resident Assessment/Change of Condition/flaveneurons. Reviewed whe importance of resident assessments for new admissions, readmissions, and when the resident has a change of condition. Reviewed appropriate and simely interventions.  ADL Documentation. Handout given to all participants. Reviewed what ADLs are and how to document them each shift. Discussed the importance of accurate coding, Reviewed person-centered care and resident independence when possible. Reviewed decline in function and range of motion.  Skilled Nursing Documentation. Implemented all residents will be assessed and documented on when the receive and when the reviewed skill documentation guidelines. Instructed the nurses where their nursing resource book is at the nurses station and the importance of referring to it when the need arises.  Upon completion of the immediate corrections; audits and observations will continue by the DON or designed fo					
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center  STREET ADDRESS, CITY, STATE, ZIP CODE  315 North Country Club Road Ada, OK 74820  SUMMARY STATEMENT OF DEFICIENCIES  Each deficiency please contact the nursing home or the state survey agency.  Well D PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  Each deficiency must be proceeded by full regulatory or LSC identifying information)  Medication Administration Policy & Procedure, Discussed medication availability, timely administration of all medications, resident refusal of medications, Reviewed the process for significant medication errors, asiatry to resident health or safety to resident health or safety  Residents Affected - Few  Residents Affected - Few  Resident Assessment/Change of Condition/Interventions. Reviewed the importance of resident assessments for new admissions, readmissions, and when the resident has a change of condition. Reviewed appropriate and timely interventions.  ADL Documentation Handout given to all participants. Reviewed what ADLs are and how to document them each shift. Discussed the importance of accurate coding, Reviewed person-centred care and resident independence when possible. Reviewed decline in function and range of motion.  Skilled Nursing Documentation - Implemented all residents will be assessed and documented on when they are receiving skilled nursing cent on each shift. Deviewed skill documentation guidelines. Instructed the nurses where their nursing resource book is at the nurses station and the importance of referring to it when the need arises.  Upon completion of the immediate corrections; audits and observations will continue by the DON or designed for 66 days.  Audit Skilled Nursing Documentation  Surveillance Monitoring on all Residents  Medication Administration/Documentation  Regional Nurse will assume the Interim DON position immediately. She is currently at the facility. An additional RN has been hiral for two days a week to relieve the DON, to ensure 7 day a week RN coverage.  On IDATE] and IDATE], interv					
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	375243	A. Building B. Wing	09/19/2022	
		b. Willig		
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Jan Frances Care Center		815 North Country Club Road Ada, OK 74820		
		Aua, OK 74020		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
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F 0600  Level of Harm - Immediate jeopardy to resident health or safety	Based on record review and interview, the facility failed to ensure residents were free from neglect for one (#152) of two residents reviewed for death in the facility. Res #152's medical records did not document an admission assessment, skilled services progress notes, ADL documentation, meal or fluid intake, completed medication administration record, vital signs, or ongoing assessment of resident status. Res #152 expired in the facility four days after admission.			
Residents Affected - Few		ions of Residents form documented 53	residents resided in the facility.	
	Findings:			
	A facility abuse policy, dated ,d+[DATE], documented the definition of neglect read in parts, .The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessar to avoid physical harm, pain, mental anguish or emotional distress .It is the responsibility of every employee to report immediately anything that could adversely affect the health and welfare of any resident .			
	An undated facility policy, titled Documentation of Medication Administration read in part, .Administration of medication must be documented immediately after (never before) it is given .			
		arting and Documentation read in part, etc., must be documented in the reside		
	An undated facility policy, titled Activities of Daily Living, read in parts, .lt is our responsibility to support residents at their highest level of function .recognize if there is a decline in the resident's abilities, report decline, make referrals for appropriate programs and develop a plan of care that meets the resident needs, preferences and choices .			
	Facility inservice records documen	ted staff received training on neglect or	n [DATE], [DATE], and [DATE].	
	acute respiratory failure with hyper	ity on [DATE] with diagnoses including capnia, COPD, atherosclerotic heart distronephrosis with renal and urethral cal	sease, history of TIA and cerebral	
	A hospital record, dated [DATE], read in parts, .was found to have DVT in R soleus vein on b/l Doppler Le studies. AC therapy discussed with pharmacy and detailed below .For follow-up provider .Further COPD work-up indicated. PFTs as able .discharged with Foley for significant urinary retention and tamsulosin/finasteride therapy. Recommend routine Foley replacement and monitoring of kidney function Lovenox 40 mg SQ daily. Continue until Cr improves. Monitor BMP daily. When Cr clearance, do full dose therapeutic Lovenox BID 1mg/kg dosing. Monitor for signs of bleeding. Check Xa level ,d+[DATE]hrs pos dose per provider discretion .7. Acute respiratory failure with hypoxia and hypercapnia .To need home O2 discharge. Desats to low-mid 80's on room air trial .Hemorrhagic shock .Continue Midodrine 10mg TID .			
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NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZI	P CODE
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Jan Frances Care Center		Ada, OK 74820	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	A nurses progress note, dated [DA skilled nursing care via a private verequired two staff to transfer into be disoriented. The note documented congestion. The resident was incorrisuses measured. The note documefed meals. The note documented the foliation of supplemental oxygen therapy or the A LTC - Admission Assessment/O observations or assessments documented the following: anticipate the resident's in provide one staff assist with bathing staff assist with eating; provide one ambulation/transferring; administer bell in reach and encourage use; we monitor for signs/symptoms of dehiguidelines; monitor for edema/dyspreport to charge nurse any redness work as ordered; monitor for signs/endurance/complications; monitor of 2 saturation every shift; assess for A MAR, dated [DATE] to [DATE], ditimes daily. There were no document and the complete of the com	TE] at 6:00 p.m., documented Res #15 shicle by his family. He was assisted to be ed. The resident was alert and oriented the resident had even and non-labored intent of bowel and bladder. Skin integented the resident required assistance he resident's vital signs. The progress of the presence of a Foley catheter.  bservation Documentation form, dated mented.  In form, dated [DATE], documented intendeds and observe for non-verbal cues glyhygiene; provide one staff assist with the to two staff assist with toileting; provide medications as ordered; assess, monitaries weekly for four weeks; monitor may dration; obtain laboratory work as ordered; perform oral care twice daily; turns symptoms of bleeding; monitor pain; as edema; monitor for signs/symptoms of or pain; and assess for constipation.  In commented diclofenac 1% topical, appleanted administrations of this medication was not documented Brovana 15 mcg nebulization twice and to be administered on [DATE] for the as provided to surveyors on [DATE]. It can be provided to surveyors on the provided	2 was transferred to the facility for a room via wheelchair and times one, confused, and respirations without cough or rity was documented and noted with all ADLs, and must be spoon note did not include documentation  [DATE], had no resident  erventions which included the ; consult PT, OT, ST as needed; dressing/grooming; provide one e two staff assist with tor; and document mood; keep call eal percentages; encourage fluids; ered; provide hydration per every two hours and as needed; breathing treatments; monitor lab ssess vital signs; monitor heart failure and dyspnea; check  by two grams to affected area four the documented on [DATE]. It documented to be administered on [DATE]. It documented to ead and [DATE] for the a.  documented to clean left heel hing treatment was not documented to graph at bedtime, calcium carbonate ity, folic acid 1 mg daily,
	No vital signs or ADL care were do	cumented from [DATE] to [DATE].	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building	(X3) DATE SURVEY COMPLETED 09/19/2022
	373243	B. Wing	00/10/2022
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Jan Frances Care Center		815 North Country Club Road Ada, OK 74820	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600	No progress notes or assessments	were documented on [DATE] or [DATI	E].
Level of Harm - Immediate jeopardy to resident health or safety	A review of the resident's clinical resupplemental oxygen.	ecords did not document an order for u	rinary catheter care or
Residents Affected - Few	An admission MDS assessment, dated [DATE], documented the resident was severely cognitively impaired, required limited assistance of one staff for bed mobility, locomotion, dressing, eating, and personal hygiene; extensive assistance of two staff for transfers and toilet use; extensive assistance of one staff for bathing, had limited range of motion in both lower extremities, was always incontinent of bowel and bladder, had shortness of breath with exertion, when sitting, and when lying flat, received no medications, and received oxygen therapy.		
	A nursing progress note, dated [DATE] at 6:11 p.m., documented therapy staff notified a nurse Res #152 needed to be assessed. The note documented when the nurse assessed the resident a temperature of 97.8 degrees F was obtained and a blood pressure could not be obtained. The note documented the nurse contacted EMS to transfer the resident to the emergency room. The note documented Res #152 expired before emergency personnel arrived to the facility.		
	A State of Oklahoma Certificate of Death, dated [DATE], documented Res #152's immediate cause of death as cardiac arrest, with acute respiratory failure documented as a condition that lead to death, and interstitial pulmonary disease documented as the underlying cause of death. The death certificate documented other significant conditions contributing to death as chronic obstructive pulmonary disease.		
	On [DATE] at 2:25 p.m., CNA #3 stated Res #152 was not in the facility very long, but she remembered he was doing good when he first admitted and was eating well. She stated the resident was total care. She stated two days after the resident admitted to the facility he stopped eating and responding to staff and died shortly after. She stated she would have reported it to the nurse if she felt like a resident was not receiving care or being neglected. She stated she did not notify the nurse for any changes for Res #152.		
	On [DATE] at 2:28 p.m., LPN #3 stated she did not remember any details of Res #152's care because she had just started at the facility around the time he was a resident. She stated to ensure residents received care she would help the CNAs whenever she could with call lights. She stated the CNAs were expected to check and change residents every two hours and turn them on the same interval. She stated the aides were supposed to fill out a shower sheet which was turned in to the nurses. She stated there was not a system in place to monitor the CNAs to ensure the required care was completed, and the nurses did not double check any documentation completed by the CNAs.		
	On [DATE] at 7:58 a.m., the ADON stated she remembered going into Res #152's room to place a pillow under his feet. She stated he had family in the room at the time and they requested another blanket for the resident. She stated there were no other issues with the resident at that time. She did not provide a date for this interaction.		
	On [DATE] at 8:00 a.m., the MDS coordinator stated she remembered Res #152 and had taken his vitals. She was unable to locate the vital signs in the EHR. She stated she had assisted him by feeding him. She stated she was the nurse who charted the progress note on [DATE] when the resident expired. She stated the nurses on the floor were responsible for completing the 48 hour care plan.		
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center		STREET ADDRESS, CITY, STATE, Z 815 North Country Club Road Ada, OK 74820	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	level nurse in the facility. She state test. She was provided with docum to the documentation on the MAR t supposed to be in charge along wit time writing a MAR as the green pahave completed the admission provide orders should have been sent the sent. She stated Res #152 should She stated if the documentation was on [DATE], the facility provided ad pharmacy drug order fill sheet which on [DATE], an additional MAR, a pathe physician assistant dated [DAT on [DATE] at 10:24 a.m., the admit completed as soon as they enter the issues documented, and hospital diresidents to be assessed and receit to discuss new admissions to ensure	ditional documentation for Res #152's h documented Res #152's blood thinn rogress note from the physician dated	s when she performed a COVID-19 ord to review. She stated according. She stated the ADON was urses should not have wasted their ry MAR. She stated they should ace. She stated the white copy of to see if his medications were ever since he was a skilled resident.  medical record. These included: a medical record. These included: a medical record to the facility [DATE], and a progress note from the mission to have their documentation resessment, orders entered, skin applicable. He stated he expected the facility has a morning meeting sure if a record was kept of what

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIE  Jan Frances Care Center	ER.	STREET ADDRESS, CITY, STATE, ZI 815 North Country Club Road Ada, OK 74820	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Provide appropriate treatment and  **NOTE- TERMS IN BRACKETS H  On [DATE], an Immediate Jeopardy assess, monitor and provide interversion (DATE) for skilled nursing service assessment, skilled services progres administration record, vital signs, or four days after admission.  On [DATE] at 1:13 p.m., the Oklahot the IJ situation.  On [DATE] at 1:19 p.m., the administration at 1:19 p.m., the administration.  On [DATE] at 9:32 a.m., an acceptate Health. The plan of removal documn [DATE]  Jan [NAME] Care Center  Plan of Removal for 4 IJs Completic All education will be done by the Real All Staff Education  Abuse and Neglect Policy & Proceed participants through group discussing Clinical Staff Education  Medication Administration Policy & medications, resident refusal of medications, resident refusal of medications, and resident assessments and Resident Assessment/Change of Comparison of the comparison o	care according to orders, resident's president according to orders, resident's president according (IJ) situation was determined to exist entions for Res #152. Res #152 admitted less. Res #152's medical records did not easy notes, ADL documentation, meal or ongoing assessment of resident status of the state of the IJ situation resident was notified of the IJ situation resident ented:  In Date [DATE] 11:00 p.m.  Regional Nurse, [name deleted], and [name deleted], and [name deleted].	eferences and goals.  DNFIDENTIALITY** 46387  related to the facility's failure to ed to the facility from the hospital to document an admission of fluid intake, completed medication is. Res #152 expired in the facility obtified and verified the existence of elated to quality of care for Reside the Oklahoma State Department of the Oklahoma State Department of elated with feedback from the elated in the facility in the facility of the Oklahoma State Department of the Oklahoma State Department of the Oklahoma State Department of the object of the object of the object of the surveillance monitoring in the for the surveillance monitoring in the object of the object

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center		STREET ADDRESS, CITY, STATE, ZI 815 North Country Club Road Ada, OK 74820	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	each shift. Discussed the important independence when possible. Revi Skilled Nursing Documentation- Im are receiving skilled nursing care on urses where their nursing resource the need arises.  Upon completion of the immediate for 60 days.  Audit Skilled Nursing Documentation Surveillance Monitoring on all Resi Medication Administration/Docume accuracy of physician orders, and a Nurse assessment on all Residents Audit ADL Documentation  Regional Nurse will assume the Intadditional RN has been hired for two On [DATE] and [DATE], interviews information pertaining to the immediand were able to verbalize underst of removal. Documentation was profit to the immediate of the IJ was lifted, effective [DATE] completed. The deficiency remained Based on record review and interview (#152) of seven residents reviewed admission assessment, skilled service in the facility four days after admission the immediation administration record, whe facility four days after admission	entation Observation. Audit of all medical accuracy of medication administration in a for change of condition, decline in funderim DON position immediately. She is to days a week to relieve the DON, to experiment of the were conducted with nursing staff regardiate jeopardy plan of removal. The state anding of the information provided in the ovided related to the medication cart are at 5:58 p.m., when all components of the data isolated level of actual harm.  The state of the information provided in the ovided related to the medication cart are at 5:58 p.m., when all components of the data isolated level of actual harm.  The state of the information provided in the ovided related to the medication cart are at 5:58 p.m., when all components of the data isolated level of actual harm.	an-centered care and resident motion.  ed and documented on when they attion guidelines. Instructed the importance of referring to it when ill continue by the DON or designee attions to ensure availability, records.  ection, and appropriate interventions.  currently at the facility. An ensure 7 day a week RN coverage.  arding education and in-service ff stated they had been in-serviced are in-service pertaining to the plan and ADL documentation audits.  The plan of removal had been  r, and provide interventions for one all records did not document an ion, meal or fluid intake, completed esident status. Res #152 expired in

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center		STREET ADDRESS, CITY, STATE, ZI 815 North Country Club Road Ada, OK 74820	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	An undated facility policy, titled Door medication must be documented in An undated facility policy, titled Charadministered, services performed, and undated facility policy, titled Act residents at their highest level of furth decline, make referrals for appropring preferences and choices.  Facility inservice records document Resident #152 admitted to the faciliacute respiratory failure with hypere infarction, acute kidney failure, hyd weakness, and dementia.  A hospital record, dated [DATE], restudies. AC therapy discussed with work-up indicated. PFTs as able damsulosin/finasteride therapy. Recovenox 40 mg SQ daily. Continue therapeutic Lovenox BID 1mg/kg dose per provider discretion .7. Act discharge. Desats to low-mid 80's of A nurses progress note, dated [DAS skilled nursing care via a private verequired two staff to transfer into be disoriented. The note documented congestion. The resident was incorrisques measured. The note documented the function of supplemental oxygen therapy or	cumentation of Medication Administration mediately after (never before) it is given arting and Documentation read in part, etc., must be documented in the reside ivities of Daily Living, read in parts, .lt inction .recognize if there is a decline in late programs and develop a plan of cast ted staff received training on neglect of ity on [DATE] with diagnoses including capnia, COPD, atherosclerotic heart diagnoses with renal and ureteral call and in parts, .was found to have DVT in pharmacy and detailed below .For foll ischarged with Foley for significant uring commend routine Foley replacement and until Cr improves. Monitor BMP daily, osing. Monitor for signs of bleeding. Clute respiratory failure with hypoxia and con room air trial .Hemorrhagic shock .CTE] at 6:00 p.m., documented Res #15 ethicle by his family. He was assisted to be ded. The resident was alert and oriented the resident had even and non-labored the resident had even and non-labored entinent of bowel and bladder. Skin integented the resident required assistance he resident's vital signs. The progress the presence of a Foley catheter.	ion read in part, .Administration of en .  .All observations, medications ent's clinical records .  is our responsibility to support in the resident's abilities, report are that meets the resident needs,  in [DATE], [DATE], and [DATE].  Interstitial pulmonary disease, sease, history of TIA and cerebral culus obstruction, muscle  In R soleus vein on b/I Doppler LE low-up provider .Further COPD mary retention and indice monitoring of kidney function .  When Cr clearance, do full dose meck Xa level ,d+[DATE]hrs post hypercapnia .To need home O2 on continue Midodrine 10mg TID .  So was transferred to the facility for a room via wheelchair and it times one, confused, and it respirations without cough or grity was documented and noted with all ADLs, and must be spoon note did not include documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Jan Frances Care Center		815 North Country Club Road Ada, OK 74820	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	following: anticipate the resident's reprovide one staff assist with bathing staff assist with eating; provide one ambulation/transferring; administer bell in reach and encourage use; we monitor for signs/symptoms of deby guidelines; monitor for edema/dyspreport to charge nurse any redness work as ordered; monitor for signs/sendurance/complications; monitor of O2 saturation every shift; assess for A MAR, dated [DATE] to [DATE], dimes daily. There were no documed A respiratory flowsheet, dated [DAT revefenacin 175 mcg nebulization of The respiratory flowshet document This medication was not document m. or p.m. dose.  A TAR, dated [DATE] to [DATE] was blister with normal saline, apply skill as completed.  A MAR, dated [DATE] to [DATE], do at bedtime, meloxicam 15 mg one to one packet two times daily, Senoko one tablet twice daily, cholecalcifered Theragran-mone tablet daily, and to of the above medications.  No vital signs or ADL care were down to progress notes or assessments. A review of the resident's clinical resupplemental oxygen.  An admission MDS assessment, darequired limited assistance of two staff for had limited range of motion in both	ocumented diclofenac 1% topical, applented administrations of this medication [FE] to [DATE] was provided to surveyodaily. This medication was not docume ed Brovana 15 mcg nebulization twice ed to be administered on [DATE] for the as provided to surveyors on [DATE]. It is provided to surveyors on [DATE]. It is not prep twice per day. The [DATE] more cocumented the facility was to administerablet every day, midodrine 10 mg threat two tablets twice daily, tamsulosin 0.0 of 1000 units daily, finasteride 5 mg dathiamine 100 mg daily. There were no desired.	; consult PT, OT, ST as needed; dressing/grooming; provide one e two staff assist with tor; and document mood; keep call eal percentages; encourage fluids; ered; provide hydration per every two hours and as needed; breathing treatments; monitor lab ssess vital signs; monitor heart failure and dyspnea; check by two grams to affected area four the son [DATE]. It documented to be administered on [DATE]. It documented to be administered on [DATE]. It documented to ep.m. dose and [DATE] for the a. It documented to clean left heel hing treatment was not documented to graph appears and the set times daily, polyethylene glycol and at bedtime, calcium carbonate et ily, folic acid 1 mg daily, documented administrations for any documented administrations for any eating, and personal hygiene; sistance of one staff for bathing, ent of bowel and bladder, had

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center		STREET ADDRESS, CITY, STATE, ZI 815 North Country Club Road Ada, OK 74820	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0684  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	A nursing progress note, dated [DA needed to be assessed. The note of degrees F was obtained and a bloc contacted EMS to transfer the reside before emergency personnel arrived.  A State of Oklahoma Certificate of as cardiac arrest, with acute respiringulmonary disease documented as significant conditions contributing to the contact of the conditions contributing to the conditions condition	full regulatory or LSC identifying information.  ATE] at 6:11 p.m., documented therapy documented when the nurse assessed of pressure could not be obtained. The defent to the emergency room. The note ed to the facility.  Death, dated [DATE], documented Regardery failure documented as a condition the underlying cause of death. The death of death as chronic obstructive pulmonal tated Res #152 was not in the facility witted and was eating well. She stated the admitted to the facility he stopped eatinhave reported it to the nurse if she felt did she did not notify the nurse for any cleated she did not remember any details and the time he was a resident. She state the time he was a resident. She state the time he was a resident. She state the time he was a turn them on the same is the which was turned in to the nurses. She re the required care was completed, and	staff notified a nurse Res #152 the resident a temperature of 97.8 note documented the nurse documented Res #152 expired  s #152's immediate cause of death that lead to death, and interstitial eath certificate documented other ary disease.  ery long, but she remembered he the resident was total care. She g and responding to staff and died like a resident was not receiving hanges for Res #152.  of Res #152's care because she ed to ensure residents received that the CNAs were expected to interval. She stated the aides were the stated there was not a system in the nurses did not double check  as #152's room to place a pillow requested another blanket for the me. She did not provide a date for the s#152 and had taken his vitals. The facility and she was the highest the resident expired. She stated blan.  The facility and she was the highest the she performed a COVID-19 and to review. She stated according The She stated the ADON was surses should not have wasted their try MAR. She stated they should ace. She stated the white copy of the see if his medications were ever
	She stated if the documentation was (continued on next page)	as blank the care did not happen.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI 815 North Country Club Road	IP CODE
Jan Frances Care Center		Ada, OK 74820	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informat	ion)
F 0684  Level of Harm - Immediate jeopardy to resident health or cofety.	pharmacy drug order fill sheet which	ditional documentation for Res #152's the documented Res #152's blood thinn rogress note from the physician dated E].	er had been delivered to the facility
safety Residents Affected - Few	completed as soon as they enter the issues documented, and hospital differentiates to be assessed and receit to discuss new admissions to ensu	nistrator stated he expected a new adrale facility including a full head to toe as ischarge documentation reviewed as a ve medications as ordered. He stated re the process is followed. He was unsmeeting regarding Res #152 since the	sessment, orders entered, skin applicable. He stated he expected the facility has a morning meeting sure if a record was kept of what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center		STREET ADDRESS, CITY, STATE, ZII 815 North Country Club Road Ada, OK 74820	P CODE
For information on the nursing home's pl	an to correct this deficiency, please conf	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	IENCIES full regulatory or LSC identifying information	on)
Evel of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	a full time basis.  **NOTE- TERMS IN BRACKETS H On [DATE], an Immediate Jeopardy designate a registered nurse to senthe facility for at least eight consect oversight for facility staff. Res #152 services. Res #152's medical reconnotes, ADL documentation, meal or ongoing assessment of resident state oversight to ensure these tasks were expired in the facility four days after On [DATE] at 1:13 p.m., the Oklahothe IJ situation related lack of DON On [DATE] at 1:19 p.m., the adminition on [DATE] at 9:32 a.m., an accepta Health. The plan of removal docum [DATE]  Jan [NAME] Care Center  Plan of Removal for 4 IJs Completic All education will be done by the Real All Staff Education  Abuse and Neglect Policy & Proceed participants through group discussic Clinical Staff Education  Medication Administration Policy & medications, resident refusal of medications, resident refusal of medication Reviewed	oma State Department of Health was no and full-time registered nurse coverage strator was notified of the IJ situation. able plan of removal was submitted to the ented:  on Date [DATE] 11:00 p.m.  egional Nurse, [name deleted], and [natheres.]	related to the facility's failure to sure a registered nurse served in o assess residents and provide al on [DATE] for skilled nursing essment, skilled services progress ministration record, vital signs, or DON to manage staff or provide in [DATE] to [DATE]. Res #152 otified and verified the existence of e.  The Oklahoma State Department of the Oklahoma State Department of ect with feedback from the clability, timely administration of all gnificant medication errors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.11.2 7.2.11.01	375243	A. Building	09/19/2022	
	0.02.0	B. Wing		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	STREET ADDRESS, CITY, STATE, ZIP CODE	
Jan Frances Care Center	Jan Frances Care Center			
		Ada, OK 74820		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0727  Level of Harm - Immediate jeopardy to resident health or	Resident Assessment/Change of Condition/Interventions. Reviewed the importance of resident assessments for new admissions, readmissions, and when the resident has a change of condition. Reviewed appropriate and timely interventions.  ADL Documentation. Handout given to all participants. Reviewed what ADLs are and how to document them each shift. Discussed the importance of accurate coding. Reviewed person-centered care and resident independence when possible. Reviewed decline in function and range of motion.			
safety  Residents Affected - Many				
	Skilled Nursing Documentation- Implemented all residents will be assessed and documented on when they are receiving skilled nursing care on each shift. Reviewed skill documentation guidelines. Instructed the nurses where their nursing resource book is at the nurses station and the importance of referring to it when the need arises.			
	Upon completion of the immediate corrections; audits and observations will continue by the DON or designee for 60 days.			
	Audit Skilled Nursing Documentation	on		
	Surveillance Monitoring on all Resi	dents		
		ntation Observation. Audit of all medica accuracy of medication administration r		
	Nurse assessment on all Residents	s for change of condition, decline in fun	ction, and appropriate interventions.	
	Audit ADL Documentation			
		erim DON position immediately. She is to days a week to relieve the DON, to e		
	On [DATE] and [DATE], interviews were conducted with nursing staff regarding education and in-service information pertaining to the immediate jeopardy plan of removal. The staff stated they had been in-serviced and were able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal. Documentation was provided related to the medication cart and ADL documentation audits. Documentation was provided to verify a full time DON and a PRN registered nurse had been hired to provide coverage seven days a week.			
	, ,	at 5:58 p.m., when all components of the	•	
	Based on observation, record review, and interview, the facility failed to designate a registered nurse to serve as DON on a full-time basis and ensure a registered nurse served in the facility for at least eight consecutive hours a day, seven days a week to assess residents and provide oversight for facility staff.			
	(continued on next page)			

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center  815 North Country Club Road Ada, OK 74820		P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0727  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	The Residents Census and Condition Findings:  Resident #152 admitted to the facilia cute respiratory failure with hyper infarction, acute kidney failure, hydweakness, and dementia.  A hospital record, dated [DATE], restudies. AC therapy discussed with work-up indicated. PFTs as able datamsulosin/finasteride therapy. RecLovenox 40 mg SQ daily. Continue therapeutic Lovenox BID 1mg/kg dose per provider discretion .7. Act discharge. Desats to low-mid 80's and required two staff to transfer in disoriented. The note documented congestion. The resident was incortissues measured. The note documented to f supplemental oxygen therapy or An LTC -Admission Assessment/O observations or assessments documented the facility for staff assist with bathin staff assist with eating; provide one ambulation/transferring; administer bell in reach and encourage use; we monitor for signs/symptoms of deh guidelines; monitor for edema/dyspreport to charge nurse any redness work as ordered; monitor for signs/endurance/complications; monitor of signs/e	ity on [DATE] with diagnoses including capnia, COPD, atherosclerotic heart di ronephrosis with renal and ureteral cal and in parts, .was found to have DVT in a pharmacy and detailed below .For foll ischarged with Foley for significant uring commend routine Foley replacement are until Cr improves. Monitor BMP daily, osing. Monitor for signs of bleeding. Chate respiratory failure with hypoxia and con room air trial .Hemorrhagic shock .Co. dated [DATE] at 6:00 p.m., documented private vehicle by his family. He was at to bed. The resident was alert and oriest the resident had even and non-labored the resident had even and non-labored the resident required assistance and the resident's vital signs. The progress in the presence of a urinary catheter.  In the presence of a urinary catheter.  In the presence of a urinary catheter and observe for non-verbal cues g/hygiene; provide one staff assist with the tot two staff assist with toileting; provide medications as ordered; assess, monitering hweekly for four weeks; monitor may obtain laboratory work as ord onea; perform oral care twice daily; turn s/skin breakdown immediately; perform symptoms of bleeding; monitor pain; and edema; monitor for signs/symptoms of or pain; and assess for constipation.	interstitial pulmonary disease, sease, history of TIA and cerebral culus obstruction, muscle  R soleus vein on b/l Doppler LE ow-up provider .Further COPD hary retention and and monitoring of kidney function . When Cr clearance, do full dose neck Xa level ,d+[DATE]hrs post hypercapnia .To need home O2 on continue Midodrine 10mg TID .  d Res #152 was transferred to the assisted to a room via wheelchair anted times one, confused, and direspirations without cough or grity was documented and noted with all ADLs, and must be spoon note did not include documentation  [DATE], had no resident and document.  erventions which included the seconsult PT, OT, ST as needed; it dressing/grooming; provide one let wo staff assist with litor; and document mood; keep call eal percentages; encourage fluids; ered; provide hydration per an every two hours and as needed; breathing treatments; monitor lab ssess vital signs; monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND FEAR OF CONNECTION	375243	A. Building B. Wing	09/19/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Jan Frances Care Center		815 North Country Club Road Ada, OK 74820	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG		JMMARY STATEMENT OF DEFICIENCIES ach deficiency must be preceded by full regulatory or LSC identifying information)	
F 0727 Level of Harm - Immediate	A MAR, dated [DATE] to [DATE], documented diclofenac 1% topical, apply two grams to affected area four times daily. There were no documented administrations of this medication.		
jeopardy to resident health or safety  Residents Affected - Many	A respiratory flowsheet, dated [DATE] to [DATE] was provided to surveyors on [DATE]. It documented revefenacin 175 mcg nebulization daily. This medication was not documented to be administered on [DATE]. The respiratory flowshet documented Brovana 15 mcg nebulization twice daily at 08:00 a.m. and 08:00 p.m. This medication was not documented to be administered on [DATE] for the p.m. dose and [DATE] for the a.		
	m. or p.m. dose.  A TAR, dated [DATE] to [DATE] was provided to surveyors on [DATE]. It documented to clean left heel blister with normal saline, apply skin prep twice per day. The [DATE] morning treatment was not documented as completed.		
	A MAR, dated [DATE] to [DATE], documented the facility was to administer gabapentin 60 mg two capsules at bedtime, meloxicam 15 mg one tablet every day, midodrine 10 mg three times daily, polyethylene glycol one packet two times daily, Senokot two tablets twice daily, tamsulosin 0.4 mg at bedtime, calcium carbonate one tablet twice daily, cholecalciferol 1000 units daily, finasteride 5 mg daily, folic acid 1 mg daily, Theragran-m one tablet daily, and thiamine 100 mg daily. There were no documented administrations for any of the above medications.		
	No vital signs or ADL care were do	cumented from [DATE] to [DATE].	
	No progress notes or assessments were documented on [DATE] or [DATE].		
	A review of the resident's clinical records did not document an order for urinary catheter care or supplemental oxygen.		
	An admission MDS assessment completed by the LPN MDS coordinator, dated [DATE], documented the resident was severely cognitively impaired, required limited assistance of one staff for bed mobility, locomotion, dressing, eating, and personal hygiene; extensive assistance of two staff for transfers and toilet use; extensive assistance of one staff for bathing, had limited range of motion in both lower extremities, was always incontinent of bowel and bladder, had shortness of breath with exertion, when sitting, and when lying flat, received no medications, and received oxygen therapy.		
	A nursing progress note documented by the LPN MDS coordinator, dated [DATE] at 6:11 p.m., documented therapy staff notified a nurse Res #152 needed to be assessed. The note documented when the nurse assessed the resident a temperature of 97.8 degrees F was obtained and a blood pressure could not be obtained. The note documented the nurse contacted EMS to transfer the resident to the emergency room. The note documented Res #152 expired before emergency personnel arrived to the facility.		
	A State of Oklahoma Certificate of Death, dated [DATE], documented Res #152's immediate cause of death as cardiac arrest, with acute respiratory failure documented as a condition that lead to death, and interstitial pulmonary disease documented as the underlying cause of death. The death certificate documented other significant conditions contributing to death as chronic obstructive pulmonary disease.		
	(continued on next page)		

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
		STREET ADDRESS, CITY, STATE, ZI 815 North Country Club Road Ada, OK 74820	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
Evel of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	required care was completed, and CNAs.  On [DATE] at 7:58 a.m., the LPN A pillow under his feet. She stated he the resident. She stated there were for this interaction.  On [DATE] at 8:00 a.m., the LPN N vitals. She was unable to locate the She stated she was the nurse who stated the nurses on the floor were On [DATE] at 10:10 a.m., the corporated of the completed in the factor of the completed nurse in the facility. She stated test. She was provided with document to the documentation on the MAR supposed to be in charge along with time writing a MAR as the green part have completed the admission prothe orders should have been sent the sent. She stated Res #152 should She stated she did not perform an care did not happen. She stated she on [DATE] at 3:32 p.m., the admin DON and had been running ads for the completed as soon as they enter the issues documented, and hospital did residents to be assessed and rece to discuss new admissions to ensure was discussed during the morning records of these meetings.	ated there was not a system in place to the nurses did not double check any double check and the nother issues with the resident at the ADS coordinator stated she remembered evital signs in the EHR. She stated she charted the progress note on [DATE] or responsible for completing the 48 hour practical completing the 48 hour pr	to Res #152's room to place a at they requested another blanket for at time. She did not provide a date and the she had assisted him by feeding him. When the resident expired. She reare plan.  The facility and she was the highest of the she had assisted the she had assisted him by feeding him. When the resident expired. She reare plan.  The facility and she was the highest of the she performed a COVID-19 of the stated the ADON was considered the ADON was considered the should acce. She stated the white copy of the stated the white copy of the see if his medications were ever since he was a skilled resident. If the documentation was blank the a week.  The advertisement for an RN and RN in the stated he expected the facility has a morning meeting the facility has a morning meeting the sidelity only sometimes kept written and the facility only sometimes kept written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. Building	(X3) DATE SURVEY COMPLETED	
	375243	B. Wing	09/19/2022	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
Jan Frances Care Center		815 North Country Club Road Ada, OK 74820		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	MENT OF DEFICIENCIES st be preceded by full regulatory or LSC identifying information)		
F 0760	Ensure that residents are free from significant medication errors.			
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387			
safety  Residents Affected - Some	ensure residents were free of signif	On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure ensure residents were free of significant medication errors. Res #152 admitted to the facility on [DATE] for		
	skilled nursing services with orders including midodrine (a medication that raises blood pressure) 10 mg three times daily. Medication administration records documented Res #152 did not receive this medication at any time during his admission. Res #152 expired in the facility four days after admission. During the course of the investigation, five additional residents (#3, 14, 34, 40, and #56) were found to have significant medication errors.			
	On [DATE] at 1:13 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation related to a significant medication error for Res #152			
	On [DATE] at 1:19 p.m., the admin	istrator was notified of the IJ situation.		
	On [DATE] at 9:32 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented:			
	[DATE]			
	Jan [NAME] Care Center			
	Plan of Removal for 4 IJs Completion Date [DATE] 11:00 p.m.			
	All education will be done by the Re	egional Nurse, [name deleted], and [na	me deleted], Regional Director.	
	All Staff Education			
	Abuse and Neglect Policy & Proceed participants through group discussion	dures. Identify types of abuse and neglion.	ect with feedback from the	
	Clinical Staff Education			
		Procedure. Discussed medication available dications. Reviewed the process for significant process.		
	_	d the importance of obtaining vitals sign nd skilled documentation when required		
	Resident Assessment/Change of Condition/Interventions. Reviewed the importance of resident assessments for new admissions, readmissions, and when the resident has a change of condition. Reviewed appropriate and timely interventions.			
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375243	A. Building B. Wing	09/19/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Jan Frances Care Center		815 North Country Club Road Ada, OK 74820	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760  Level of Harm - Immediate jeopardy to resident health or	ADL Documentation. Handout given to all participants. Reviewed what ADLs are and how to document them each shift. Discussed the importance of accurate coding. Reviewed person-centered care and resident independence when possible. Reviewed decline in function and range of motion.  Skilled Nursing Documentation- Implemented all residents will be assessed and documented on when they are receiving skilled nursing care on each shift. Reviewed skill documentation guidelines. Instructed the nurses where their nursing resource book is at the nurses station and the importance of referring to it when the need arises.		
safety  Residents Affected - Some			
	Upon completion of the immediate corrections; audits and observations will continue by the DON or designee for 60 days.		
	Audit Skilled Nursing Documentation		
	Surveillance Monitoring on all Resi	dents	
	Medication Administration/Documentation Observation. Audit of all medications to ensure availability, accuracy of physician orders, and accuracy of medication administration records.		
	Nurse assessment on all Residents	s for change of condition, decline in fun	ction, and appropriate interventions.
	Audit ADL Documentation		
	Regional Nurse will assume the Interim DON position immediately. She is currently at the facility. An additional RN has been hired for two days a week to relieve the DON, to ensure 7 day a week RN coverage.		
	On [DATE] and [DATE], interviews were conducted with nursing staff regarding education and in-service information pertaining to the immediate jeopardy plan of removal. The staff stated they had been in-serviced and were able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal. Documentation was provided related to the medication cart and ADL documentation audits.		
	The IJ was lifted, effective [DATE] completed. The deficiency remained	at 5:58 p.m., when all components of the	ne plan of removal had been
		ew, and interview, the facility failed to 6 (#3, 14, 34, 40, 56, and #152) of 13 re	
	The Residents Census and Conditi	ons of Residents form documented 53	residents resided in the facility.
	Findings:		
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022	
NAME OF PROVIDER OR SUPPLII	NAME OF PROVIDED OR CURRULED		P CODE	
		STREET ADDRESS, CITY, STATE, ZI 815 North Country Club Road	PCODE	
Jan Frances Care Center		Ada, OK 74820		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0760 Level of Harm - Immediate	An undated facility policy, titled Charting and Documentation read in part, .All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.			
jeopardy to resident health or safety		An undated facility policy, titled Medication Errors and Drug Reactions read in part, .Report all medication errors and drug reactions immediately to the attending physician, Director of Nursing Service and		
Residents Affected - Some	A undated facility policy titled Identifying and Managing Medication Errors and Adverse Consequences read in parts, .The staff and practioner shall try to prevent medication errors and adverse medication consequences, and shall strive to identify and manage them appropriately when they occur .1. A Nurse or Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR) .2. Administration of medication must be documented immediately after (never before) it is given .			
	1. Resident #152 admitted to the facility on [DATE] with diagnoses including interstitial pulmonary disease, acute respiratory failure with hypercapnia, COPD, atherosclerotic heart disease, history of TIA and cerebral infarction, acute kidney failure, hydronephrosis with renal and ureteral calculus obstruction, muscle weakness, and dementia.			
	studies. AC therapy discussed with work-up indicated. PFTs as able .d tamsulosin/finasteride therapy. Rec Lovenox 40 mg SQ daily. Continue therapeutic Lovenox BID 1mg/kg d dose per provider discretion .7. Act	and in parts, .was found to have DVT in a pharmacy and detailed below .For folloischarged with Foley for significant urin commend routine Foley replacement ar until Cr improves. Monitor BMP daily. osing. Monitor for signs of bleeding. Chate respiratory failure with hypoxia and on room air trial .8. Hemorrhagic shock	ow-up provider .Further COPD arry retention and and monitoring of kidney function . When Cr clearance, do full dose neck Xa level ,d+[DATE]hrs post hypercapnia .To need home O2 on	
	An LTC -Admission Assessment/O assessment or observations docum	bservation Documentation form, dated nented.	[DATE], had no resident	
	skilled nursing care via a private verequired two staff to transfer into be disoriented. The note documented congestion. The resident was incorrissues measured. The note docum	TE] at 6:00 p.m., documented Res #15 shicle by his family. He was assisted to ed. The resident was alert and oriented the resident had even and non-labored nitinent of bowel and bladder. Skin integented the resident required assistance he resident's vital signs. The progress rethe presence of a Foley catheter.	a room via wheelchair and times one, confused, and respirations without cough or prity was documented and noted with all ADLs, and must be spoon	
	anticipate the resident's needs and breathing treatments; monitor lab w assess vital signs; monitor endurar	on form, dated [DATE], documented into observe for non-verbal cues; administrative as ordered; monitor for signs/sympace/complications; monitor edema; mor uration every shift; assess for pain; and	er medications as ordered; perform otoms of bleeding; monitor pain; hitor for signs/symptoms of heart	
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Jan Frances Care Center		815 North Country Club Road	r CODE
dan Frances date Schief		Ada, OK 74820	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760	A MAR, dated [DATE] to [DATE], documented the facility was to administer diclofenac 1% topical, apply two grams to affected area four times daily. There were no documented administrations of this medication.		
Level of Harm - Immediate jeopardy to resident health or	A respiratory flowsheet dated IDA	ΓΕ] to [DATE] was provided to surveyo	rs on [DATE]. It documented
safety	revefenacin 175 mcg nebulization of	daily. This medication was not docume	nted as administered on [DATE].
Residents Affected - Some	The respiratory flowsheet documented to administer Brovana 15 mcg nebulization twice daily at 08:00 a.m. and 08:00 p.m. This medication was not documented as administered on [DATE] for the p.m. dose and [DATE] for the a.m. or p.m. dose.		
	A TAR, dated [DATE] to [DATE] was provided to surveyors on [DATE]. It documented to clean left heel blister with normal saline, apply skin prep twice per day. The [DATE] morning treatment was not documented as administered.		
	A MAR, dated [DATE] to [DATE], documented the facility was to administer:		
	- gabapentin 60 mg two capsules at bedtime,		
	- meloxicam 15 mg one tablet ever	y day,	
	- midodrine 10 mg three times daily		
	- polyethylene glycol one packet two times daily,		
	- Senokot two tablets twice daily,		
	- tamsulosin 0.4 mg at bedtime,		
	- calcium carbonate one tablet twic	e daily,	
	- cholecalciferol 1000 units daily,		
	- finasteride 5 mg daily,		
	- folic acid 1 mg daily,		
	- Theragran-m one tablet daily, and	I	
	- thiamine 100 mg daily.		
	There were no documented admini	strations for any of the above medicati	ons.
	required limited assistance of one sextensive assistance of two staff for had limited range of motion in both shortness of breath with exertion, vand received oxygen therapy.	ated [DATE], documented the resident staff for bed mobility, locomotion, dress r transfers and toilet use; extensive as: lower extremities, was always incontinuous thing, and when lying flat, receivable.	ing, eating, and personal hygiene; sistance of one staff for bathing, ent of bowel and bladder, had
	(continued on next page)		

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center  STREET ADDRESS, CITY, STATE, ZIP CODE  815 North Country Club Road Ada, OK 74820		P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG		IMMARY STATEMENT OF DEFICIENCIES ach deficiency must be preceded by full regulatory or LSC identifying information)	
F 0760  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	A nursing progress note, dated [DATE] at 6:11 p.m., documented therapy staff notified a nurse Res #152 needed to be assessed. The note documented when the nurse assessed the resident a temperature of 97.8 degrees F was obtained and a blood pressure could not be obtained. The note documented the nurse contacted EMS to transfer resident to the emergency room. The note documented Res #152 expired before emergency personnel arrived to the facility.  A State of Oklahoma Certificate of Death, dated [DATE], documented Res #152's immediate cause of death as cardiac arrest, with acute respiratory failure documented as a condition that lead to death, and interstitial pulmonary disease documented as the underlying cause of death. The death certificate documented other significant conditions contributing to death as chronic obstructive pulmonary disease.  On [DATE] at 2:25 p.m., CNA #3 stated Res #152 wasn't in the facility very long, but she remembered he		
	stated two days after the resident a shortly after. She stated she would care or being neglected. She stated neglect for Res #152.  On [DATE] at 7:58 a.m., the ADON under his feet. She stated he had foresident. She stated there were no this interaction.	itted and was eating well. She stated the dmitted to the facility he stopped eating have reported it to the nurse if she felt of she did not notify the nurse for any column and the time and requestion of the resident at that the coordinator stated she remembered Resident at the coordinator stated she remembered Resident at the state of the remembered Resident at t	g and responding to staff and died like a resident was not receiving nange in condition or suspicion of as #152's room to place a pillow ested another blanket for the me. She did not provide a date for
	on [DATE] at 10:15 a.m., corporate level nurse in the facility. She state was provided with documentation f documentation on the MAR the me be in charge along with the charge MAR as the green page on the car the admission process and ensure have been sent to the pharmacy at Res #152 should have had a full as documentation was blank the care  On [DATE], the facility provided ad pharmacy drug order fill sheet which	ditional documentation for Res #152's ch documented Res #152's blood thinned I MAR, a progress note from the physic	the resident expired.  The facility and she was the highest when she Covid tested him. She ew. She stated according to the stated the ADON was supposed to not have wasted their time writing a stated they should have completed he white copy of the orders should ations were ever sent. She stated killed resident. She stated if the medical record. These included: a er, Lovenox, had been delivered to
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022	
NAME OF PROVIDER OR SUPPLII	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		P CODE	
Jan Frances Care Center		815 North Country Club Road Ada, OK 74820		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	EFICIENCIES d by full regulatory or LSC identifying information)		
F 0760  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	completed as soon as they enter the issues documented, and hospital differentiation residents to be assessed and receit to discuss new admissions to ensu	4 a.m., the administrator stated he expected a new admission to have their documentation as they enter the facility including: a full head to toe assessment, orders entered, skin d, and hospital discharge documentation reviewed as applicable. He stated he expected sessed and received medications as ordered. He stated the facility has a morning meeting missions to ensure the process is followed. He was unsure if a record was kept of what ring the morning meeting regarding Res #152 since the facility only		
Residents Affected - Some	2. Resident #14 had diagnoses wh	ich included hypertension, heart failure	, and edema.	
	A physician order, dated [DATE], documented to give carvedilol 6.25 mg by mouth twice per day and hold medication for systolic blood pressure below 100, diastolic blood pressure under 60, and heart rate below 5			
	Physician orders, dated [DATE], documented to give Eliquis 2.5 mg twice per day and documented nursing was to monitor residents on anticoagulants for bleeding every shift.			
	An annual MDS, dated [DATE], documented the resident was severely cognitively impaired and received anticoagulants seven out of seven days during the review period.		gnitively impaired and received	
	On [DATE] at 8:20 a.m., CMA #1 was observed during medication pass taking VS for Res #14 which included a blood pressure reading of ,d+[DATE]. The CMA stated that she was going to hold the resident's blood pressure medication because of the reading. The CMA prepared the medications and included the carvedilol. The medications passed did not include the resident's dose of Eliquis.		e was going to hold the resident's e medications and included the	
	available in the cart and had to be	On [DATE] at 4:12 p.m., CMA #1 stated that she did not give the Eliquis for Res #14 because it was not available in the cart and had to be ordered from the pharmacy. She stated she should have held Res #14's carvedilol based on the blood pressure reading.  On [DATE] at 10:02 a.m., the corporate RN stated for medications that were not on the cart the staff should have gone into their cubbies in the medication room to make sure it was not in there, then check to see if it was ordered, and if ordered, check if it was delivered and look for it. She stated if a resident had an out of parameter blood pressure reading the medication should have been held and the nurse notified so that it could be re-checked.		
	have gone into their cubbies in the was ordered, and if ordered, check parameter blood pressure reading			
	34945			
	3. Res #56 had diagnoses which in	cluded diabetes mellitus.		
	A physician order, dated [DATE], documented the facility was to administer Levemir FlexTouch U-100 insulin pen, 60 units subcutaneous twice a day.			
	A physician order, dated [DATE], d subcutaneous before meals.	ocumented the facility was to administe	er Novolog Flexpen Insulin, 25 units	
	-	DATE], documented the resident was in essment documented the resident had		
	(continued on next page)			

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243  an to correct this deficiency, please contents	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing  STREET ADDRESS, CITY, STATE, ZII  815 North Country Club Road Ada, OK 74820	(X3) DATE SURVEY COMPLETED 09/19/2022 P CODE
	815 North Country Club Road	P CODE
an to correct this deficiency, please cont	•	
an to correct this deficiency, please cont		
	act the nursing home or the state survey a	agency.
SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
A nurse note, dated [DATE] at 8:50 #56. The note documented the nurs was notified and the resident was s On [DATE] at 2:54 p.m., Res #56 w because the facility administered to On [DATE] at 9:51 a.m., the corpora documented the staff member who medication administration.  Res #56's insulin records were revire [DATE], [DATE], [DATE], and [DAT administered on [DATE] before breameal. One dose on [DATE] documents insulin was given.  On [DATE] at 10:28 a.m., the ADOI were not documented they were not the resident should have received 2 significant error.  4. Res #34 had diagnoses which in infection.  A physician order, dated [DATE], do anticonvulsant medication sometim pain. A review of the [DATE] MAR of [DATE], and [DATE].  A physician order, dated [DATE], do medication) 2.5 mg twice a day for [DATE] MAR did not document Eliq [DATE].  A physician order, dated [DATE], do medication) 50 mg daily for a diagn document sertraline was administer.  A physician order, dated [DATE], do medication) 5 mg three times daily. on [DATE], [DATE], [DATE], [DATE] for both the 8:00 a.m. and the 2:00 [DATE] MAR did not document Bust	p.m., documented a nurse had administe gave Novalog insulin instead of Level ent to the hospital.  as observed sitting in her room. She sto much insulin.  ate director of operations provided a coself reported the insulin error had been ewed and the records did not documented, for the evening dose. The records of akfast, [DATE] before the noon meal, a ented the resident's blood sugar was 11 of the very limited the resident's blood sugar was 12 of the insulin error had been expected to the noon meal, a sented the facility was to administered. She confirmed on the cost of the commented the facility was to administe es used for chronic pain, long term use of a commented the facility was to administe es used for chronic pain) 300 mg twice a diagnosis of long term (current) use of the commented the facility was to administe a diagnosis of long term (current) use of the commented the facility was to administered on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [Date],	istered the wrong insulin to Resemir. The note documented the PA stated she had to go to the hospital and to go to the incident report which in in-serviced on the five rights of and the Levemir was administered on the did not document Novolog was and [DATE] before the evening 10 prior to the noon meal and no go and stated if the missing doses that of [DATE] at the noon dose, dered. She stated this was a stated in the interest of the stated this was a state of [DATE] and urinary tract and go to g
	documented the staff member who medication administration.  Res #56's insulin records were revie [DATE], [DATE], [DATE], and [DAT administered on [DATE] before breameal. One dose on [DATE] docume insulin was given.  On [DATE] at 10:28 a.m., the ADON were not documented they were not the resident should have received 2 significant error.  4. Res #34 had diagnoses which incompains a review of the [DATE], do anticonvulsant medication sometim pain. A review of the [DATE] MAR of [DATE], and [DATE].  A physician order, dated [DATE], do medication) 2.5 mg twice a day for a [DATE] MAR did not document Eliq [DATE].  A physician order, dated [DATE], do medication) 50 mg daily for a diagnocument sertraline was administer a physician order, dated [DATE], do medication) 5 mg three times daily. on [DATE], [DATE], [DATE], [DATE] for both the 8:00 a.m. and the 2:00 [DATE] MAR did not document Bus [DATE] for both the 8:00 a.m. and the 2:00 [DATE] for both the 8:00 a.m. and	documented the staff member who self reported the insulin error had beer medication administration.  Res #56's insulin records were reviewed and the records did not document [DATE], [DATE], [DATE], and [DATE], for the evening dose. The records of administered on [DATE] before breakfast, [DATE] before the noon meal, a meal. One dose on [DATE] documented the resident's blood sugar was 11 insulin was given.  On [DATE] at 10:28 a.m., the ADON reviewed the [DATE] diabetic records were not documented they were not administered. She confirmed on the other esident should have received 25 units of Novolog as the physician or significant error.  4. Res #34 had diagnoses which included chronic pain, long term use of a infection.  A physician order, dated [DATE], documented the facility was to administe anticonvulsant medication sometimes used for chronic pain) 300 mg twice pain. A review of the [DATE] MAR did not document gabapentin was administed medication) 2.5 mg twice a day for a diagnosis of long term (current) use of [DATE], and [DATE].  A physician order, dated [DATE], documented the facility was to administed medication) 5.5 mg twice a day for a diagnosis of long term (current) use of [DATE] MAR did not document Eliquis was administered on [DATE], [DATE].  A physician order, dated [DATE], documented the facility was to administed medication) 5.0 mg daily for a diagnosis of depressive episodes. A review of document sertraline was administered on [DATE], [DATE], [DATE], and [DATE],

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  815 North Country Club Road Ada, OK 74820	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey :	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0760  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	medication) twice daily for 10 days administered on [DATE], [DATE], a 5. Res #3 had diagnoses which incepisode severe with psychotic diso and abnormal weight loss.  A physician order, dated [DATE], designed medication sometimes used to increase weight loss. A [DATE] MAR did not [DATE], [DATE], through [DATE], [IDATE], and [DATE], through [DATE], designed medication) 2 mg twice a day. A result of the morning doses on [DATE], [DATE], and [DATE], and [DATE], and [DATE], and [DATE], designed medication) 1 ml every four hours of did not document Ativan Gel was a doses on [DATE], [DATE] and [DATE]. The dose on [DATE], and [DATE]. The dose on [DATE], and [DATE]. The dose on [DATE] and [DATE]. The p.m., and 8:00 p.m., on [DATE] was a physician order, dated [DATE], and [DATE], and [DATE] was a physician order, dated [DATE], and [DATE], [DATE], and [DATE], and [DATE], and [DATE], and [DATE] was a dispersion order, dated [DATE], and and an instead on [DATE], and an instead on an	luded restlessness and agitation, majorder, unspecified symptoms involving concumented the facility was to administered adocument Remeron was administered DATEJ, [DATE], and [DATE]. A review of the [DATE], and the evening occumented the facility was to administered or a diagnosis of restlessness and agit administered for all doses on [DATE], and [DATE], and [DATE], [DATE]	r depressive disorder single ognitive functions and awareness, or Remeron (an antidepressant daily for a diagnosis of abnormal on [DATE], [DATE], [DATE], E] through [DATE]. A review of the ATE], [DATE], [DATE] MAR did not document dose of [DATE].  For Ativan Gel (an antianxiety ation. A review of the [DATE] MAR and the 8:00 a.m. and 12:00 p.m. ot document Ativan gel was [DATE], [DATE], [DATE], [DATE], not administered at the 12:00 p.m. van at 08:00 a.m., 12:00 p.m., 4:00 for Risperdal 0.5 mg once a day at sperdal was administered on lid not document the noon dose of the was an issue with medications of medications such as insulin or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022	
NAME OF PROVIDER OR SUPPLIER  Jan Frances Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  815 North Country Club Road Ada, OK 74820		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)	
F 0760  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	A physician order, dated [DATE] and continued on [DATE], read in part, Novolog U-100 Insulin aspart (insulin aspart u-100) solution; 100 unit/mL; amt: Per Sliding Scale; If Blood Sugar is less than 60, call MD. If Blood Sugar is 101 to 120, give 3 Units. If Blood Sugar is 121 to 150, give 4 Units. If Blood Sugar is 151 to 200, give 5 Units. If Blood Sugar is 201 to 250, give 8 Units. If Blood Sugar is 251 to 300, give 10 Units. If Blood Sugar is 301 to 350, give 12 Units. If Blood Sugar is 351 to 400, give 16 Units. If Blood Sugar is greater than 400, call MD. subcutaneous Three Times A Day 07:00 AM, 11:30 AM, 04:30 PM  A five day assessment, dated [DATE], documented the resident was intact with cognition and required			
	extensive assistance with most ADLs. The assessment documented the resident received insulin four days during the look back period.  A care plan, last reviewed [DATE], documented Res #40 had a diagnosis of diabetes and required insulin as			
	ordered to manage. The care plan documented to administer medications and insulins as ordered.  Review of the diabetic flow sheets for Res #40, dated [DATE] - [DATE], reveled six missed doses of Novolog 5 units to be given with meals.			
		e diabetic flow sheet documented a BS resident should have received 4 units.		
	On [DATE] on the evening shift, the diabetic flow sheet documented a BS of 236 with 4 units of insulin given. The sliding scale order documented the resident should have received 8 units.  A physician order, dated [DATE], documented to administer Lantus (a type of insulin) 18 units subcutaneous twice daily.			
	On [DATE] on the morning shift, the diabetic flow sheets, documented a BS of 253 and the resident was administered 5 units of Novolog insulin. The sliding scale order documented the resident should have received 10 units.			
	Lantus insulin was not documented	s insulin was not documented as being administered on [DATE] and [DATE].		
	On [DATE] at 10:20 a.m., LPN #2 stated with a BS of 253, the resident should have received 10 units when it documented 5 units was given. The LPN stated with a BS of 236, the resident should have been given 8 units and was given 4 units. The LPN stated with a BS of 121, the resident was given zero units and should have received 4 units. LPN #2 stated it looked like it was two different nurses who had made the insulin errors. LPN #2 stated the errors were significant medication errors. The LPN stated when there are blanks for the insulin on the MAR, if it was not documented given it was not done.			

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NAME OF PROVIDER OF CURRUES		STREET ARRESTS OF CHARLES TO SORE	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  815 North Country Club Road	
Jan Frances Care Center		Ada, OK 74820	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0835	Administer the facility in a manner that enables it to use its resources effectively and efficiently.		
Level of Harm - Minimal harm or	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 34945
potential for actual harm  Residents Affected - Many	Based on record review, observation, and interview, the facility failed to have an effective administration to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure:  a. residents were not in common areas of the facility while wearing hospital gowns instead of appropriate clothing and foot coverings.  b. grievances presented during resident council meetings were acted on or provide rationale as to why concerns could not be met.  c. advanced directives (Do Not Resuscitate) were completed to include the required signatures.  d. residents were free from neglect.  e. resident assessments accurately reflected the resident status.  f. a registered nurse reviewed, dated, signed, and transmitted the resident assessments to CMS when completed.  g. baseline care plans were intimated and to provide a copy of the care plan to residents and/or their representatives.  h. comprehensive care plans were developed which reflected the residents' current status.		
		ensure residents' care plans were reviewed and updated and failed to ensure the resident and/or presentative participation in the care plan process.	
	j. to assess, monitor, and provide interventions for residents reviewed for quality of care.		quality of care.
	k. resident's fall was investigated and steps to prevent recurrence of falls.		
	I. residents with an indwelling catheter received the appropriate care and services to prevent urinary tract infections.		
m. respiratory orders were followed.			
	n. assess and monitor for pain every shift according to the plan of care.		
	o. the staff performed ongoing assessment and oversight of the resident after dialysis treatments.		
	p. to monitor blood pressures before administering medications which were ordered with blood pressure monitoring.		
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375243	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2022	
NAME OF PROVIDER OR CURRULES		CTREET ARRESC SITUATION CORE		
	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  815 North Country Club Road	
Jan Frances Care Center		Ada, OK 74820		
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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 0835	q. behaviors and side effects monitoring related to the administration of psychotropic medications were conducted.			
Level of Harm - Minimal harm or potential for actual harm	r. a medication error rate below five	e percent.		
Residents Affected - Many	s. residents were free of significant	medication errors.		
	t. expired supplies and medications	s were disposed of.		
	u. the person designated to serve a	as the DM had a current certification.		
	v. a resident's nutritional preference was accommodated and provide substitutions for food dislikes.			
	w. food was provided which was palatable and at a safe and appetizing temperature.			
	x. food was prepared, stored, and distributed in a sanitary manner.			
	y. residents' medical records were complete, readily accessible, and systematically organized.			
	z. the facility employed the services of a qualified social worker on a full time basis.			
	The Resident Census and Conditions of Residents form documented 53 residents resided in the facility.			
	Findings:			
		.m., the administrator stated the facility had 138 licensed beds. The administrator stated ave a qualified social worker on staff.		
	On [DATE] at 10:10 a.m., the corporate RN was shown the missing documentation on the [DATE] and [DATE] MAR. She stated the MAR should not have been blank and this has been a problem with the CMA staff for a while. She stated the facility not having a DON to monitor documentation has contributed to this problem.			
	On [DATE] at 10:15 a.m., corporate RN #1 stated there was no DON at the facility and she was the highest level nurse in the facility. She stated the only time she saw Res #152 was when she performed a COVID-19 test. She was provided with documentation from Res #152's medical record to review. She stated according to the documentation on the MAR the medications were not administered. She stated the ADON was supposed to be in charge along with the charge nurses. She stated the nurses should not have wasted their time writing a MAR as the green page on the carbon copy was a temporary MAR. She stated they should have completed the admission process and ensured everything was in place. She stated the white copy of the orders should have been sent to the pharmacy and she would check to see if his medications were ever sent. She stated Res #152 should have had a full assessment every shift since he was a skilled resident. She stated she did not perform an assessment on Res #152. She stated if the documentation was blank the care did not happen. She stated she was normally at the facility two days a week.			
	(continued on next page)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0835  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	stated he was present for the [DAT responded to grievances presented personally talk to the individual resignievance. The administrator denie interventions acted upon to resolve rationale of how the grievances we On [DATE] at 12:47 p.m., the MDS did not document a baseline care padmitted and the initial assessmen plan. She stated the facility needed coordinator stated the resident or rewas unaware the baseline care pla On [DATE] at 10:24 a.m., the admit completed as soon as they enter the issues documented, and hospital diresidents to be assessed and recei	coordinator reviewed Res #60's clinical lan was completed. The MDS coordinate was done, the admission nurse should to have someone to monitor this to experience the representative was to get a copy of the naws to contain the physician orders, nistrator stated he expected a new admits facility including a full head to toe as ischarge documentation reviewed as a ve medications as ordered. He stated re the process is followed. He was unstantial to the process is followed.	gs. He was asked how he e meeting minutes and tried to nat could be done to resolve the or having documentation of the did not keep documentation of the all records and stated the records ator stated when a resident was done have completed a baseline care naure it was done. The MDS baseline care plan. She stated she treatments, diet order, and therapy. The mission to have their documentation applicable. He stated he expected the facility has a morning meeting