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, ZIP 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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents were free from neglect. Res #152 admitted to the facility from the hospital on [DATE] for skilled nursing services. 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. On [DATE] at 1:13 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On [DATE] at 1:19 p.m., the administrator was notified of the IJ situation related to neglect for Res #152. 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 Regional Nurse, [name deleted], and [name deleted], Regional Director. All Staff Education Abuse and Neglect Policy & Procedures. Identify types of abuse and neglect with feedback from the participants through group discussion. Clinical Staff Education (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Medication Administration Policy & Procedure. Discussed medication availability, timely administration of all medications, resident refusal of medications. Reviewed 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/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. 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 Surveillance Monitoring on all Residents 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 for change of condition, decline in function, 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 carts and ADL documentation audits. The IJ was lifted, effective [DATE] at 5:58 p.m., when all components of the plan of removal had been completed. The deficiency remained at a isolated level of actual harm. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. The Residents Census and Conditions 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 necessary 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 . 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 . An undated facility policy, titled Activities of Daily Living, read in parts, .It 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 documented staff received training on neglect on [DATE], [DATE], and [DATE]. 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 urethral calculus obstruction, muscle weakness, and dementia. 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 post dose per provider discretion .7. Acute respiratory failure with hypoxia and hypercapnia .To need home O2 on discharge. Desats to low-mid 80's on room air trial .Hemorrhagic shock .Continue Midodrine 10mg TID . (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurses progress note, dated [DATE] at 6:00 p.m., documented Res #152 was transferred to the facility for skilled nursing care via a private vehicle by his family. He was assisted to a room via wheelchair and required two staff to transfer into bed. The resident was alert and oriented times one, confused, and disoriented. The note documented the resident had even and non-labored respirations without cough or congestion. The resident was incontinent of bowel and bladder. Skin integrity was documented and noted issues measured. The note documented the resident required assistance with all ADLs, and must be spoon fed meals. The note documented the resident's vital signs. The progress note did not include documentation of supplemental oxygen therapy or the presence of a Foley catheter. An LTC -Admission Assessment/Observation Documentation form, dated [DATE], had no resident observations or assessments documented. A LTC - 48 Hour Baseline Care Plan form, dated [DATE], documented interventions which included the following: anticipate the resident's needs and observe for non-verbal cues; consult PT, OT, ST as needed; provide one staff assist with bathing/hygiene; provide one staff assist with dressing/grooming; provide one staff assist with eating; provide one to two staff assist with toileting; provide two staff assist with ambulation/transferring; administer medications as ordered; assess, monitor; and document mood; keep call bell in reach and encourage use; weigh weekly for four weeks; monitor meal percentages; encourage fluids; monitor for signs/symptoms of dehydration; obtain laboratory work as ordered; provide hydration per guidelines; monitor for edema/dyspnea; perform oral care twice daily; turn every two hours and as needed; report to charge nurse any redness/skin breakdown immediately; perform breathing treatments; monitor lab work as ordered; monitor for signs/symptoms of bleeding; monitor pain; assess vital signs; monitor endurance/complications; monitor edema; monitor for signs/symptoms of heart failure and dyspnea; check O2 saturation every shift; assess for pain; and assess for constipation. 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. 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 flowsheet 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 documented from [DATE] to [DATE]. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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, 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)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 if the documentation was blank the care did not happen. On [DATE], the facility provided additional documentation for Res #152's medical record. These included: a pharmacy drug order fill sheet which documented Res #152's blood thinner had been delivered to the facility on [DATE], an additional MAR, a progress note from the physician dated [DATE], and a progress note from the physician assistant dated [DATE]. On [DATE] at 10:24 a.m., the administrator stated he expected a new admission to have their documentation completed as soon as they enter the facility including a full head to toe assessment, orders entered, skin issues documented, and hospital discharge documentation reviewed as applicable. He stated he expected residents to be assessed and receive medications as ordered. He stated the facility has a morning meeting to discuss new admissions to ensure the process is followed. He was unsure if a record was kept of what was discussed during the morning meeting regarding Res #152 since the facility only sometimes kept written records of these meetings.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to assess, monitor and provide interventions for Res #152. Res #152 admitted to the facility from the hospital on [DATE] for skilled nursing services. 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. On [DATE] at 1:13 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On [DATE] at 1:19 p.m., the administrator was notified of the IJ situation related to quality of care for Res #152. 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 Regional Nurse, [name deleted], and [name deleted], Regional Director. All Staff Education Abuse and Neglect Policy & Procedures. Identify types of abuse and neglect with feedback from the participants through group discussion. Clinical Staff Education Medication Administration Policy & Procedure. Discussed medication availability, timely administration of all medications, resident refusal of medications. Reviewed 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/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)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 Residents 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 for change of condition, decline in function, 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] at 5:58 p.m., when all components of the plan of removal had been completed. The deficiency remained at a isolated level of actual harm. Based on record review and interview, the facility failed to assess, monitor, and provide interventions for one (#152) of seven residents reviewed for quality of care. 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. The Residents Census and Conditions of Residents form documented 53 residents resided in the facility. Findings: (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 . 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 . An undated facility policy, titled Activities of Daily Living, read in parts, .It 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 documented staff received training on neglect on [DATE], [DATE], and [DATE]. 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. 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 post dose per provider discretion .7. Acute respiratory failure with hypoxia and hypercapnia .To need home O2 on discharge. Desats to low-mid 80's on room air trial .Hemorrhagic shock .Continue Midodrine 10mg TID . A nurses progress note, dated [DATE] at 6:00 p.m., documented Res #152 was transferred to the facility for skilled nursing care via a private vehicle by his family. He was assisted to a room via wheelchair and required two staff to transfer into bed. The resident was alert and oriented times one, confused, and disoriented. The note documented the resident had even and non-labored respirations without cough or congestion. The resident was incontinent of bowel and bladder. Skin integrity was documented and noted issues measured. The note documented the resident required assistance with all ADLs, and must be spoon fed meals. The note documented the resident's vital signs. The progress note did not include documentation of supplemental oxygen therapy or the presence of a Foley catheter. An LTC -Admission Assessment/Observation Documentation form, dated [DATE], had no resident observations or assessments documented. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A LTC - 48 Hour Baseline Care Plan form, dated [DATE], documented interventions which included the following: anticipate the resident's needs and observe for non-verbal cues; consult PT, OT, ST as needed; provide one staff assist with bathing/hygiene; provide one staff assist with dressing/grooming; provide one staff assist with eating; provide one to two staff assist with toileting; provide two staff assist with ambulation/transferring; administer medications as ordered; assess, monitor; and document mood; keep call bell in reach and encourage use; weigh weekly for four weeks; monitor meal percentages; encourage fluids; monitor for signs/symptoms of dehydration; obtain laboratory work as ordered; provide hydration per guidelines; monitor for edema/dyspnea; perform oral care twice daily; turn every two hours and as needed; report to charge nurse any redness/skin breakdown immediately; perform breathing treatments; monitor lab work as ordered; monitor for signs/symptoms of bleeding; monitor pain; assess vital signs; monitor endurance/complications; monitor edema; monitor for signs/symptoms of heart failure and dyspnea; check O2 saturation every shift; assess for pain; and assess for constipation. 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. 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 documented 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, 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 if the documentation was blank the care did not happen. (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, ZIP 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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the facility provided additional documentation for Res #152's medical record. These included: a pharmacy drug order fill sheet which documented Res #152's blood thinner had been delivered to the facility on [DATE], an additional MAR, a progress note from the physician dated [DATE], and a progress note from the physician assistant dated [DATE]. On [DATE] at 10:24 a.m., the administrator stated he expected a new admission to have their documentation completed as soon as they enter the facility including a full head to toe assessment, orders entered, skin issues documented, and hospital discharge documentation reviewed as applicable. He stated he expected residents to be assessed and receive medications as ordered. He stated the facility has a morning meeting to discuss new admissions to ensure the process is followed. He was unsure if a record was kept of what was discussed during the morning meeting regarding Res #152 since the facility only sometimes kept written records of these meetings.

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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 0727 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure 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. Res #152 admitted to the facility from the hospital on [DATE] for skilled nursing services. 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. There was no registered nurse or DON to manage staff or provide oversight to ensure these tasks were completed seven days per week from [DATE] to [DATE]. Res #152 expired in the facility four days after admission. On [DATE] at 1:13 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation related lack of DON and full-time registered nurse coverage. On [DATE] at 1:19 p.m., the administrator 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 Regional Nurse, [name deleted], and [name deleted] Regional Director. All Staff Education Abuse and Neglect Policy & Procedures. Identify types of abuse and neglect with feedback from the participants through group discussion. Clinical Staff Education Medication Administration Policy & Procedure. Discussed medication availability, timely administration of all medications, resident refusal of medications. Reviewed 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. (continued on next page)

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F 0727 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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. 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 Surveillance Monitoring on all Residents 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 for change of condition, decline in function, 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. Documentation was provided to verify a full time DON and a PRN registered nurse had been hired to provide coverage seven days a week. The IJ was lifted, effective [DATE] at 5:58 p.m., when all components of the plan of removal had been completed. The deficiency remained at a widespread level of actual harm. 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)

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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 0727 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Residents Census and Conditions of Residents form documented 53 residents resided in the facility. Findings: 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. 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 post dose per provider discretion .7. Acute respiratory failure with hypoxia and hypercapnia .To need home O2 on discharge. Desats to low-mid 80's on room air trial .Hemorrhagic shock .Continue Midodrine 10mg TID . A nurse progress note by LPN #5, dated [DATE] at 6:00 p.m., documented Res #152 was transferred to the facility for skilled nursing care via a private vehicle by his family. He was assisted to a room via wheelchair and required two staff to transfer into bed. The resident was alert and oriented times one, confused, and disoriented. The note documented the resident had even and non-labored respirations without cough or congestion. The resident was incontinent of bowel and bladder. Skin integrity was documented and noted issues measured. The note documented the resident required assistance with all ADLs, and must be spoon fed meals. The note documented the resident's vital signs. The progress note did not include documentation of supplemental oxygen therapy or the presence of a urinary catheter. An LTC -Admission Assessment/Observation Documentation form, dated [DATE], had no resident observations or assessments documented by the LPN #5 who opened the document. A LTC - 48 Hour Baseline Care Plan form, dated [DATE], documented interventions which included the following: anticipate the resident's needs and observe for non-verbal cues; consult PT, OT, ST as needed; provide one staff assist with bathing/hygiene; provide one staff assist with dressing/grooming; provide one staff assist with eating; provide one to two staff assist with toileting; provide two staff assist with ambulation/transferring; administer medications as ordered; assess, monitor; and document mood; keep call bell in reach and encourage use; weigh weekly for four weeks; monitor meal percentages; encourage fluids; monitor for signs/symptoms of dehydration; obtain laboratory work as ordered; provide hydration per guidelines; monitor for edema/dyspnea; perform oral care twice daily; turn every two hours and as needed; report to charge nurse any redness/skin breakdown immediately; perform breathing treatments; monitor lab work as ordered; monitor for signs/symptoms of bleeding; monitor pain; assess vital signs; monitor endurance/complications; monitor edema; monitor for signs/symptoms of heart failure and dyspnea; check O2 saturation every shift; assess for pain; and assess for constipation. (continued on next page)

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F 0727 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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. 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 documented 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)

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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 0727 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 2:28 p.m., LPN #3 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 LPN 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 LPN 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. 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. On [DATE] at 3:32 p.m., the administrator stated the facility had placed an advertisement for an RN and RN DON and had been running ads for sometime. On [DATE] at 10:24 a.m., the administrator stated he expected a new admission to have their documentation completed as soon as they enter the facility including a full head to toe assessment, orders entered, skin issues documented, and hospital discharge documentation reviewed as applicable. He stated he expected residents to be assessed and receive medications as ordered. He stated the facility has a morning meeting to discuss new admissions to ensure the process is followed. He was unsure if a record was kept of what was discussed during the morning meeting regarding Res #152 since the facility only sometimes kept written records of these meetings. On [DATE] at 3:06 p.m., the BOM stated the facility had not had a full time RN or DON since [DATE].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 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 administrator 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 Regional Nurse, [name deleted], and [name deleted], Regional Director. All Staff Education Abuse and Neglect Policy & Procedures. Identify types of abuse and neglect with feedback from the participants through group discussion. Clinical Staff Education Medication Administration Policy & Procedure. Discussed medication availability, timely administration of all medications, resident refusal of medications. Reviewed 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/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)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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 Residents 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 for change of condition, decline in function, 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] at 5:58 p.m., when all components of the plan of removal had been completed. The deficiency remained at a pattern level of actual harm. Based on observations, record review, and interview, the facility failed to ensure residents were free of significant medication errors for six (#3, 14, 34, 40, 56, and #152) of 13 residents reviewed for medications. The Residents Census and Conditions of Residents form documented 53 residents resided in the facility. Findings: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 . 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 Administrator . 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. 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 post dose per provider discretion .7. Acute respiratory failure with hypoxia and hypercapnia .To need home O2 on discharge. Desats to low-mid 80's on room air trial .8. Hemorrhagic shock .Continue Midodrine 10mg TID . An LTC -Admission Assessment/Observation Documentation form, dated [DATE], had no resident assessment or observations documented. A nurses progress note, dated [DATE] at 6:00 p.m., documented Res #152 was transferred to the facility for skilled nursing care via a private vehicle by his family. He was assisted to a room via wheelchair and required two staff to transfer into bed. The resident was alert and oriented times one, confused, and disoriented. The note documented the resident had even and non-labored respirations without cough or congestion. The resident was incontinent of bowel and bladder. Skin integrity was documented and noted issues measured. The note documented the resident required assistance with all ADLs, and must be spoon fed meals. The note documented the resident's vital signs. The progress note did not include documentation of supplemental oxygen therapy or the presence of a Foley catheter. A LTC - 48 Hour Baseline Care Plan form, dated [DATE], documented interventions which included anticipate the resident's needs and observe for non-verbal cues; administer medications as ordered; perform breathing treatments; monitor lab work as ordered; monitor for signs/symptoms of bleeding; monitor pain; assess vital signs; monitor endurance/complications; monitor edema; monitor for signs/symptoms of heart failure and dyspnea; check O2 saturation every shift; assess for pain; and assess for constipation. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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 as administered on [DATE]. 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 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. 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 anticoagulant medication, and received oxygen therapy. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jan Frances Care Center	815 North Country Club Road 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 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 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 change in condition or suspicion of neglect for Res #152. 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 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. 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 Covid tested him. 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 shouldn't 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 if the documentation was blank the care did not happen. On [DATE], the facility provided additional documentation for Res #152's medical record. These included: a pharmacy drug order fill sheet which documented Res #152's blood thinner, Lovenox, had been delivered to the facility on [DATE], an additional MAR, a progress note from the physician dated [DATE], and a progress note from the physician assistant dated [DATE]. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:24 a.m., the administrator stated he expected a new admission to have their documentation completed as soon as they enter the facility including: a full head to toe assessment, orders entered, skin issues documented, and hospital discharge documentation reviewed as applicable. He stated he expected residents to be assessed and received medications as ordered. He stated the facility has a morning meeting to discuss new admissions to ensure the process is followed. He was unsure if a record was kept of what was discussed during the morning meeting regarding Res #152 since the facility only 2. Resident #14 had diagnoses which 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 55. 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. 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. 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. 34945 3. Res #56 had diagnoses which included 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], documented the facility was to administer Novolog Flexpen Insulin, 25 units subcutaneous before meals. An admission assessment, dated [DATE], documented the resident was intact in cognition and required limited to total assistance. The assessment documented the resident had a diagnosis of diabetes mellitus. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nurse note, dated [DATE] at 8:50 p.m., documented a nurse had administered the wrong insulin to Res #56. The note documented the nurse gave Novalog insulin instead of Levemir. The note documented the PA was notified and the resident was sent to the hospital. On [DATE] at 2:54 p.m., Res #56 was observed sitting in her room. She stated she had to go to the hospital because the facility administered too much insulin. On [DATE] at 9:51 a.m., the corporate director of operations provided a copy of the incident report which documented the staff member who self reported the insulin error had been in-serviced on the five rights of medication administration. Res #56's insulin records were reviewed and the records did not document Levemir was administered on [DATE], [DATE], [DATE], and [DATE], for the evening dose. The records did not document Novolog was administered on [DATE] before breakfast, [DATE] before the noon meal, and [DATE] before the evening meal. One dose on [DATE] documented the resident's blood sugar was 110 prior to the noon meal and no insulin was given. On [DATE] at 10:28 a.m., the ADON reviewed the [DATE] diabetic records and stated if the missing doses were not documented they were not administered. She confirmed on the date of [DATE] at the noon dose, the resident should have received 25 units of Novolog as the physician ordered. She stated this was a significant error. 4. Res #34 had diagnoses which included chronic pain, long term use of anticoagulants, and urinary tract infection. A physician order, dated [DATE], documented the facility was to administer gabapentin capsule (an anticonvulsant medication sometimes used for chronic pain) 300 mg twice daily for a diagnosis of chronic pain. A review of the [DATE] MAR did not document gabapentin was administered on [DATE], [DATE], [DATE], and [DATE]. A physician order, dated [DATE], documented the facility was to administer Eliquis (an anticoagulant medication) 2.5 mg twice a day for a diagnosis of long term (current) use of anticoagulants. A review of the [DATE] MAR did not document Eliquis was administered on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. A physician order, dated [DATE], documented the facility was to administer sertraline (an antidepressant medication) 50 mg daily for a diagnosis of depressive episodes. A review of the [DATE] MAR did not document sertraline was administered on [DATE], [DATE], [DATE], and [DATE]. A physician order, dated [DATE], documented the facility was to administer Buspar (an antianxiety medication) 5 mg three times daily. A review of the [DATE] MAR did not document Buspar was administered on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] for both the 8:00 a.m. and the 2:00 p.m. shift and the 8:00 p.m. dose on [DATE] and [DATE]. A review of the [DATE] MAR did not document Buspar was administered on [DATE], [DATE], [DATE], and [DATE] through [DATE] for both the 8:00 a.m. and the 2:00 p.m. dose. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A physician order, dated [DATE], documented the facility was to administer Macrobid (an antibiotic medication) twice daily for 10 days. A review of the [DATE] MAR did not document Macrobid was administered on [DATE], [DATE], and [DATE] for the morning dose. 5. Res #3 had diagnoses which included restlessness and agitation, major depressive disorder single episode severe with psychotic disorder, unspecified symptoms involving cognitive functions and awareness, and abnormal weight loss. A physician order, dated [DATE], documented the facility was to administer Remeron (an antidepressant medication sometimes used to increase a patient's appetite) 15 mg once daily for a diagnosis of abnormal weight loss. A [DATE] MAR did not document Remeron was administered on [DATE], [DATE], [DATE], [DATE], [DATE], through [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] through [DATE]. A review of the [DATE] MAR did not document Remeron was administered on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. A physician order, dated [DATE], documented the facility was to administer Risperdal (an antipsychotic medication) 2 mg twice a day. A review of the [DATE] MAR did not document Risperdal was administered on the morning doses on [DATE], [DATE], and [DATE]. A review of the [DATE] MAR did not document Risperdal was administered on [DATE], [DATE], [DATE], and the evening dose of [DATE]. A physician order, dated [DATE], documented the facility was to administer Ativan Gel (an antianxiety medication) 1 ml every four hours for a diagnosis of restlessness and agitation. A review of the [DATE] MAR did not document Ativan Gel was administered for all doses on [DATE], and the 8:00 a.m. and 12:00 p.m. doses on [DATE], [DATE] and [DATE]. A review of the [DATE] MAR did not document Ativan gel was administered for the 8:00 a.m. and 12:00 p.m. doses on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The MAR documented the Ativan dose was not administered at the 12:00 p.m. dose on [DATE] and [DATE]. The MAR did not document the doses of Ativan at 08:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., on [DATE] was administered. A physician order, dated [DATE], documented the facility was to administer Risperdal 0.5 mg once a day at noon. A review of the [DATE] MAR did not document the noon dose of Risperdal was administered on [DATE], [DATE], [DATE], [DATE], and [DATE]. A review of [DATE] MAR did not document the noon dose of Risperdal was administered on [DATE]. On [DATE] at 12:18 p.m., the corporate RN confirmed she was aware there was an issue with medications being administered as ordered. She stated errors or omissions of doses of medications such as insulin or psychotropic medications were considered significant. 38495 5. Res #40 had diagnoses which included diabetes mellitus. A physician order, dated [DATE], documented Novolog administer 5 units subcutaneous with meals. This order was not on the order set, dated [DATE]. (continued on next page)

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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. On [DATE] on the morning shift, the diabetic flow sheet documented a BS of 121 with 0 insulin given. The sliding scale order documented the 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 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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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34945 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. i. ensure residents' care plans were reviewed and updated and failed to ensure the resident and/or representative participation in the care plan process. j. to assess, monitor, and provide interventions for residents reviewed for quality of care. k. resident's fall was investigated and steps to prevent recurrence of falls. l. 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)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	q. behaviors and side effects monitoring related to the administration of psychotropic medications were conducted. r. a medication error rate below five percent. s. residents were free of significant medication errors. t. expired supplies and medications were disposed of. u. the person designated to serve 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: On [DATE] at 2:28 p.m., the administrator stated the facility had 138 licensed beds. The administrator stated the facility did not have 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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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:00 p.m., the administrator was shown the grievances on the resident council minutes. He stated he was present for the [DATE] and [DATE] resident council meetings. He was asked how he responded to grievances presented in the meetings. He stated he read the meeting minutes and tried to personally talk to the individual resident who voiced the concern about what could be done to resolve the grievance. The administrator denied having an official grievance process or having documentation of the interventions acted upon to resolve the residents' concerns. He stated he did not keep documentation of the rationale of how the grievances were or were not addressed. On [DATE] at 12:47 p.m., the MDS coordinator reviewed Res #60's clinical records and stated the records did not document a baseline care plan was completed. The MDS coordinator stated when a resident was admitted and the initial assessment was done, the admission nurse should have completed a baseline care plan. She stated the facility needed to have someone to monitor this to ensure it was done. The MDS coordinator stated the resident or representative was to get a copy of the baseline care plan. She stated she was unaware the baseline care plan was to contain the physician orders, treatments, diet order, and therapy. On [DATE] at 10:24 a.m., the administrator stated he expected a new admission to have their documentation completed as soon as they enter the facility including a full head to toe assessment, orders entered, skin issues documented, and hospital discharge documentation reviewed as applicable. He stated he expected residents to be assessed and receive medications as ordered. He stated the facility has a morning meeting to discuss new admissions to ensure the process is followed. He was unsure if a record was kept of what was discussed during the morning meetings.