STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375303	A. Building B. Wing	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wewoka Healthcare Center	1400 West First Street Wewoka, OK 74884

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33148 Based on observation and interview, the facility failed to ensure: a. comfortable and safe temperature levels, and b. housekeeping and maintenance services to maintain a clean, homelike environment. The Resident Census and Conditions of Residents report, dated 10/21/22, documented 35 residents resided in the facility. Findings: 1. On 10/25/22 at 3:42 p.m., Res #40 was asked if the temperatures in the facility were comfortable. They stated when they were on the COVID unit this month there was no heat. On 10/25/22 at 5:32 p.m., Res #19 who was currently on the COVID unit stated she was cold. She was observed to have one blanket on her bed which she was covered up with. On 10/27/22 at 9:28 a.m., CNA #2 was observed working on the COVID unit in a coat. Res #19 told the CNA she was cold and wanted toe socks because her toes were cold. The CNA came out of the residents room to find her some socks. The temperature in the door way of the resident's room was 68 degrees F . The temperature on the COVID hallway was 69 degrees F. On 10/27/22 at 9:30 a.m., the digital thermostat on the wall on the COVID hall was 63 degrees. A dial thermostat read 64 degrees and was set on 70 degrees. On 10/27/22 at 9:34 a.m., The middle hall of the facility had a temperature ranging from 69 to 70 degrees. It was 72 in dining room, and the east hallway was 74, and west hallway was 72. On 10/31/22 at 12:42 p.m., the maintenance supervisor was asked what temperature the thermostats are set at in the facility. They stated they set them at 70 degrees F for the residents. They were made aware of the temperature observations below 71 degrees F and the resident complaints about being cold. (continued on next page)

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/02/22 at 8:20 a.m., Res #35 stated she was cold and ask for a blanket. She was sitting in her recliner in only a shirt and brief. On 11/02/22 at 9:49 a.m., Res #1 in room [ROOM NUMBER] stated he gets very cold in his room he was laying in the bed with at least four blankets observed and Res #1 stated he could use another one. On 11/02/22 at 10:02 a.m., the temperature in room [ROOM NUMBER] between the resident beds on the floor was 69.7 degrees. 2. On 10/25/22 at 3:20 p.m., room [ROOM NUMBER] on the east front hall was observed to be empty with a bag of clothing on the bed. CNA #1 stated she heard the resident who lived in room [ROOM NUMBER] moved herself back to the back hall. room [ROOM NUMBER] smelled of urine and no one was in the room. On 10/25/22 at 3:25 p.m., the smell of urine was very strong when the door to room [ROOM NUMBER] was opened. Res #5 was observed asleep in a wheelchair just inside the room. On 10/25/22 at 3:42 p.m., Res #40 stated when they were on the COVID unit this month toilets were not working. On 10/26/22 at 8:04 p.m., Res #19's toilet in the bathroom had a dark substance on the lid of the toilet. Another toilet on the COVID unit room [ROOM NUMBER] and 51 was observed to not be in working order. These rooms were not occupied this time. This toilet does not have a seat on it and the lid tot he back was in the floor. The toilet had black/brown substance on and in the toilet. Toilet paper was observed in the toilet and on the floor next to the toilet. On 10/26/22 at 8:17 p.m., observed room [ROOM NUMBER] again. The smell of urine was still strong in the room. There was not a resident currently in the room. On 10/26/22 at 8:35 p.m., the utility closet/hopper room on the front East hall was observed. There was an accumulation of yellow residue and a plastic bag was stored in the hopper sink. There was an accumulation of brown residue on the base of the hopper sink and the floor around the sink. On 10/31/22 at 11:54 a.m., the housekeeping supervisor was asked what areas housekeeping was responsible for cleaning and how often they cleaned. They stated utility closets and resident rooms were a few of the areas they cleaned. They stated they cleaned every room even if it was not occupied. They stated the CNAs cleaned after hours and on the COVID hall. They stated if there were maintenance issues they filled out a form and returned the form to maintenance for repairs. They were made aware of the above observations. On 10/31/22 at 12:42 p.m., the maintenance supervisor was asked about maintenance repairs. They stated staff filled out a form for maintenance repairs. They stated after completion they would write on the form what repairs were done. They stated before COVID they had been working on the hall they put the COVID residents on. They stated there was one toilet on that hall that needs to be replaced. They were made aware of the above observations.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 33148 Based on record review, observation, and interview, the facility failed to ensure a resident was free from injuries of unknown origin for one (#12) of five sampled residents reviewed for accidents. The Resident Census and Conditions of Residents report, dated 10/21/22, documented 35 residents resided in the facility. Findings: The Abuse policy and procedure, updated 07/23/21, read in parts, .IDENTIFYING, INVESTIGATING, & REPORTING .All .injuries of unknown origin .shall be promptly reported to Administrator and investigated by Facility management. Administrator will report the allegation of the Oklahoma State Department of Health . Res #12 had diagnoses which included arthropathy, vascular dementia with behavioral disturbance, and a history of falls. A quarterly resident assessment, dated 07/19/22, documented the resident's cognition was severely impaired. It was documented they required extensive assistance with transfers and ambulation. A nurse's note, dated 09/03/22 at 8:00 a.m., documented the CNA summoned the nurse to the resident's room. It was documented upon entering the resident's room the resident was lying in their bed on their right side. It was documented there was an open laceration to the resident's right eyebrow with a moderate amount of red blood noted in their bed from the site. It was documented the resident was unable to report how the incident occurred and there was blood noted to the bedside table. It was documented the resident complained of pain to their right eyebrow and neuro's were initiated. It was documented the ARNP was notified and there was a new order to send the resident to the ER for evaluation and treatment as indicated. It was documented the administrator was notified at the present time. It was documented the resident left the facility to the ER at 8:35 a.m. A nurse's note, dated 09/03/22 at 10:55 a.m., documented the resident returned from the hospital with new orders for Bactrim (antibiotic medication). It was documented the open area to the resident's head was glued by the ER doctor. On 10/21/22 at 12:08 p.m., Res #12 was observed with a scar above their right eyebrow. On 11/03/22 at 9:54 a.m., the DON was asked to provide facility incident/accident reports and state incident reports for September 2022. On 11/03/22 at 10:24 a.m., the DON provided an incident/accident report for the 09/03/22 incident. The report was prepared by LPN #3 and described the incident, and documented the resident was to be monitored as closely as possible as a step taken to prevent recurrence. The DON stated they were still looking for state incident reports. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 11/03/22 at 10:35 a.m., the administrator stated there were no state incident reports for September 2022 to current for the resident. On 11/03/22 at 12:42 p.m., the DON was asked what was the protocol if a resident had an injury of unknown origin and they required more than first aid. She stated they would send them to the hospital, complete an incident report, conduct an internal investigation, and complete and submit a report to the state. She stated injuries of unknown origin were to be reported to the administrator immediately and the report was to be completed and submitted to the state within the designated timeline. She stated the initial report to the state should be submitted within two hours. The DON was shown the nurses notes and incident/accident report provided for the above incident where their abuse policy was not implemented. She stated they had other fall documentation they would provide. On 11/03/22 at 1:08 p.m., the DON provided two pages of a fall scene investigation report prepared by LPN #3. It documented it was unknown what the resident was doing during or just prior to the fall. It documented the fall was unwitnessed. It documented the re-enactment of the fall due to the root cause not being determined as the resident was confused. It documented the resident walked and tripped, hitting their head on the bedside table, then laid themselves in their bed. On 11/03/22 at 1:30 p.m., the DON was asked to explain what it meant when the nurse documented the re-enactment of the fall due to the root cause not being determined on the fall investigation report. She was asked if it was an assumption of what happened. She stated the guessed so. On 11/03/22 at 2:52 p.m., the administrator stated Res #12 did not require anything more than first aid and they looked over the fall scene investigation report.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 33148 Based on record review, observation, and interview, the facility failed to implement their abuse policy for investigating an injury of unknown origin for one (#12) of five sampled residents reviewed for accidents. The Resident Census and Conditions of Residents report, dated 10/21/22, documented 35 residents resided in the facility. Findings: The Abuse policy and procedure, updated 07/23/21, read in parts, .IDENTIFYING, INVESTIGATING, & REPORTING .All .injuries of unknown origin .shall be promptly reported to Administrator and investigated by Facility management. Administrator will report the allegation of the Oklahoma State Department of Health . Res #12 had diagnoses which included arthropathy, vascular dementia with behavioral disturbance, and a history of falls. A quarterly resident assessment, dated 07/19/22, documented the resident's cognition was severely impaired. It was documented they required extensive assistance with transfers and ambulation. A nurse's note, dated 09/03/22 at 8:00 a.m., documented the CNA summoned the nurse to the resident's room. It was documented upon entering the resident's room the resident was lying in their bed on their right side. It was documented there was an open laceration to the resident's right eyebrow with a moderate amount of red blood noted in their bed from the site. It was documented the resident was unable to report how the incident occurred and there was blood noted to the bedside table. It was documented the resident complained of pain to their right eyebrow and neuro's were initiated. It was documented the ARNP was notified and there was a new order to send the resident to the ER for evaluation and treatment as indicated. It was documented the administrator was notified at the present time. It was documented the resident left the facility to the ER at 8:35 a.m. A nurse's note, dated 09/03/22 at 10:55 a.m., documented the resident returned from the hospital with new orders for Bactrim (antibiotic medication). It was documented the open area to the resident's head was glued by the ER doctor. On 10/21/22 at 12:08 p.m., Res #12 was observed with a scar above their right eyebrow. On 11/03/22 at 9:54 a.m., the DON was asked to provide facility incident/accident reports and state incident reports for September 2022. On 11/03/22 at 10:24 a.m., the DON provided an incident/accident report for the 09/03/22 incident. The report was prepared by LPN #3 and described the incident, and documented the resident was to be monitored as closely as possible as a step taken to prevent recurrence. The DON stated they were still looking for state incident reports. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/03/22 at 10:35 a.m., the administrator stated there were no state incident reports for September 2022 to current for the resident. On 11/03/22 at 12:42 p.m., the DON was asked what was the protocol if a resident had an injury of unknown origin and they required more than first aid. She stated they would send them to the hospital, complete an incident report, conduct an internal investigation, and complete and submit a report to the state. She stated injuries of unknown origin were to be reported to the administrator immediately and the report was to be completed and submitted to the state within the designated timeline. She stated the initial report to the state should be submitted within two hours. The DON was shown the nurses notes and incident/accident report provided for the above incident where their abuse policy was not implemented. She stated they had other fall documentation they would get. On 11/03/22 at 1:08 p.m., the DON provided two pages of a fall scene investigation report prepared by LPN #3. It documented it was unknown what the resident was doing during or just prior to the fall. It documented the fall was unwitnessed. It documented the re-enactment of the fall due to the root cause not being determined as the resident was confused. The resident walked and tripped, hitting their head on the bedside table, then laid themselves in their bed. On 11/03/22 at 1:30 p.m., the DON was asked to explain what it meant when the nurse documented the re-enactment of the fall due to the root cause not being determined on the fall investigation report. She was asked if it was an assumption of what happened. She stated the guessed so. On 11/03/22 at 2:52 p.m., the administrator stated Res #12 did not require anything more than first aid and they looked over the fall scene investigation report.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 33148 Based on record review, observation, and interview, the facility failed to ensure an injury of unknown origin was reported to the State Survey Agency no later than two hours after the injury for one (#12) of five sampled residents reviewed for accidents. The Resident Census and Conditions of Residents report, dated 10/21/22, documented 35 residents resided in the facility. Findings: The Abuse policy and procedure, updated 07/23/21, read in parts, .IDENTIFYING, INVESTIGATING, & REPORTING .All .injuries of unknown origin .shall be promptly reported to Administrator and investigated by Facility management. Administrator will report the allegation of the Oklahoma State Department of Health . Res #12 had diagnoses which included arthropathy, vascular dementia with behavioral disturbance, and a history of falls. A quarterly resident assessment, dated 07/19/22, documented the resident's cognition was severely impaired. It was documented they required extensive assistance with transfers and ambulation. A nurse's note, dated 09/03/22 at 8:00 a.m., documented the CNA summoned the nurse to the resident's room. It was documented upon entering the resident's room the resident was lying in their bed on their right side. It was documented there was an open laceration to the resident's right eyebrow with a moderate amount of red blood noted in their bed from the site. It was documented the resident was unable to report how the incident occurred and there was blood noted to the bedside table. It was documented the resident complained of pain to their right eyebrow and neuro's were initiated. It was documented the ARNP was notified and there was a new order to send the resident to the ER for evaluation and treatment as indicated. It was documented the administrator was notified at the present time. It was documented the resident left the facility to the ER at 8:35 a.m. A nurse's note, dated 09/03/22 at 10:55 a.m., documented the resident returned from the hospital with new orders for Bactrim (antibiotic medication). It was documented the open area to the resident's head was glued by the ER doctor. On 10/21/22 at 12:08 p.m., Res #12 was observed with a scar above their right eyebrow. On 11/03/22 at 9:54 a.m., the DON was asked to provide facility incident/accident reports and state incident reports for September 2022. On 11/03/22 at 10:24 a.m., the DON provided an incident/accident report for the 09/03/22 incident. The report was prepared by LPN #3 and described the incident, and documented the resident was to be monitored as closely as possible as a step taken to prevent recurrence. The DON stated they were still looking for state incident reports. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/03/22 at 10:35 a.m., the administrator stated there were no state incident reports for September 2022 to current for the resident. On 11/03/22 at 12:42 p.m., the DON was asked what was the protocol if a resident had an injury of unknown origin and they required more than first aid. She stated they would send them to the hospital, complete an incident report, conduct an internal investigation, and complete and submit a report to the state. She stated injuries of unknown origin were to be reported to the administrator immediately and the report was to be completed and submitted to the state within the designated timeline. She stated the initial report to the state should be submitted within two hours. The DON was shown the nurses notes and incident/accident report provided for the above incident. On 11/03/22 at 2:52 p.m., the administrator stated Res #12 did not require anything more than first aid and they looked over the fall scene investigation report.

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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** 38495 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 #144, who was found in the floor after being there for an unknown period of time and had been reported to have a change in baseline status related to being cold to the touch and minimally responsive, at shift change around 6:00 a.m., on [DATE]. The resident was moved to a wheelchair and placed in the lobby and was not assessed for close to two and a half hours. EMS was contacted at 8:30 a.m., for him becoming unresponsive and being unable to obtain vital signs. Staff interviews conducted with those present at the time stated CPR was not initiated due to unknown code status of resident. Hospital records documented the resident was hypothermic, hypotensive, and hypoglycemic and .must have been in a cool environment without being found down for a fairly long period of time before discovery . Res #144 expired in the hospital on [DATE]. On [DATE] at 3:13 p.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation. On [DATE] at 3:19 p.m., the administrator was notified of the IJ situation related to quality of care for Res #144. On [DATE] at 6:40 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal read in entirety: Corrective Action: Plan of Removal On,[DATE], All staff In-serviced on Facility Policy and Procedure regarding code status and where code status is located. 1. All newly hired personnel will be educated on location of resident code status 2. DON/Designee will review new hire packets to ensure all training is completed. 3. Up to date code status will be maintained on resident charts and on 24- hour report sheet for quick reference. 4. DON/Designee will review physician's orders 5 times per week to ensure all resident's code status is up to date. 5. DON/Designee will report any negative findings quarterly to QAPI Completed by 8 p.m. [DATE] On [DATE], All nursing staff educated on how to recognize change in resident baseline condition\orientation and\or change in vital signs. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. All newly hired direct care staff will be educated on how to recognize change in resident baseline condition\orientation and\or change in vital signs. 2. All facility staff will be in-served quarterly on how to recognize change in resident baseline condition\orientation and\or change in vital signs. Completed by 8:00 pm [DATE] On [DATE], all licensed RN/LPN In-serviced on Facility Policy and Procedure properly assessing, monitoring, and intervening effectively and timely in the event of change in resident condition, and completion of Incident reports. 1. All licensed new hires will be educated on Facility Policy and Procedure on properly assessing, monitoring, intervening effectively and timely in the event of change in resident condition, and completion of incident reports. 2. Don/designee will review all new hire packets to ensure all training is completed. 3. Don/designee will report any negative findings quarterly to QAPI Completed by 8 p.m. [DATE] On [DATE] Chart review of all 35 resident's code status orders were reviewed and code status stickers and 24 -hour report sheet updated Completed by 8p.m. [DATE] The immediacy was lifted, effective [DATE] at 11:03 a.m., when all elements of the plan of removal had been implemented. The deficiency remained at a potential for harm at an isolated level. Based on record review, observation, and interview, the facility failed to provide needed care and services in accordance with professional standards of practice for three (#144, #16, and #43) of six residents reviewed for quality of care issues. The facility failed to: a. assess, monitor, and provide interventions for Res #144 who was found on the floor around 6:00 a.m., cold to the touch and minimally responsive, on [DATE]. EMS was not notified until 8:30 a.m. The resident was admitted to the hospital and records documented the resident was hypothermic, hypotensive, and hypoglycemic. Res #144 expired in the hospital on [DATE]. b. conduct wound assessments and follow physician orders for Res #16. c. conduct an admission assessment for Res #43. Findings: 1. Res #144 admitted to the facility from the hospital on [DATE] and had diagnoses which included malignant neoplasm of unspecified site, DM, HTN, COPD, schizophrenia, and Alzheimer's disease. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Base line care plan, dated [DATE], documented Res #144 was a full code. An admission assessment, dated [DATE], documented the resident was severely impaired with cognition and was independent with bed mobility, transfer, walking, and eating. The assessment documented the resident required limited asssistance with dressing, toilet use, and personal hygiene. The assessment documented a bath did not occur for the look back period. A care plan, dated [DATE], documented the resident had a history of falling which was added to the care plan on [DATE]. The plan documented to observe for signs and symptoms of hypoglycemia. The care plan documented to monitor for signs of hypertension and hypotension. A nurse paper note, dated [DATE] at 8:20 a.m., documented the following: Res #144 was sitting up in the lobby in a wheelchair waiting for breakfast to be served. This nurse called resident's name with no response and watched resident's chest rise and fall. Res #144 was snoring every other inhale. This nurse started a full assessment on the resident, no vital signs were obtained. The vital machine wound not read, pulse faint, sternum rub performed and resident responded. Weakness still noted. A nurse paper note, dated [DATE] at 8:30 a.m., documented EMT called. The note documented the nurse continued sternum rubs and the resident was placed in supine position on the floor in case CPR needed to be performed. The note documented the nurse continued to talk to the resident and moaning sounds were noted. A nurse paper note, dated [DATE] at 8:40 a.m., documented EMT arrived and took resident to hospital. The note documented the family, DON, and administrator were notified at that time. A nurse paper note, dated [DATE] at 12:50 p.m., documented the nurse spoke with the hospital staff and stated Res #144 had been sent to a hospital in Tulsa via med flight. The note documented hospital staff stated the resident was sent due to hypothermia, hypovolemia, and hypoglycemia. Local hospital records, dated [DATE], documented the following: Resident was found down on the floor at local nursing home with low BP and low blood sugar according to EMS. Code status was unknown. Patient only responsive to painful stimuli. At 9:41 glucose was 58. At 9:46 a.m. BP ,d+[DATE], P 51, R 18. At 10:56 a. m. resident was intubated. At 11:08 compressions initiated. At 11:10 a.m. temperature 84 degrees F. At 11:22 compressions initiated. Time of transfer to Tulsa hospital 12:53 p.m. Tulsa hospital records, dated [DATE], documented on page 12, on arrival to the ICU, the patient was unresponsive, intubated, temperature 84.2 F, systolic blood pressure was ,d+[DATE], bilateral breath sounds present, heart regular rate and rhythm, nontender abdomen, cool skin, no visible skin lesions, and trace bilateral lower extremity edema. The patient is admitted for treatment status postcardiac arrest for hypothermia, shock with severe sepsis, pneumonia, renal insufficiency, and acute neuromuscular respiratory failure. Tulsa hospital records, dated [DATE], read in part on page 16, .hypothermia likely secondary to septic shock. Must have been in a cool environment without being found down for a fairly long period of time before discovery and eventually being taken to the other facility . Tulsa hospital records, dated [DATE], documented on page 46, the resident's time of death as 5:59 a.m. on [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:36 a.m., CNA #10 stated when she came in for her day shift, she found Res #144 that morning on his roommate's side of the room on the floor ice cold. CNA #10 stated she notified the night shift charge nurse LPN #3, who she stated did not assess the resident. CNA #10 stated the day nurse arrived and talked to the night nurse then they had us put Res #144 in his wheelchair and put him in the living area of the facility. On [DATE] at 9:49 a.m., the resident's roommate, Res #1, stated he was hard of hearing. Res #1 stated his roommate laid on the floor all night long. He stated he did not think any one ever came down to check on them that night and Res #144 did not say anything to him. He was asked if he used his call light for help. Res #1 stated he did not think he called for help. He stated he didn't know what happened after someone got Res #144 off of the floor. He stated he got very cold in his room. The resident was observed to have at least four blankets on his bed. Res #1 stated he could use another blanket. On [DATE] at 10:02 a.m., the temperature in the residents' room was 69.7 degrees. On [DATE] at 10:15 a.m., CNA #11 stated she was working on [DATE], the 6 a.m. to 2 p.m. shift. She stated her and another aide went to check on the residents that morning and Res #144 was on the floor in his room. CNA #11 stated his roommate told her he was on the floor all night long and didn't know if he should have used the call light. CNA #11 stated the nurse got his vital signs and then the other aids helped get him up into a wheel chair to the lobby. She stated she believed the day nurse was the one who got the vital signs. CNA #11 stated Res #144 was sent out to the ER. On [DATE] at 10:23 a.m., CNA #9 stated the morning of [DATE] was a complete shit show. CNA #9 stated wouldn't let him do CPR and they didn't know if he was a full code or DNR. The CNA stated When he was found on the floor in his room there was a nurse from the night shift who did full ROM, he was still responsive and they brought him up to the lobby so he could be monitored frequently. The CNA stated the resident eventually became unresponsive, he was still breathing, but they couldn't get an O2 or pulse on him. The CNA stated they had me help him into the floor and eventually told me to just go back into the dining room. The CNA stated we came in at 6:00 a.m. and breakfast was usually done by nine, so he sat in the lobby around three hours before he was sent out. The CNA stated It was terrible. I left that place because my license was not worth it. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:04 a.m., LPN #6 stated the following: When she first got there she received report then the aides were getting everyone up for breakfast. They had wheeled Res #144 to the front lobby. It was cold and he had a blanket over him. She stated she was doing fingersticks and everyone was waiting for breakfast. The resident was sitting with his head down and the blanket wrapped around his shoulders. The resident did not respond to me when I called his name, so I touched his hands and they were very cold, freezing. I told people I needed oxygen, I could not get a SPO2 or a BP on him. I had a CNA to help me lower the resident to the floor while we were getting everything together. I did a sternal rub on him and constantly talked to him and he was not saying anything. He started moaning and I was about to perform CPR. The facility did not have the code status available. I had an RN with me at the time and she was looking through the charts while I was doing this. I already had the EMT's on the phone and they were in route. The resident was responding with the sternal rubs with moaning. He reached up to move my hand but was not strong enough to move my hand. I did not have to do CPR on him, but the vitals were still not reading. I put the oxygen on him because I still couldn't get the SPO2. I continued doing sternal rubs on him since I was still getting a response out of him and I wanted to keep getting a response. I could not get a blood pressure on him with the machine. The manual BP cuff was gone. I did not check his FSBS. It was not reported to me that he was on the floor in his room. The resident's chart did not have the code status. During this time RN #1 was there. The EMT came and took him out. On [DATE] at 11:32 a.m., CNA # 12 stated the following: She saw the resident in a wheelchair but he usually walks. The other CNA went over to get the resident and bring him to breakfast from the lobby. CNA #12 stated the resident was not responsive so the other CNA notified the RN and LPN. At some point they got him on the floor. They did not perform CPR because right as they were about to the ambulance arrived. On [DATE] at 12:15 p.m., CNA #13 she stated she remembered Res #144 was sent out in the morning on a Sunday due to being unresponsive. She stated the nurse got him on the ground and was calling his name until the EMT got there. CNA #13 state she was pretty sure he was in a wheelchair but he usually walked. On [DATE] at 12:16 p.m., RN #1 stated she did not recall resident Res #144. On [DATE] at 12:34 p.m., the DON stated the resident did not have an incident report for [DATE]. The DON stated she did not start at the facility until [DATE]. On [DATE] at 12:41 p.m., the administrator stated she started at the facility the end of July. She stated she got a phone call that morning from the nurse saying that she had brought him up front because he was kind of lethargic and not acting himself and wanted to watch him. I got a text message that he was going out to the hospital. We heard from the hospital that he had passed. She stated there was not an incident report. She stated she was not aware that he was found in the floor in his room. On [DATE] at 9:32 a.m., the DON stated an unresponsive resident should immediately be assessed, the physician notified, and the resident sent out if required. 2. Res #16 had diagnoses which included cellulitis and unspecified open wound to lower leg. A physician order, dated [DATE], documented weekly skin audits on Mondays a.m. shift. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An admission assessment, dated [DATE], documented the resident was moderately impaired with cognition and was independent with most activities of daily living. The assessment documented the resident had no skin issues. A care plan, dated [DATE], documented open skin lesions. A quarterly assessment, dated [DATE], documented the resident was moderately impaired with cognition and was independent with most activities of daily living. The assessment documented the resident did not have a pressure ulcer but had other wounds/skin problems/open lesions. The assessment documented application of nonsurgical dressings and ointments. A physician order, dated [DATE], documented to cleanse bilateral lower legs with wound cleanser, pat dry, apply medi honey to open areas and paint scabs with betadine wrap with kerlix every day and PRN for soiling. Weekly wound assessments were reviewed. There were no wound assessments for the weeks of [DATE] and [DATE]. A nurse noted, dated [DATE], documented the wound care physician was here today and was unable to see the resident due to being on the COVID unit. A physician wound assessment, dated [DATE], documented the resident had a non pressure wound of the left anterior shin for at lest 141 days duration. The assessment documented wound #1 was non pressure to the left anterior shin with partial thickness measuring 20 x 16 x not measurable cm cluster wound with no exudate. The assessment documented a physician order to change the treatment to Betadine once daily for nine days to scabs. The new order was not changed on the October TAR and was not documented as completed. A physician wound assessment, dated [DATE], documented wound #2 skin tear to right shin full thickness, wound size 34 x 16 x 0.1 cm clustered wound. The physician order was to apply medihoney once daily for nine days to open areas, betadine apply once daily for nine days to scabs and apply roll gauze once daily for nine days. On [DATE] at 4:09 p.m., Res #16 stated he was not sure why he had bandages to his right arm and left leg. The bandages were observed to be dated [DATE]. Res #16 stated the staff were treating his wounds. On [DATE] at 9:50 a.m. the DON stated she looked in the chart and could not find the skin assessments for October. On [DATE] at 11:13 a.m., the ADON stated it looked like the change in the would care order was missed on [DATE] to the left leg. 46387 3. Resident #43 admitted on [DATE] with diagnoses which included schizoaffective disorder, frontotemporal dementia, hypertension and anxiety. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The baseline care plan did not include interventions related to cognition, behaviors, assistance required with ADLs, pressure ulcer risk, fall risk, or high risk medications. An admission assessment, dated [DATE] documented the resident was severely cognitively impaired, had behaviors that interfered with resident care and social activities, had rejection of care, required extensive assistance of one staff with dressing, toileting, personal hygiene and bathing, was always incontinent of bowel and bladder, was at risk for developing pressure ulcers, and received antipsychotic and antidepressant medications. A nurse progress note, dated [DATE] at 9:21 p.m., documented the CNA notified the nurse the Res #43 had fallen. The note documented when the nurse entered the room the resident was laying on his right side next to the sink on the ground with a sheet under his head. The note documented the nurse noticed the resident was having periods of apnea. The note documented she rolled the resident onto his back and was able to find a pulse. The note documented when she applied the blood pressure cuff the resident no longer had a pulse and CPR was initiated. The note documented another nurse took over compressions and 911 was contacted. The note documented upon EMS arrival the paramedics took over CPR and transferred resident out of the facility. On [DATE] Res #43's medical record was reviewed for nursing assessments. The medical record did not contain documentation of nursing assessments of the resident. On [DATE] at 12:37 p.m., the DON was asked to double check to ensure all documentation pertaining to Res #43 was provided to surveyors. On [DATE] at 12:50 p.m., the DON provided documentation regarding Res #43's fall and stated there were no further records for the resident available. On [DATE] at 3:15 p.m., the DON stated upon admission a resident should receive a head to toe assessment and orders should be reviewed. She stated a fall risk assessment should be completed at least quarterly. She stated she had not been in the facility long enough to figure out what their system was. She stated the resident should have had a fall risk assessment initially documented either in the computer or in the paper chart. She stated she was unsure who was responsible for the assessments. She stated after a fall a resident is supposed to be assessed to see if they need to be sent out or for injury and there should have been a post-fall assessment that included the interventions on either the nurses progress note or on the incident report. She stated she was unaware if the MDS coordinator was doing the fall risk assessments. On [DATE] at 3:45 p.m., the MDS coordinator stated it was likely there had not been any RN assessments completed for Res #43. He stated the nurses on the floor were supposed to do the fall risk assessments. On [DATE] at 4:11 p.m., the MDS coordinator stated there was a corporate nurse helping with MDS assessments, but the assessments she completed did not include a fall risk assessment or a head-to-toe assessment of the resident upon admission or throughout the resident's stay. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:17 a.m., the MDS coordinator stated the baseline care plan was completed prior to his employment but fall risk and interventions were not care-planned. He stated falls should have been on the baseline care plan and any other concerns based on what was in the resident's referral, but he doesn't think that the prior MDS coordinator was scrubbing the referrals as they were supposed to when residents were admitted . He stated the prior MDS coordinator was using a template and failed to customize the responses to the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on record review, observation, and interview, the facility failed to ensure: a. chemicals/toxins and sharps were not accessible to vulnerable residents, b. implement interventions for falls and update the care plan to reflect the interventions for four (#12,13,18, and #19) of six residents reviewed for accident hazards. The Resident Census and Conditions of Residents report documented 35 residents resided in the facility. The DON identified seven residents who wandered. Findings: 1. Res #19 had diagnoses which included epileptic seizures. An incident report, dated 02/15/22 at 5:30 p.m., documented the resident was observed sitting on the floor in front of the toilet. The riser was sitting between the resident and toilet. The resident stated she bent forward to pull up her underwear and fell off the toilet. The incident report documented the resident did not have any injuries other than a red area on the buttocks from sitting on the floor. The resident complained of pain to right outer wrist. The physician was notified and received an order for an X- ray to right wrist. The intervention was to tighten the toilet riser. The care plan was not updated with an intervention for this fall. There was not a nurse note documented for the fall on 02/15/22. The X-ray report documented no broken bones to the wrist. An incident report, dated 02/20/22 at 10:00 a.m., documented a CNA reported the resident fell in the doorway of the room. No injury noted. There was not an intervention on the incident report. The care plan was not updated with the fall or an intervention. An incident report, dated 06/19/22 at 9:15p.m., documented the resident was found by a CNA during rounds laying in the floor with blood on nose and lip. The resident states she fell out of her chair. There was not an intervention documented on the incident report. The care plan had not been updated with this fall or an intervention. An undated incident report documented the resident was trying to get up from using the restroom and fell . There is not a documented intervention for the resident on the report. Unable to find out the date of the incedent and a nurse note was not found. The care plan had not been updated with an intervention for a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An incident report, dated 07/02/22 at 6:30 p.m., documented the resident fell in the hallway and hit her head on the right side. Res #19 hit her left shoulder and left knee. The resident was walking without her walker. There was not an intervention documented on the incident report or on the care plan. A quarterly assessment, dated 08/16/22, documented the resident was moderately impaired with cognition and was independent with most activities of daily living. The assessment documented the resident had two or more falls with injury (not major) since admit, reentry, or prior assessment. A care plan, last reviewed 10/21/22, documented under falls to remind staff to assist with ambulation and ensure call lights are within reach while the resident is in her room. The care plan documented the resident needed a night light to help see at night. The care plan documented to monitor for changes in condition that may warrant increased supervision or assistance and notify the physician and wear non skid socks at all times. An incident report, dated 10/04/22 at 3:55 p.m., documented the resident returned with her sister from an outing. The resident went to get out of the car and lost her balance and fell to her buttock in the parking lot. The resident denied hitting her head head. The resident complained of pain to buttocks. The intervention was for the resident to take walker on outings. The care plan was not updated with this intervention. An incident report, dated 10/20/22 at 530 a.m., documented the resident was sitting on the floor at the foot of her bed facing the hallway. The resident denied pain and no apparent injuries noted. The resident stated she just sort of slid down to sit. The intervention was to encourage resident to use the call light for assistance with needs. This was not a new intervention for the resident. On 10/21/22, the care plan was updated with he intervention to wear non skin socks at all times. An incident report, dated 10/30/22 time unknown, documented the resident stated she lost balance and fell on her knees. There was not an intervention documented on the on the incident report. On 11/01/22 at 3:34 p.m., the ADON stated there should be an intervention with every incident. She stated the nurse should have written a note and an incident report should have been completed when a resident falls. 33148 2. On 10/26/22 at 8:30 p.m., two utility closets on the front East hall were unlocked and the keys were observed hanging on the side of the doors. The following chemicals/toxins and sharps were observed: a. multiple boxes of peritoneal wash, b. 22-16 ounce bottles of hydrogen peroxide, c. multiple 2 oz and 16 oz bottles of PVP prep solution, d. multiple boxes of insulin safety syringes and safety lancets, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. multiple 16 oz bottles of hand sanitizer, f. multiple dispensing bags of shampoo and conditioner, and g. one 32 oz bottle of Comet bleach spray. There were no residents observed attempting to open doors to rooms. On 10/26/22 at 9:11 p.m., CNA #1 was asked how staff ensured residents were free from accident hazards such as chemicals/toxins and sharps. They stated they should be locked up in the supply closet. On 10/26/22 at 9:25 p.m., LPN #2 was asked how staff ensured residents were free from accident hazards such as chemicals/toxins and sharps. They stated they should be behind locked doors. They stated they had the keys hanging next to the doors. On 10/26/22 at 9:30 p.m., the DON was made aware of the above observations. 3. Resident #12 had diagnoses which included arthropathy, vascular dementia with behavioral disturbance, and a history of falls. A quarterly resident assessment, dated 07/19/22, documented the resident's cognition was severely impaired. It was documented they required extensive assistance with transfers and ambulation. A nurse's note, dated 09/22/22 at 11:15 a.m., documented staff heard a noise and the resident was laying on the floor. It was documented the resident denied pain and hitting their head. It was documented the resident had an abrasion to their right knee and a red area noted to their right shoulder. There was no documentation neuro checks were initiated. A nurse's note, dated 10/06/22 at 5:37 p.m., documented the resident slid onto the floor from their wheelchair in the dining room. It was documented a head to toe assessment was completed and there was no visible injuries. An incident/accident report was completed and there were no steps taken to prevent recurrence. A nurse's note, dated 10/18/22 at 8:40 a.m., documented the resident was laying on the floor in supine position. It was documented the resident stated they rolled out of bed and denied hitting their head. It was documented there was a small red area to the right side of the resident's back. There was no documentation neuro checks were initiated. On 11/03/22 at 9:54 a.m., the DON was asked to locate documentation of neuro checks for Resident #12. On 11/03/22 at 10:36 a.m., the DON stated they were still looking for neuro checks for the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/03/22 at 12:42 p.m., the DON was asked what was the protocol for conducting neuro checks. They stated neuro checks should be conducted if there was an unwitnessed fall, a resident hit their head, or if a resident had a change in their mental status. They were asked when steps/interventions should taken to prevent recurrence of a fall. They stated after the fall something should be in place. They stated the best intervention should be as soon as possible. The DON was shown the nurses notes and incident/accident report for Resident #12's falls where there were no neuro checks and/or steps/interventions taken to prevent recurrence. 46387 4. Res #13 admitted on [DATE] and had diagnoses which included frontotemporal dementia, Parkinson's disease, and schizoaffective disorder. An Admission Intake Data form, dated 03/07/22, documented the resident had a history of falls, The baseline care plan did not include interventions related to cognition, wandering, risk for pressure ulcers, risk of falls, or high risk medications. An admission assessment, dated 03/14/22, documented the resident was severely cognitively impaired, had wandering behaviors, and required physical assistance for bathing. The assessment documented the resident received an antipsychotic and antianxiety medication. An incident report, dated 05/20/22 at 12:50 p.m., documented Res #13 had a fall in which the resident stated he just fell when he leaned on a table. The incident report documented Res #13 was witnessed striking his head and back in the fall. The incident report documented the nurse assessed the resident and found no obvious injury. No steps to prevent recurrence were documented on the incident report. An incident report, dated 05/21/22 at 8:00 a.m., documented Res #13 was found by the sink in his room with a new skin tear to the right arm. The incident report documented no other injuries were noted. The incident report documented the resident complained of 4/10 pain to the right arm. No steps to prevent recurrence were documented on the incident report. Neuro-checks were not re-started for this fall. An incident report, dated 05/23/22 at 1:15 p.m., documented Res #13 reported to staff he was in his room and stated he tripped over his feet. The incident report documented steps to prevent recurrence was to encourage the resident to use the call light before getting up and have the call light in reach. An incident report, dated 06/02/22 at 4:15 p.m., documented Res #13 was found in the floor of his room. The incident report documented the resident stated he was trying to get up and fell . The incident report documented the resident reported no injuries and there were no obvious injuries observed. No steps to prevent recurrence were documented on the incident report. There was no progress note in the clinical record for this fall. There were no neuro-checks documented for this fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An incident report, dated 06/02/22 at 5:45 p.m., documented Res #13 was in the hallway in his wheelchair when he attempted to get up from his wheelchair and fell . The incident report documented there were no obvious injuries observed. No steps to prevent recurrence were documented on the incident report. There was no progress note in the clinical record for this fall. An incident report, dated 07/25/22 at 3:50 p.m., documented Res #13 reported to staff he was trying to get up from bed and fell . The incident report documented there were no injuries reported and the resident reported he did not hit his head. The incident report documented neuro-checks would be initiated due to the fall being unwitnessed. The incident report documented steps to prevent recurrence as nursing staff were to ensure the resident was out of bed at least twice daily between meals. No neuro-checks were documented for this fall. No progress notes were documented for this fall. An incident report, dated 09/26/22 at 6:00 p.m., documented Res #13 was found lying on his right side in front of his wheelchair in the lobby. The incident report documented the resident received a skin tear to his right eyebrow, top of right hand, and right outer elbow. The incident report documented steps to prevent recurrence as evaluate for high back chair or geri-chair. There was no progress note documented for this fall. On 10/27/22 at 10:00 a.m., Res #13 was observed in a high back wheelchair in the lobby. He did not respond to surveyor's attempts to speak with him. A fall care plan, reviewed 10/31/22, documented interventions which included: remind resident to ask for assistance with ambulation and/or transfers, needs a night light on to help see at night, monitor for changes in condition that may warrant increased supervision/assistance and notify the physician, encourage Res #13 to wear appropriate, well fitting footwear, Res #13 had some falls and noted to have an unsteady gait, staff encouraged use of walker but resident refused, PT/OT to evaluate and treat as indicated, educate staff to have items Res #13 may want or need within easy reach. The care plan did not include the steps to prevent recurrence documented on the 05/23/22, 07/25/22, or 09/26/22 incident report. On 11/01/22 at 3:10 p.m., the ADON stated that there was an issue with agency nursing staff not documenting anything including progress notes because they couldn't get logged into the computer which is part of the reason that they had to go back to paper charting. She stated that there was a possibility that there were nurses notes about the falls if it could be found in the stacks of papers that have not been filed or in the computer. On 11/01/22 at 3:30 p.m., the ADON stated that neuro-checks should be initiated for all unwitnessed falls or for witnessed falls in which the resident hit their head. She stated neuro-checks should have been restarted for Res #13 after the fall on 05/21/22 but were not. She stated the MDS coordinator was provided with the fall interventions listed on the incident reports during morning meetings or it was discussed and new interventions were devised. She stated there were no steps to prevent recurrence documented on the incident reports for the falls on 05/20/22, 05/21/22, and both falls 06/02/22. 5. Res #18 admitted on [DATE] and had diagnoses which included Alzheimer's disease, bipolar disorder, schizoaffective disorder, and chronic pain. A Fall Risk Assessment,dated 10/11/21, documented the resident was at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An incident report, dated 06/13/22 at 1:00 p.m., documented Res #18 reported to staff that he slipped and fell while walking to the bathroom with his walker. The incident report documented Res #18 sustained a small scratch to his right elbow and no other injuries were noted. The incident report did not document steps to prevent recurrence. There was no documentation of neuro-checks. No progress notes regarding this fall were documented. A fall care plan, reviewed 06/30/22, documented interventions which included: needs a night light on to help see at night, monitor for changes in condition that may warrant increased supervision/assistance and notify the physician, non-skid footwear, ensure call light is in reach when in room and encourage Res #18 to ask for assist with transfers when he is tired, frequent observations to be initiated per nursing staff. A progress note, dated 07/04/22 at 6:00 p.m., documented Res #18 was status post fall with no delayed injuries. The note documented neuro-checks remained in place with no abnormalities. The note documented the resident reported he fell trying to reach for his shoes. No incident report for this date was provided. An incident report, dated 07/08/22 at 10:38 a.m., documented Res #18 was found lying on his right side in the bathroom floor and had a skin tear to left posterior shoulder. The incident report documented no other injuries noted. There were no steps to prevent recurrence documented on the incident report. An incident report, dated 07/13/22 at 7:30 a.m., documented Res #18 reported to staff he was self transferring from wheelchair to standing with his walker when he lost his balance and fell . The incident report documented the resident reported soreness to the right knee and elbow and reported hitting his head. A note in the incident report documented see nurses notes. The incident report did not document steps to prevent recurrence. There was not a progress note documented regarding the fall. An incident report, dated 07/15/22 at 10:15 a.m., documented the resident had an unwitnessed fall in his room and was observed lying on his left side in the floor. The incident report documented the nurse assessed the resident and no injuries were reported or observed. There were no steps to prevent recurrence documented on the incident report. There were no progress notes documented regarding the fall. A nurse progress note, dated 08/16/22 at 2:00 p.m., documented the nurse was called to Res #18's room and observed the resident laying in floor on left side with the wheelchair across the room. The note documented the resident stated he was trying to get into his refrigerator and lost his balance. The note documented staff assisted resident to bed and no delayed injuries were noted. An incident report, dated 08/17/22 at 6:15 p.m., documented Res #18 was observed laying on the floor in doorway on his left side with his knees bent. The incident report documented no apparent injuries. There were no steps to prevent recurrence documented on the incident report. An incident report, dated 10/19/22 at 7:45 a.m., documented Res #18 reported to staff he was making his bed and lost his grip on the bed and fell , hitting his head on the floor. The incident report documented the resident denied pain or injuries. There were no steps to prevent recurrence documented on the incident report. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse progress note, dated 10/19/22 at 1:00 p.m., documented the intervention for the fall was to make resident's bed first thing in the morning before he attempted it. A re-admission assessment, dated 10/31/22 documented the resident was moderately cognitively impaired, required limited assistance of one staff with transfers, walking, dressing, toileting, required transfer assistance to bathe, used tobacco, had a history of falls before admission, had two or more falls since admission without injury, had one fall since admission with minor injury, and received antipsychotic and opioid medications. On 11/01/22 at 10:55 a.m., Res #18 was observed resting in bed. A fall mat was observed at bedside. The resident stated he was able to use the call light and bed controls and had some falls in the past. On 11/01/22 at 3:10 p.m. the ADON stated that there was a possibility there were nurses notes about the falls if they could be found in the stacks of papers that have not been filed or in the computer. On 11/01/22 at 3:30 p.m., the ADON stated that neuro-checks should be initiated for all unwitnessed for or for witnessed falls in which the resident hit their head. She stated it did not appear that neuro-checks were completed for some of Res #18's falls. She stated there were no steps to prevent recurrence documented on the incident reports for the falls on 07/08/22, 07/13/22, 07/15/22, 08/17/22, or 10/10/22.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 33148 Based on record review and interview, the facility failed to ensure medications were administered as ordered by the physician for two (#17 and #40) of five sampled residents reviewed for unnecessary medications. The Resident Census and Conditions of Residents report, dated 10/21/22, documented 35 residents resided in the facility. Findings: 1. Res #40 had diagnoses which included schizoaffective disorder, major depressive disorder, anxiety disorder, suicidal ideations, and insomnia. Physician orders, dated 06/29/22, documented duloxetine HCL DR (antidepressant medication) 30 mg capsule every day with noon meal, duloxetine HCL DR 60 mg capsule every day with evening meal, and Seroquel (antipsychotic medication) 100 mg tablet at bedtime. An admission assessment, dated 07/05/22, documented the resident's cognition was intact. A physician order, dated 07/13/22, documented lorazepam (antianxiety medication) 0.5 mg tablet. Give 1/2 tablet to equal 0.25 mg at bedtime. The order was discontinued 09/07/22. A physician order, dated 09/07/22, documented lorazepam 0.5 mg tablet. Give 1/2 tablet to equal 0.25 mg twice daily. A physician order, dated 09/16/22, documented to increase Seroquel to 200 mg at 9:00 p.m. due to hearing voices. The September 2022 MARs were reviewed and documented the following: a. duloxetine HCL DR 60 mg was administered 29 out of 30 opportunities, b. lorazepam 0.5 mg 1/2 tablet twice daily was administered 44 out of 46 opportunities, and c. Seroquel 200 mg was administered 11 out of 14 opportunities. On 10/25/22 at 3:42 p.m., Resident #40 stated until a month ago they had not been receiving some of their medications that help them sleep. They stated it happened more on the weekends. The October 2022 MARs documented the following: a. duloxetine HCL DR 30 mg was administered 30 out of 31 opportunities, b. lorazepam 0.5 mg 1/2 tablet twice daily was administered 60 out of 62 opportunities, and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Seroquel 200 mg was administered 28 out of 31 opportunities. On 11/02/22 at 2:32 p.m., the DON was asked what was the process for ordering medications. They stated medications should be ordered two to three days before the medication runs out. They stated if there were blanks on the MARs then the medication was not administered. They stated if there were circled staff initials there should be a reason the medication was not administered on the back of the MAR. They were shown Res #40's MARs for September and October 2022 where the medications were not administered. 46387 2. Res #17 had diagnoses which included quadriplegia, pneumonitis, dysphagia, HTN, major depressive disorder, diabetes, acute embolism and thrombosis of deep vein of upper extremity, and COPD. Physician orders, dated 07/07/22, documented montelukast 10 mg at bedtime for allergy symptoms; Remeron 15 mg at bedtime; Namenda 10 mg twice daily; ascorbic acid 500 mg two times daily for nutritional supplement; baclofen 10 mg two times daily for inflammatory polyneuropathies; clonazepam 1 mg twice daily for anxiety; docusate sodium 100 mg two times daily for constipation; Eliquis 5 mg two times daily for acute embolism and thrombosis of deep vein unspecified upper extremity; guifenesin 100 mg/5 ml syrup give 10 ml four times daily for cough/congestion; metoclopramide 5 mg/5 ml solution give 10 ml four times daily for GERD; Lipitor 40 mg tablet at bedtime for hyperlipidemia; glycopyrrolate 1 mg three times daily for disturbances of salivary secretion; metoprolol tartrate 25 mg two times daily for hypertension, hold if systolic blood pressure below 100 or diastolic blood pressure below 60, hold medication if pulse less than 60 and notify physician. A quarterly assessment, dated 08/23/22, documented the resident was severely cognitively intact, was totally dependent on two staff for bed mobility, dressing, toilet use, personal hygiene, and bathing; was totally dependent on one staff to eat; did not walk or transfer; had an ostomy; was always incontinent of urine; received antianxiety, antidepressant, anticoagulant, insulin and opioid medication. The September 2022 MAR documented, on 09/04/22, Res #17 did not receive guaifenesin or metoclopramide as ordered for the 4:00 p.m. doses, glycopyrrolate as ordered for the 5:00 p.m. dose, Namenda as ordered for the 7:00 p.m. dose, and ascorbic acid; baclofen; clonazepam; metoprolol; docusate sodium; Eliquis; guaifenesin; Lipitor; montelukast; Remeron; and metoclopramide as ordered for the 8:00 p. m. dose. The September 2022 MAR documented, on 09/07/22, a heart rate reading of 54 and documented the metoprolol was given for the 8:00 a.m. dose. The September 2022 MAR documented on 09/11/22, Res #17 did not receive metoclopramide as ordered for the 8:00 p.m. dose. The October 2022 MAR documented on 10/09/22, Res #17 did not receive montelukast, Remeron, and metoprolol as ordered for the 8:00 p.m. dose. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/01/22 at 2:40 p.m., the DON stated the blanks on the MARs indicated the medications were not given. She stated the metoprolol should have been held on 09/07/22 based on the heart rate documented and the hold parameters on the order.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33148 Based on observation and interview, the facility failed to ensure food was palatable, attractive, and at appetizing temperatures for one of one meal services observed. The Resident Census and Conditions of Residents report, dated 10/21/22, documented 35 residents resided in the facility. Findings: On 10/25/22 at 1:00 p.m., the lunch meal service was observed. Dietary aide #1 was observed scooping enchiladas from a pan on the steam table with a spatula. The enchiladas in the sheet pans on the steam table appeared to be burned. The DM was heard stating to dietary aide #1 the enchiladas were dry and cooked too long. On 10/25/22 at 1:17 p.m., observations were made of residents' food plates in the dining room. The enchiladas appeared to be burned. On 10/25/22 at 1:29 p.m., Res #39 stated the food was burned today and they do not like burned food. On 10/25/22 at 1:40 p.m., the last resident meal was plated in the kitchen and a food test tray was requested to be added to the hall cart. On 10/25/22 at 1:41 p.m., Res #33 stated lunch was a little burned today, but it was a treat to get Mexican food. On 10/25/22 at 1:44 p.m., the hall tray cart was pushed out of the kitchen to the halls. On 10/25/22 at 2:00 p.m., the last hall try was served and the test tray was removed from the cart. The temperature of the enchiladas were 126 degrees F and the rice was 110.6 degrees F. The enchiladas were black in color and looked dry. They were difficult to cut with a utensil, the tortilla was soggy, the meat was dry, and it tasted burned. The rice was cool and stuck together. On 10/25/22 at 3:25 p.m., Res #15 was asked about the food. They stated the food was sometimes burned. On 10/25/22 at 3:42 p.m., Res #40 was asked about the food. They stated sometimes the food was good and sometimes it was not. They stated sometimes the food was hard. They stated hall trays were cold by the time they got them. On 10/31/22 at 9:36 a.m., the DON was asked how staff ensured the food appeared appetizing, served at appetizing temperatures and palatable. They stated they tried the food and that was what a thermometer was for. They were made aware of the above observations the the resident complaints regarding the food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33148 Based on observation and interview, the facility failed to ensure: a. the kitchen was maintained clean and in good repair, and b. food was stored and served in a sanitary manner. The Resident Census and Conditions of Residents report, dated 10/21/22, documented 35 residents resided in the facility. Findings: 1. On 10/25/22 at 12:27 p.m., a tour of the kitchen was conducted. The following observations were made: a. There was condensation buildup on the inside ceiling area of the Aortic Air two door reach in cooler. Cartons of liquid eggs were sweating inside of the cooler. The ambient air temperature inside of the cooler with a handheld thermometer was 59 degrees F. The internal food temperature of a pitcher of sloppy Joe's was 52 degrees F, two plastic bags of cooked sausage links were 54 and 56 degrees F, a plastic bag of cooked chicken patties was 52 degrees F, and a plastic bag of cooked seasoned chicken was 50 degrees F, b. a bus tub of a raw boneless pork loin was stored above boxes of juice cups and oranges, and a 15 pound box of raw bacon was stored above containers of milk, a pan of brownies, bags of lettuce and cooked chicken in the Arctic Air door reach in cooler, c. a pitcher of leftover sloppy Joe's was date marked 10/19/22, two plastic bags of leftover sausage links was date marked 10/20/22, a plastic bag of leftover cooked chicken patties was date marked 10/22/22, and a plastic bag of leftover seasoned chicken was date marked 10/23/22 in the Arctic Air two door reach in cooler, d. a spray bottle of quaternary ammonium was stored on the silverware table next to utensils and drinks used for meal service, e. a damp cloth when not in use was stored on top of the spray bottle of quaternary ammonium stored on the silverware table, f. the light shield was cracked near near the dish machine, g. lights were burned out and/or not working, h. the floor was not finished. [NAME] pieces were not sealed and floor tiles were cracked and/or missing, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i. the ceiling and walls were not finished. There were holes and the sheetrock was not sealed, j. there was an accumulation of black residue on the floor under the dish machine, and k. there was an accumulation of black residue inside of the ice machine. On 10/25/22 at 12:58 p.m., the DM was asked what was the facility's date marking policy. They stated hold food for three days. They were asked if they held potentially hazardous foods that were leftovers for three days. They stated they did. They were asked what temperature cold food should be held at. They stated below 45. They were shown the accumulation of condensation in the Aortic Air two door reach in cooler and made aware temperature readings of internal food products were above 41 degrees F. On 10/25/22 at 1:00 p.m., the lunch meal service was observed. Dietary aide #1 was observed scooping enchiladas from a pan off of the steam table with a spatula with their right hand. When they plated the enchiladas they were observed using their left bare hand to push the enchiladas onto the plate off of the spatula. On 10/31/22 at 9:36 a.m., the DM was asked at what temperature should cold foods be held. They stated below 41 and now their policy for date marking was 24 hours for leftover foods that were potentially hazardous. They were asked how staff ensure food was protected from cross-contamination. They stated staff were to wash their hands and use gloves, and not to store raw food above ready to eat food. They stated the use of bare hands was probably not allowed. The DM was asked how staff ensured the physical environment and equipment was maintained clean and in good repair. They stated they cleaned daily and as needed, and the ice machine was cleaned once a week. The stated there was a maintenance request form to fill out for any requests with maintenance issues. They were asked where chemicals were to be stored. They stated they had a chemical room or chemicals are attached to the dish machine. They stated cloths in use should be stored in sanitizer. The DM was made aware of the above observations. 38495 2. On 10/25/22 at 1:12 p.m., CNA #3 served a meal, hand hygiene was not observed before serving the meal. The CNA touched the strings on her sweatshirt, touched her glasses and then served another meal. CNA went back to the window pass, touched her pants, and served another meal, then back to the pass. Hand hygiene was not observed. The other staff member in the dining room was observed to used hand hygiene, then touch her glasses, and delivered a meal. On 10/25/22 at 1:49 p.m., CNA #4 was observed to pick a fork up from the floor and did not perform hand hygiene before delivering a meal to a resident. On 10/25/22 at 1:52 p.m., CNA #5 was observed to carry a drinking glass by rim to room [ROOM NUMBER], used hand hygiene before getting another tray. Then carried the drinking glass by the rim to room [ROOM NUMBER] sat down to assist a resident to eat. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/25/22 at 1:56 p.m., CNA # 5 was observed to put the meal tray that came from a resident room back on the food cart with other meals not yet served. CNA #5 then took another meal to another resident. Hand hygiene was not perform. On 10/26/22 at 8:57 p.m., the snack cart went out to the East Hall there were four bowls of oranges, four yogurts, nine chicken sandwiches, and three ice creams on the cart. CNA #6 was observed to pass ice to some residents but not to all the residents. On 10/16/22 At 9:00 p.m., the CNA #6 was observed to pick up ice that had been dropped on the floor, then placed the lid on a water container, and then performed hand hygiene. CNA #6 did not pass snacks to all the resident's on the East Hall rooms 1, 2, 3 or 16 were not asked if they wanted snacks. At 9:07 p.m., CNA #6 put ice and water in a pitcher for Res #17 and took a chicken sandwich in his room. CNA #6 did not perform hand hygiene between residents and passed snack to resident in room [ROOM NUMBER]. CNA #6 was observed to pick up ice off the floor and did not perform hand hygiene before passing the next snack. CNA #6 picked up more ice from the floor placed it on the bottom of the snack cart, proceeded to pass snacks. She touched her pants, the door facing of room [ROOM NUMBER], scooped ice and put water in a cup, then passed snack to the next room. Hand hygiene was not performed. At 9:14 p.m., CNA #6 touched her mask, pulled it down to talk to a resident, gave the resident in room [ROOM NUMBER] a snack, opened his water container, placed ice in container, sat it on the snack cart to place the lid on the water container. Hand hygiene was not performed before she went to the next room. On 11/01/22 at 8:18 a.m., LPN #1 stated hand hygiene should be performed between each tray when passing meals or snacks. LPN #1 stated if something is dropped on the floor and picked up staff should perform handy hygiene before moving on to pass another meal or snack.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46387 Based on record review, observation, and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment, and to help prevent the development and transmission of disease. The facility failed to: a. provide signs on the entry door instructing visitors on when and how infection control measures were to be utilized while in the facility. b. wear full PPE per facility protocol while caring for COVID-19 positive residents. c. ensure infection control measures were maintained while checking glucose levels with point of care finger stick blood sugar meters. The Resident Census and Conditions of Residents form documented 35 residents resided in the facility. 1. An undated facility document titled Visitation Guidance Reliefs documented .Facilities are now required to provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19 . On 10/25/22 at 11:45 a.m., surveyors entered facility. There was no sign posted at the entrance for visitors instructing on COVID-19 preventative measures. On 10/26/22 at 7:50 a.m., surveyors entered facility. There was no sign posted at the entrance for visitors instructing on COVID-19 preventative measures. On 11/02/22 at 7:46 a.m., surveyors observed a sign on a table by the front door. On 11/03/22 at 7:45 a.m., there was no sign posted at the entrance for visitors instructing on COVID-19 preventative measures. 2. On 10/26/22 at 8:03 p.m., CNA #7 was observed on the COVID-19 unit donning PPE. The CNA put on a gown and went into the resident's room to talk to the resident. The CNA was not observed donning a shield or gloves prior to entering the resident's room. On 10/26/22 at 8:06 p.m., CNA #7 was asked if she should use a face shield when she went in the COVID positive resident's room. She stated she should use a face shield. On 11/03/22 at 9:32 a.m., the DON stated staff should wear full PPE when caring for COVID-19 positive residents. She stated full PPE included gloves, a gown, a mask, and a face shield. 3. A facility policy titled Obtaining a Fingerstick Glucose Level, dated 10/2011, documented .Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375303	A. Building B. Wing	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wewoka Healthcare Center	1400 West First Street Wewoka, OK 74884

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An undated user manual for Glucocard Vital Blood Glucose Monitoring system read in parts, .meters are for single-patient use only and should never be shared with another person, even a family member . and .Clean the outside of the meter with a damp cloth only . On 10/31/22 at 11:12 a.m., LPN #1 was observed during insulin pass. She removed the glucometer from the top drawer of the medication cart and did not sanitize it prior to obtaining a FSBS. She was not observed sanitizing the glucometer after use. On 10/31/22 at 11:17 a.m., LPN #1 was observed removing equipment from medication cart to obtain a FSBS. She was observed wiping the base of the glucometer where the test strip is inserted with an alcohol wipe. On 10/31/22 at 11:27 a.m., LPN #1 was observed removing the glucometer from the drawer to obtain a FSBS. LPN #1 was observed cleaning the base of the glucometer with an alcohol wipe prior to and after she obtained the FSBS. On 10/31/22 at 11:29 a.m., LPN #1 stated she could use either a sani-wipe or alcohol wipe to clean the glucometer. She stated she always just cleaned the ends where the strips went in. On 10/31/22 at 11:55 a.m., LPN #1 was observed cleaning base of glucometer with an alcohol wipe prior to a FSBS test. She was not observed sanitizing glucometer after use. On 10/31/22 at 12:04 p.m., LPN #1 was observed removing glucometer from top drawer of medication cart and cleaning the base of it with an alcohol wipe. The LPN was not observed sanitizing the glucometer prior to placement in the medication cart. On 10/31/22 at 12:10 p.m., LPN 1 was observed removing glucometer from top drawer of medication cart and wiping the base with an alcohol wipe. The LPN was not observed sanitizing the glucometer prior to placement in the medication cart. On 10/31/22 at 4:00 p.m., the DON was notified of the policy and manufacturer's instructions for the glucometer. She stated she was not previously aware that their current process was not in accordance with policy and manufacturer's instructions. 33148 4. On 10/25/22 at 1:00 p.m., the lunch meal service was observed in the kitchen. Dietary aide #1 and dietary cook #1 were observed with their masks below their noses while handling food. On 10/31/22 at 9:36 a.m., the DM was asked how staff were instructed to wear their masks. They stated their masks should cover their noses.