STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375334	A. Building B. Wing	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Rest Care Center	210 South Adair Pryor, OK 74361

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41809 Based on observation and interviews the facility failed to ensure chemicals were secured to prevent accident hazards. The Resident Census and Conditions of Residents report, dated 05/17/22, identified 34 residents who resided at the facility. Findings: On 05/17/22 at 10:20 a.m., during the initial tour, a shower room on the central hall was unlocked. In the whirlpool area of the shower room was a cabinet on the wall unlocked with multiple bottles of shampoo, conditioner, body wash, and deodorant with labels that documented to keep out of reach of children. In the entryway of the shower room was a wall of cabinets, with the ability to be locked, was unlocked with multiple bottles which contained labels that documented keep out of reach of children. Ten residents were identified to reside on the hall. No residents were in the hall at the time of discovery. A catalog was taken of the bottles: 1 - 18 oz bottle of Surge Body wash for men 1 - 5.5 oz bottle of darling heart pear and blossom scented body lotion 1 - 12 oz bottle of dove men + care dermacare scalp anti-dandruff fortifying shampoo + condition + pyrithione zinc 6 - 1.8 oz speed stick deodorants 2 - 2.6 oz right guard deodorants 2 - 5.1 oz [NAME] after shave balm 1 - 2.8 oz screem power stick body spray 1 - 8.0 oz Blue cedar 75% hand sanitizer bottle 1 - 1.5 oz Medline roll-on anti-perspirant (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 - 2.6 oz Secret coconut antiperspirant 1 - 1.4 oz Suave powder invisible solid deodorant 1 - 1.5 oz fresh mint fluoride toothpaste 1 - gallon bottle of light orange liquid with approximately two inches of liquid 1 - 1.1 oz can of medspa shave cream 18 - 4 oz mouth wash dukal corp 2 - 7.5 oz peri wash dermarite 4 - 1 gallon perifresh dermarite 47 - 1.5 oz Medline roll on deodorant On 05/17/22 at 10:31 a.m., the activities director was asked how many residents wandered in the facility. The activities director stated six, three on central hall, and three on the north hall. On 05/17/22 at 10:46 a.m., two CNAs entered and exited the shower room. The CNA's did not remove the hazards from the room and secure them. On 05/17/22 at 10:47 a.m., the shower room was confirmed to be locked. The key to the shower room was tied to a rubber, stretch strap, hanging on the wall next to the door to the shower room. The key was accessible to residents. On 05/25/22 at 3:29 p.m., the administrator was asked how it was ensured the shower rooms were kept locked. The administrator stated usually the door is closed and we check the door knob and if it were open we would close and lock it. The administrator was asked why the cabinets in the shower room that contained chemicals were not locked. The administrator stated, I don't know.

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 On 05/19/22 at 2:38 p.m., an Immediate Jeopardy (IJ) was verified with the Oklahoma State Department of Health (OSDH) regarding the facility's failure to identify, implement, monitor, and modify interventions to prevent an extreme weight loss. Record review and interview revealed the resident's weight loss had not been identified, monitored, or intervened by the facility from December 2021 to May 2022. Resident #13 was readmitted in December with a documented weight of 190.3 pounds and a recent weight documented on 05/03/22 of 123.68 pounds. This accounted for a severe weight loss of 33.43% in five months. Documentation from the dietician identified the significant weight loss and informed the facility. No documentation was provided by the facility that interventions had taken place on recommendation of the dietician. At 2:46 p.m., the facility's administrator, and regional consultant nurse were made aware of the IJ situation related to the facility's failure to prevent severe weight loss. A plan of removal of the IJ situation was requested. On 05/20/22 at 10:06 a.m., the regional consultant nurse provided an acceptable plan of removal. The plan of removal documented, Plan of Removal 05/19/2022 Resident at [Risk- Resident #13], and all residents Current Information/Plan in Place 1. Medical Director has been notified about IJ our Plan of Removal with respect to [Resident #13] 15:00 05/19/2022. 2. IJ situation brought to the attention of Administrator at 14:50 05/19/2022. [Resident #13] was sent to ER in [name removed] Hospital at 13:36. Hospital to draw labs 15:00 05/19/2022. 3. All residents except hospice and actively passing residents will be weighed, and weights will be reviewed by nurse consultant to be completed by 2200 05/19/2022. Physician will be notified of weight variances with orders to be obtained and interventions to be implemented and order written, and intervention place on care plan 20:00 05/19/2022. 4. In-services on meal percentages documentation and refusal of meal documentation on 05/19/2022 by nurse consultant for nursing staff to include both in-person and over the phone education of meal percentages, who to notify of refusal being the charge nurse, documentation of meal percentages, with documentation of meal percentages sheet placed in DON/Nurse Consultant for review with a supplement to be given if intake eaten is less than 50% completed 18:00 05/19/2022 6. Nurse Consultant to review all current weights and supplement orders at 22:00 5/19/2022. 7. Dietitian report obtained for visit to facility today 05/19/2022, reviewed by nurse consultant, physician reviewed , copies place in dietary binder, recommendations signed and orders written, and intervention will be implemented and placed on care plans 20:00 05/19/2022. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Systems: nurse consultant will review weight weekly and notification to physician with order obtained and actions take with interventions and care plans updated 20:00 05/19/2022. On 05/20/22, interviews were conducted with a total of ten employees who worked different shifts. The employees verified they had been in-serviced regarding the components documented in the plan of removal and that they understood the information provided. On 05/20/22 at 1:19 p.m., the corporate nurse was informed the IJ had been lifted as of 05/19/22 at 7:30 p. m. The deficient practice remained at a level of actual harm, isolated. Based on record review, observation, and interview, the facility failed to assess, monitor, and intervene for severe weight loss of one (#13) of three residents sampled for weight loss. Resident #13 was readmitted in December with a documented weight of 190.3 pounds and a recent weight documented on 05/03/22 of 123. 68 pounds. This accounted for a severe weight loss of 33.43% in five months. The Resident Census and Conditions of Residents identified 34 residents lived at the facility. Findings: Resident #13 was readmitted to the facility on [DATE] with diagnoses that included intracerebral hemorrhage and dysphagia. The resident was documented to weigh 190.3 pounds. Resident #13's MDS assessments did not document a significant change or weight loss for the resident. Resident #13's care plan, dated 12/14/21, did not document a weight loss or any interventions for weight loss. The care plan was not updated for the need to monitor during meals. A Physician's Order, dated 12/14/21, documented the resident's diet as a regular diet with mechanical soft texture. Review of meal percentages revealed: December 15th through 31st meal percentages were documented 10 out of 51 opportunities as 76-100% 3 times, 51-75% one time, 26-50% three times, 1-25% three times. A progress note, dated 12/16/2021 at 11:00 a.m., read in part, .Ate about 40% breakfast with assistance. Will not eat by himself @ this time . A physician's note, dated 12/16/21, documented a decrease of 20-30 pounds while at home with wife/hospital. No orders were provided. A progress note, dated 12/19/2021 at 1:26 p.m., read in part .Staff assist [name removed] with lunch, good appetite while someone is at bedside . January 1st through 31st meal percentages were documented five out of 93 opportunities as 76-100% two times, 51-75% two times, 26-50% one time. On 01/06/22 the resident's weight was documented as 166.5 pounds. No interventions were documented. This was a 23.8 pound loss from December 2021. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Admission Nutrition Assessment, dated 01/26/22 at 1:55 p.m., read in part, [Resident #13's] weight 166.5 as of 01/06/22 .Requires feeding assistance. Diet is adequate to meet nutritional needs. Noted he was sent out to hospital this morning. Will rec [recommend] d/c [discontinue] heart healthy from diet order at next visit. February 1st through 28th, meal percentages were documented once out of 93 opportunities as 1-25%. A Physician's Order, dated 02/02/22 at 10:47 a.m., documented, per Speech Therapy. Mech soft and nectar thick liquids. On 02/16/22 resident #13's weight was documented as 170.2 pounds. This was a 20.1 pound loss or 10.5% loss from readmission in December 2021. A dietician note, dated 02/16/22 at 11:09 a.m., documented the resident's weight as 170 pounds as of 02/16/22. A weight increase of 3.7 pounds for one month and a diet as mechanical soft, heart healthy. A progress note, dated 02/25/22 at 1:01 p.m., read in part, .Resident refused to eat lunch, states will drink the fluids but is not going to eat anything at this time .WCTM [will continue to monitor] for any changes or continued behavior . There were no further notes documenting continued monitoring. March meal percentages were not documented out of 93 opportunities. No weights were documented for this month. Resident #13 had a significant weight loss during this month. The facility had not implemented interventions for severe weight loss of 10.5 pounds experienced by Resident #13. A dietary note, dated 03/22/22 at 2:03 p.m., documented, .March wt [weight] not confirmed. Diet: Regular, Mechanical Soft, nectar thickened liquids. Wound R [right] ankle per wound report 3/2. Receives Vit C and Zinc. Rec: Daily MVI [multivitamin] with minerals. No weights were documented for March 2022. April meal percentages were documented three out of 90 opportunities as 76-100% two times, 26-50% one time. A dietary note, dated 04/13/22 at 3:00 p.m., read in part, .Weight 132# [pounds] as of 4/11. Reflects a significant weight loss compared to February. Staff reports that resident has very poor meal intake. He doesn't like thickened liquids. Diet: Regular, Mechanical Soft, nectar thickened liquids .Noted hospice being considered. Will notify physician of significant weight change. If resident does not go on hospice soon, is he a candidate for enteral nutrition support? May meal percentages were documented 11 out of 51 opportunities as 76-100% five times, 51-75% two times, 26-50% two times, 1-25% two times. On 05/03/22 resident #13's weight was documented as 126.68 pounds, which is a 33.43% loss since readmission on 12/14/21. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 05/13/22 at 8:01 p.m., read in part, .[Resident #13] did not want to get OOB [out of bed] for the evening meal today, with two different people asking. States, no, I'm waiting for my wife. The note did not document if the resident was offered a meal in his room or a supplement drink. A progress note, dated 05/16/22 at 6:07 a.m., read in part, .Resident began yelling out at about 0500 [5:00 a.m.], stating he missed his meals, he did not miss his meals .states he wants food now . No documentation provided for resident being offered any food or snack options. There were no documented inteventions for Resident #13 severe weight loss experinced from 12/14/21 through 05/03/22. On 05/18/22 at 3:27 p.m., CNA #3 stated the meal percentages were documented on a clipboard and then entered in the computer by the CNAs. On 05/18/22 at 4:31 p.m., the corporate nurse consultant stated the dietician will be here tomorrow. The nurse stated, I know the doctor saw April recommendations but I need to look for the other ones, I don't think the dietician sends individual recommendations to the doctor but they send the whole report. On 05/19/22 at 8:23 a.m., Res #13 was observed in bed, sitting at a 30 degree angle, a plate was on the over bed table with a half eaten sausage patty, remnants of egg on the plate and on the resident. Staff was not present in the room. Resident #13 required assistance to eat and supervision for choking. On 05/19/22 at 8:43 a.m., CNA #1 stated several residents required assistance with eating. Resident #13 required assistance sometimes. The CNA was asked how they knew which residents required assistance. The CNA stated when it was charted or given in report. The CNA stated breakfast was typically passed by the CNAs but today breakfast was passed by the regional nurse and activities director because they were short a CNA. The CNA was asked if they were able to meet the needs of residents when staff was missing. The CNA stated no. On 05/19/22 at 8:54 a.m., The activities director stated they had assisted residents and helped pass trays to residents, including resident #13's tray. The activities director stated none of which required assistance or supervision while eating. Resident #13 required assistance to eat and for risk of choking due to dysphagia. On 05/19/22 at 8:55 a.m., CNA #2 stated resident #13 required limited assistance with supervision for choking. The CNA was asked how they assisted residents to eat when there were only two aides for the building. The CNA stated, We do the best we can. On 05/19/22 at 9:50 a.m., the registered dietician stated they came once a month and saw everyone. The dietician stated the recommendations to the physician and a summary for the facility were left with the DON. The dietician stated if recommendations were not addressed from the previous month the recommendation would be made again the next month. The dietician was asked to describe the weight loss from December on readmission to the May weight. The dietician stated very significant. The dietician was asked if the weight loss were to continue, what would be the end result. The dietician stated the resident cannot continue like that. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/19/22 at 10:49 a.m., the corporate nurse consultant was asked how weights were monitored. The nurse stated a list was given to the previous DON when the consultant nurse arrived. The previous DON did not follow through with the list, weights were not monitored or assess for variance. The corporate nurse was asked if the dietician recommendations were addressed by the physician. The nurse stated they would have to look for them. The corporate nurse was asked when it was noticed the weights were not addressed. The nurse stated the second week in March. The nurse stated the weights were not addressed because the weight report had not been pulled. On 05/25/22 at 1:34 p.m., the administrator was asked how weights were monitored and addressed. The administrator stated that was the responsibility of the DON. The administrator was asked who was responsible to ensure the weights were monitored and addressed. The administrator stated the corporate nurses. The administrator was asked, as the administrator, how did you ensure that you utilized resources to ensure weight loss did not occur. The administrator stated they were not made aware of the weight loss.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on record review and interview the facility failed to notify the physician of a severe weight loss for one (#13) resident with severe weight loss. The corporate LPN #1 identified seven residents at risk for significant weight loss. Findings: Resident #13 was readmitted to the facility on [DATE] with diagnoses that included hemiplegia and dysphagia. The resident's weight was documented as 190.3 pounds. Review of Resident #13's weights revealed a readmission weight of 190.3 pounds on 12/14/21, a 01/06/22 weight of 166.5 pounds, a 02/04/22 weight of 170 pounds, no weight was documented in March, a 04/11/22 weight as 132.6 pounds, and a 05/03/22 weight of 126.68 pounds. This was a total weight loss of 33.43%. No evidence was provided to indicate the physician was involved in/notified of the weight loss of Resident #13. On 01/26/22 the dietician made recommendations to discontinue a heart healthy diet restriction and to give a house supplement with meals. Resident #13's weight was not addressed on the recommendation by the dietician. These recommendations were not ordered by the physician. On 02/16/22 the dietician made recommendations to discontinue a heart healthy diet restriction and to give an extra serving of protein with meals. Resident #13's weight was not addressed on the recommendation by the dietician. The heart healthy diet restriction was discontinued. The extra serving of protein with meals was not ordered by the physician. The consultation report was submitted to the administrator for review and approval. On 03/22/22 the dietician made a recommendation to give daily MVI with minerals for wound management to Resident #13. This recommendation was ordered by the physician on 03/30/22. No weight was documented by the facility for this month. On 04/13/22 the dietician made note of the significant weight loss. The dietician documented Resident #13's weight for February was 170 pounds, and April weight of 132 pounds. The dietician documented poor intake, wounds, thickened liquids. The dietician questioned if Resident #13 was a candidate for enteral nutrition support. This recommendation was not addressed. The consultation report was emailed to the administrator and a copy was left with the dietary manager. On 05/03/22 Resident #13 was documented to weigh 123.68 pounds, this was a 33.43% loss in five months. On 05/19/22 at 9:50 a.m., the dietician was asked if the April recommendations were addressed by the physician. The dietician stated no, they were left with the former DON. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/19/22 at 10:49 a.m., the corporate LPN #1 was asked if weights had been addressed by the former DON. The nurse stated, no the former DON would get started but not finish. The nurse was asked if the April dietician's recommendations were addressed. The nurse stated they were given to the DON and reviewed with the physician, but they were unable to locate the recommendations or the physician's orders. The nurse was asked if the weights were reviewed after the DON left. The nurse stated the weight report had not been pulled.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 41809 Based on record review, observation, and interview, the facility failed to ensure sufficient support staff for food and nutrition services. The corporate LPN #1 identified 33 residents received meals from the kitchen. Findings: Kitchen serving times posted in the dining room were to be: Breakfast 7:30 a.m. Snack 10:00 a.m. Lunch 12:00 p.m. Snack 2:00 p.m. Dinner 5:00 p.m. Snack 7:00 p.m. On 05/17/22 at 9:51 a.m., the DM was observed to be the only person in the kitchen preparing the noon meal. The DM was asked if there were anyone else to assist in the kitchen. The DM stated during the week it was just the DM. The DM stated they had a cook and an aide to work the weekends, none are certified yet. The DM stated the facility was sending them to class next week. On 05/17/22 at 11:29 a.m., Res #22 and #25 stated meals are typically 30 minutes late, silverware is not always available and the food was cold. On 05/17/22 at 12:14 p.m., cook #1 was present in kitchen to assist during noon meal. The meal was served to residents at 12:30 p.m. On 05/24/22 at 10:46 a.m., the DM was asked who assisted in the kitchen for the AM meal. The DM stated the administrator helped with dishes today. The DM was asked what time breakfast was served. The DM stated it was served at 7:45 a.m. The DM stated it was just themselves during the week and two people on the weekend. The DM was asked if that were enough staff to provide meals in a timely manner on the weekends. The DM stated yes. The DM was asked if it were enough staff during the week. The DM stated not always. On 05/24/22 at 12:00 p.m., corporate nurse consultant #1 was present in the kitchen to assist with setup for lunch. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/24/22 at 12:27 p.m., the DM began serving lunch. Lunch was scheduled for 12:00 p.m. The DM was the only personnel in the kitchen. On 05/25/22 at 1:34 p.m., the administrator was asked how they ensured meal delivery was timely. The administrator stated, I go to the dining room, residents come tell me, employees come tell me. The administrator was asked what the plan was. The administrator stated they have hired people, but they don't stay. The administrator stated the money isn't enough, or they will no call no show. The administrator stated they are trying to get the DM help, they now have weekend people. The administrator was asked about pulling staff from a sister home. The administrator stated, I would rather not say anything about that. You can't pull if they don't have staff. On 05/25/22 at 3:26 p.m., the DM was asked how long there had not been sufficient dietary staff to provide timely meals. The DM stated since before the beginning of March. The DM stated at that time it was just themselves for weekends and everything.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41809 Based on record review, observation, and interview, the facility failed to administer in a manner that enabled the use of its resources to effectively and efficiently attain or maintain the highest practicable level of well-being for each resident. The Resident Census and Conditions of Residents report, dated 05/17/22, identified 34 residents who resided at the facility. Findings: 1. The facility failed to assess, monitor, and intervene for severe weight loss of one (#13) of three residents sampled for weight loss. Resident #13 had a severe weight loss of 33.43% from December 2021 to May 2022 which was identified during the survey. Weights were obtained each month except in March 2022. The dietician identified and notified the administrator via recommendation sheets in February 2022, and via email in April 2022 of the significant weight loss. No actions were taken by administration. This resulted in an IJ being identified by the Oklahoma State Department of Health (OSDH). When the immediacy was removed it remained at a pattern level harm. On 05/25/22 at 1:34 p.m., the administrator was asked how they ensured they utilized resources to ensure weight loss did not occur. They stated they were not informed of the weight loss. They were asked if it was addressed with QAA or QAPI. They stated no. The administrator was asked if resources were effectively used in regards to the weight loss. They stated no because they were not informed of the weight loss. The administrator was asked if they should have been aware of the resident's weight loss. They stated yes. The administrator was asked if they had provided oversight of the DON. The administrator stated, I was giving them a list of tasks to complete, the DON and corporate nurses, weights were one of them. The administrator was asked how they followed up. The administrator stated, I had regular meetings with my nurses, checking in with them. The administrator was asked if they had specific meetings in March and April. The administrator stated, No the nurses did. They were asked if they were involved in the meetings. The administrator stated no the nurses communicated the information to them. The administrator was asked why they were not an active part of the meetings. The administrator stated, I had to fix other things. 2. The facility failed to ensure dependent residents were offered/provided showers/baths as scheduled for three (#1, #23, and #30) of three sampled residents who were reviewed for ADL care. During the survey three residents were identified as not receiving baths/showers as scheduled. Resident #1 was offered/received eight out of 17 showers for the months of April and May. Resident #23 was offered/received 10 out of 13 showers for the months of April and May. Resident #30 was in the facility 03/01/22 through 03/10/22 and was not offered any showers. Resident #30 was offered/received nine out of 13 showers for April and May. On 05/24/22 at 10:42 a.m., CNA #4 was asked about residents receiving showers/baths as scheduled. They stated with only two CNAs showers were 'hit and miss'. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375334	A. Building B. Wing	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Rest Care Center	210 South Adair Pryor, OK 74361

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The facility failed to have a full time DON and failed to provide eight hours of RN coverage for 11 of 15 days reviewed for RN coverage. On 05/17/22 at 10:51 a.m., the administrator was asked if the facility had a full time DON. They stated the former DON had resigned approximately one week ago. The administrator was asked who had provided RN coverage for the facility. They stated they had not had RN coverage since the DON resigned. The administrator was asked if the facility had a staffing waiver. They stated no. 4. The facility failed to ensure staffing met the state minimum requirements for ten of 45 shifts reviewed and ensured sufficient staffing to provide care to the residents for three (#1, #23, and #30) of three sampled residents who were reviewed for ADL care. On 05/25/22 at 1:34 p.m., the administrator was asked who was responsible to ensure daily staffing was sufficient to meet minimum state requirements and residents' needs. The administrator stated corporate LPN #2 had been working on the daily staffing. They stated their roll was to look at the numbers and ensure there were enough staff. The administrator stated they made the decision on if the facility utilized agency staff. The administrator was asked why ten shifts had not met the state's minimum staffing requirements. They stated staff had probably called in and they had been directed to not use agency staffing by the Regional Director but have recently began using agency staffing services again. The administrator was asked if they were receiving new admissions. They stated yes but they did not get a lot of new admissions. They stated they received a new admission on 05/24/22 but the facility's census averaged approximately 35 residents.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 41809 Based on record review and interview, the facility failed to identify, develop, and implement corrective actions for weight loss and ADL assistance for dependant residents through the facility's quality assurance and performance improvement (QAPI) program. The Resident Census and Conditions of Residents report, dated 05/17/22, identified 34 residents who resided at the facility. Findings: 1. The facility failed to assess, monitor, identify, and intervene for severe weight loss of one (#13) of three residents sampled for weight loss. Resident #13 had a severe weight loss of 33.43% from December 2021 to May 2022 which was identified during the survey. Weights were obtained each month except in March 2022. The dietician identified and notified the administrator via recommendation sheets in February 2022, and via email in April 2022 of the significant weight loss. No actions were taken by administration. This resulted in an IJ being identified by the Oklahoma State Department of Health (OSDH). When the immediacy was removed it remained at a pattern level harm. On 05/25/22 at 1:34 p.m., the administrator was asked how they ensured they utilized resources to ensure weight loss did not occur. They stated they were not informed of the weight loss. They were asked if weight loss had been addressed with QAA or QAPI. They stated no. 2. The facility failed to ensure dependent residents were offered/provided showers/baths as scheduled for three (#1, #23, and #30) of three sampled residents who were reviewed for ADL care. During the survey three residents were identified as not receiving baths/showers as scheduled. Resident #1 was offered/received eight out of 17 showers for the months of April and May 2022. Resident #23 was offered/received 10 out of 13 showers for the months of April and May 2022. Resident #30 was in the facility 03/01/22 through 03/10/22 and was not offered any showers. Resident #30 was offered/received nine out of 13 showers for April and May 2022. On 05/24/22 at 10:42 a.m., CNA #4 was asked about residents receiving showers/baths as scheduled. They stated with only two CNAs showers were 'hit and miss'. On 05/25/22 at 2:13 p.m., the corporate LPN #1 stated they had not assessed 'formally' weight loss or showers for quality assurance. The LPN stated they had given information to the former DON regarding weight monitoring but had not implemented a formal plan and had not identified a concern with weight loss or showers prior to the survey.

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	375334	A. Building B. Wing	05/25/2022

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on observation, record review and interview, the facility failed to ensure the prevention of COVID-19 spread and that their facility contingency plan was followed. The infection preventionist identified six of 58 employees who were unvaccinated. Findings: A facility policy, titled Covid-19 Vaccine Policy, dated 02/25/22, read in parts, .Additional Precautions and Contingency Plans for Unvaccinated Staff .Staff who receive an exemption to the COVID-19, which includes: Staff who receive an exemption to the Covid-19 vaccine and staff who are not fully vaccinated will wear a KN95 face covering while at work regardless of assigned work area . A review of the facility's employee vaccination report showed 6 of 58 employees were partially vaccinated (2) and unvaccinated (4). On 05/17/22 at 9:30 a.m., maintenance worker #1 was observed to enter the facility with a surgical mask. On 05/17/22 at 10:45 a.m., the administrator was asked if the facility had COVID-19 currently or in the past four weeks. The administrator stated no. On 05/19/22 at 3:18 p.m., the MDS coordinator was observed to wear a surgical mask. On 05/20/22 at 11:28 a.m., CNA # [NAME] sharp was observed to wear a surgical mask. On 05/23/22 at 4:26 p.m., the infection preventionist was asked how they ensured residents were protected from employees who were not fully vaccinated. They stated by having the unvaccinated employees wear a KN95 mask. They were asked how they ensured the policy was followed. They stated they were not monitoring to ensure the policy was followed.