| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31949<br><br>Based on interview and record review, it was determined the facility failed to ensure a resident's right to privacy was not violated by posting a video to social media for one (#1) of ten residents reviewed. The facility reported 37 residents lived in the facility. Findings:<br><br>A facility employee handbook, dated 10/01/20, documented employee discipline policies and professional and personal responsibility related to cell phones. The handbook documented cell phones were only permitted during breaks or lunch. The handbook documented the employees were not permitted to carry or use their cell phones while on duty.<br><br>Resident #1 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and anxiety.<br><br>A quarterly assessment, dated 02/19/21, documented the resident was severely impaired with cognition and required total care for all activities of daily living.<br><br>An initial state reportable incident report, dated 04/30/21, documented it was brought to my attention certified nurse aide in training (CNAT) #1 had made a video in the resident's room and posted on social media. The report documented the CNAT had been suspended immediately. The report documented an investigation had been initiated. The report documented the physician, family, the local police department and adult protective services had been notified.<br><br>A final state reportable incident report, dated 04/30/21, documented the investigation had been concluded. The report documented negative findings against CNAT #1. The local police department reported there was no criminal case. The report documented the CNAT #1 was terminated and reported to the nurse aide registry.<br><br>On 05/17/21 at 4:21 p.m., the administrator (AM) reported CNAT #1 had posted a video of the resident on social media. The ADM reported he had seen the video. The ADM reported the video lasted between 15 and 20 seconds. The ADM reported the video showed the resident with his shirt on and a brief. The ADM reported the CNAT was immediately place on suspension until the investigation was completed. The ADM reported once the investigation was completed the CNAT was terminated. The ADM reported the CNAT had received the employee handbook containing the policy regarding the use of cell phones. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31949<br><br>Based on observation, interview, and record review, it was determined the facility failed to provide care and treatment according to physician's orders for two (#4 and #9) of 10 residents reviewed. The facility failed to obtain an order prior to administering medications for resident #4. The facility failed to administer medications as prescribed by a physician for resident #9. The facility reported 37 residents lived in the facility. Findings:<br><br>1. Resident #4 was admitted to the facility on [DATE] with diagnoses which include pulmonary hypertension, seizures, and diabetes mellitus with neuropathic arthropathy.<br><br>A quarterly assessment, dated 02/01/21, documented the resident was cognitively intact and was totally dependent on staff for activities of daily living.<br><br>A combined initial and final state reportable incident report, dated 04/23/20, documented an allegation the director of nursing (DON) had directed staff to administer bio freeze to the resident's testicles with no order. The report documented the nurse practitioner was unaware of the incident and reported they would not give such an order because the bio freeze would be contraindicated for the use of this kind. The report documented the resident reported the bio freeze burned. The report documented the DON was suspended pending the investigation. The report documented the physician, family, adult protective services, the local law enforcement, and the appropriate licensing board were notified.<br><br>An Oklahoma Board of Nursing report of nursing practice incident, dated 04/24/20, documented registered nurse (RN) #1 directed nursing staff to apply an ointment on a resident which was contraindicated and without a physician's order.<br><br>An Oklahoma Board of Nursing report of nursing practice incident, dated 04/24/20, documented licensed practical nurse (LPN) #1 applied topical cream to a resident that was contraindicated without a physician's order at the direction of RN #1.<br><br>On 05/17/21 at 9:20 a.m., the resident was observed lying in bed with his eyes closed.<br><br>On 05/18/21 at 9:55 a.m., the resident reported RN #1 ordered LPN #1 to apply bio freeze to my scrotum. The resident reported it burned like fire for a long time.<br><br>On 05/18/21 at 11:00 a.m., the administrator (ADM) reported he was not the ADM at the time the incident occurred.<br><br>33629<br><br>2. Resident #9 had diagnoses which included diabetes, quadriplegia, pain, depression, and anxiety.<br><br>A quarterly assessment, dated 11/03/20, documented the resident required extensive assistance with most of his activities of daily living.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A Medication administration record (MAR), dated 04/01/20 through 04/30/20, documented Baclofen 15 milligram (mg) by mouth four times a day was not given at 8:00 p.m. (2000) on the 18th, 26th, and 29th. Nor was it given at 8:00 a.m. (0800) on the 24th.<br><br>The MAR also documented Gabapentin 300 mg by mouth four times a day was not given at 8:00 p.m. (2000) on the 18th, 26th, and 29th. Nor was it given at 8:00 a.m. (0800) on the 24th.<br><br>The clinical record contained no documentation the resident had refused his medication.<br><br>On 05/18/21 at 2:35 p.m., certified medication aide #1 reported the MAR should have been initialed on those dates and times if given or a 2 for resident refused. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31949<br><br>On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to prevent the development and worsening of pressure ulcers (PU's), to consistently and thoroughly assess the resident's skin, and to notify the physician and intervene in a timely manner for the PU's. The resident did not have weekly skin assessments conducted and developed a stage II pressure ulcer to the left inner buttock. The resident later developed a pressure ulcer to the right upper buttock that progressed to a Stage IV. Both wounds joined each other creating an unstageable pressure ulcer due to necrosis, to the sacrum. An infection was identified in the wound.<br><br>On [DATE], the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.<br><br>At 2:30 p.m., the administrator was notified of the IJ situation.<br><br>At 5:16 p.m., an acceptable plan of removal was provided. The plan of removal was updated on [DATE]. The plan of removal documented:<br><br>.On [DATE] Administrator/designee began an instant in-service with all nursing staff on Policy and Procedures for assessing, monitoring and intervening for pressure ulcers. Emphasis was made on how to identify skin breakdown, subsequent actions such as notifying the charge nurse immediately, who in turn notify the physician and the wound care physician immediately. DON was in serviced on weekly monitoring and making sure wound care physician's order and recommendations are strictly followed. To be completed by [DATE] @ 5:30 PM<br><br>Facility QA from [DATE] till present for wound care and documentation will be reviewed and updated to represent new findings. Physician and wound care doctor will be notified immediately of all skin breakdown.<br><br>Skin assessments to be completed on all residents [DATE] @5:00PM. All skin breakdown will be reported to the physician and the wound care doctor immediately.<br><br>On, [DATE] DON/MDS Coordinator will begin chart review and identify residents that have the potential to be affected by this deficient practice. Care Plans will be reviewed and updated to be completed by [DATE] @ 5:45 PM. Findings will be reported to physician immediately for further review and recommendations<br><br>DON will review the [name of company] wound care recommendations and orders and make sure they are adhered to. To be completed by [DATE] @ 5:45 PM<br><br>Beginning [DATE], Admin and nurse managers will conduct weekly at-risk meetings to monitor for pressure ulcers. Findings will be reported to physician immediately for further review and recommendations.<br><br>All immediate actions will be completed by 5:45 PM [DATE] and monitoring to continue thereafter .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On [DATE] at 10:40 a.m., the IJ was removed when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at pattern level.<br><br>On [DATE] and [DATE], interviews were conducted with the nursing staff regarding education and in-service information pertaining to the immediate jeopardy plan of removal. The staff stated an in-service was provided on [DATE] and [DATE]. The staff was able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal.<br><br>Based on staff interview and record review, it was determined the facility failed to provide treatment and services necessary to promote healing and to prevent the worsening of a pressure ulcer for one (#10) of five residents reviewed with pressure ulcers. The facility reported six residents required pressure wound treatment.<br><br>The resident did not have weekly skin assessments conducted and developed a stage II pressure ulcer to the left inner buttock. The resident later developed a pressure ulcer to the right upper buttock that progressed to a Stage IV. Both wounds joined each other creating an unstageable pressure ulcer due to necrosis, to the sacrum. An infection was identified in the wound.<br><br>Findings:<br><br>A facility pressure ulcer/skin breakdown protocol, dated [DATE], documented the nurse shall describe and document/report a full assessment of the pressure sore including the location, stage, length, width, presence of exudates or necrotic tissue, pain assessment, mobility status, and current treatments. The protocol documented the physician would authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings, and application of topical agents if indicated for the type of skin alteration. The protocol documented the physician would help the staff review and modify the care plan as appropriate, especially when wounds were not healing as anticipated.<br><br>Resident #10 was admitted to the facility on [DATE] with diagnoses which included dementia, initial encounter for closed fracture of left and right femur, and unspecified severe protein-calorie malnutrition.<br><br>A physician's order, dated [DATE], documented for the resident to receive a supplement of Ensure with meals.<br><br>A care plan, dated [DATE], documented the resident had a right and left femur fracture and was at risk for skin breakdown. The care plan documented the resident had a protein calorie mal-nutrition diagnosis and was at risk for skin breakdown. The care plan documented the resident had potential impairment to skin integrity related to fragile skin, surgical wound, malnutrition and decreased mobility. The care plan documented for the staff to monitor for skin changes.<br><br>A care plan, dated [DATE], documented the resident had a diagnosis of protein calorie mal-nutrition and was at risk for skin breakdown, weight loss, and poor healing of fractures. The care plan documented a goal was for the resident to have gradual weight gain of at least two pounds weekly. The care plan documented for the staff to monitor, record, and report to the physician signs and symptoms of malnutrition such as significant weight loss of greater than 5% in one month. The care plan documented for the staff to provide supplements as ordered such as Ensure or house supplement with meals.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The care plan contained no documentation regarding the pressure ulcer.<br><br>An admission assessment, dated [DATE], documented the resident was severely impaired with cognition and required extensive assistance with activities of daily living. The assessment documented the resident was at risk for developing a pressure ulcer. The assessment documented the resident did not have a pressure ulcer upon admission. The assessment documented the resident was frequently incontinent of bowel and bladder. The assessment documented the resident weighed 163 pounds. The assessment documented the resident required a pressure reducing device for his chair and his bed. The assessment documented the resident required a turning and or repositioning program. The assessment documented the resident required a nutrition or hydration intervention to manage skin problems. The assessment documented the resident was to receive physical therapy and occupational therapy.<br><br>A nurse's note, dated [DATE] at 12:34 p.m., documented, Stage II pressure sore noted to L inner buttock measuring approx 3.5 x 3.0 x 0.1 cm. Barrier cream applied. Referral to Dr. [name deleted].<br><br>The clinical record contained no physician's order for the barrier cream. The clinical record contained no physician's order for treatment of the stage II pressure ulcer.<br><br>The treatment administration record, dated February 2021, contained no treatments for the Stage II pressure ulcer.<br><br>A physician's telephone order, dated [DATE], documented to cleanse wound to left (L) inner buttock with normal saline solution (NSS), pat dry, apply gauze island border one time a day.<br><br>A wound care physician's note, dated [DATE], documented an initial wound evaluation and management summary. The note documented the chief complaint was a wound on the left heel. The physician's note documented recommendations for the resident to receive a multivitamin once daily, vitamin C 500 milligrams (mg) twice daily, and Zinc sulphate 220 mg once daily for 14 days. The physician's note contained no documentation regarding the pressure ulcer to the L inner buttock.<br><br>A medication administration record (MAR), dated [DATE], contained no documentation the resident received the multivitamin, vitamin C, or Zinc sulfate as ordered by the wound care physician.<br><br>A nurse's note, dated [DATE] at 7:29 p.m., documented the wound care doctor was here. The note documented new orders had been received for treatment to the left heel and to continue current treatment to the buttocks at this time.<br><br>A nurse's note, dated [DATE] at 12:13 p.m., documented, Telemed with PCP, new orders for Bactrim DS BID x 10 days for infection, new dx (diagnosis) of L heel DTI (deep tissue injury), Stg IV to Right upper buttock, and failure to thrive .<br><br>A physician's telephone order, dated [DATE], documented to cleanse wound to right (R) upper buttock with NSS, pat dry, apply Santyl to wound bed, pack with iodoform, cover with calcium alginate, skin prep to peri-wound, secure with bordered gauze every day and as needed if soiled.<br><br>The clinical record contained no documentation regarding the size or assessment of the pressure ulcer to the right upper buttock.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A dietary note, written by the Registered Dietician, dated [DATE], documented, Wt. [weight] 146# [pounds], down 17# past month. 10% weight loss past month. Recent hip replacement, as well as femur fx. [fracture]. Receives a Regular, Puree diet with intakes of ,d+[DATE]%,. Also receives Ensure with meals. Pressure areas present. Will follow weights for any needed interventions.<br><br>The clinical record contained no documentation the physician had been notified of the severe weight loss. The clinical record contained no documentation the care plan had been updated to reflect the severe weight loss. The clinical record contained no new interventions to prevent further weight loss.<br><br>A medication administration record (MAR), dated [DATE], contained no documentation the resident received the supplement of Ensure as ordered by the physician.<br><br>The clinical record contained no documentation regarding the condition of the pressure ulcer to the left buttock or the right buttock.<br><br>A monthly weight record, dated [DATE], documented the resident weighed 139.2 pounds.<br><br>The clinical record contained no documentation the physician or dietitian had been notified regarding the continued weight loss.<br><br>A wound care telemedicine follow up evaluation, dated [DATE], documented, .At the request of the referring provider .a thorough wound care assessment and evaluation was performed today. He has an unstageable (due to necrosis) sacrum for at least 1 days duration. There is moderate serous exudate . The evaluation documented the size of the wound was 2.3 x 3.0 x 2.5 centimeters (cm). The evaluation documented the treatment plan was to apply Santyl daily, Alginate calcium daily and cover with gauze island border. The evaluation documented recommendations for the resident to receive a multivitamin once daily, vitamin C 500 milligrams (mg) twice daily, and Zinc sulphate 220 mg once daily for 14 days.<br><br>A wound care telemedicine follow up evaluation, dated [DATE], documented, .At the request of the referring provider .a thorough wound care assessment and evaluation was performed today. He has an unstageable (due to necrosis) sacrum for at least 5 days duration. There is moderate serous exudate . The evaluation documented the size of the wound was 9.0 x 10.0 x 4.0 cm. The evaluation documented the treatment plan was to start Dakins cleanses. Cleanse and scrub wound with Dakins solution, rinse completely with normal saline, pat dry, then apply Santyl daily, and cover with gauze island border. The evaluation documented recommendations for the resident to receive a multivitamin once daily, vitamin C 500 milligrams (mg) twice daily, and Zinc sulphate 220 mg once daily for 14 days.<br><br>A wound evaluation management summary, dated [DATE], documented the wound to the sacrum was unstageable due to necrosis. The summary documented the wound size was 10.0 x 3.5 x 2.6. The summary documented the physician debrided the wound to remove the necrotic tissue and establish the margins of viable tissue. The evaluation documented recommendations for the resident to receive a multivitamin once daily, vitamin C 500 milligrams (mg) twice daily, and Zinc sulphate 220 mg once daily for 14 days.<br><br>A medication administration record (MAR), dated [DATE], contained no documentation the resident received the multivitamin, vitamin C, or Zinc sulfate as ordered by the wound care physician.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A treatment administration record (TAR), dated [DATE], contained two blank spaces where treatments had not been completed on the wound to the left inner buttock. The TAR contained two blank spaces where treatments had not been completed on the wound to the sacrum. The TAR contained two blank spaces where treatments had not been completed for the wound on the upper right buttock.<br><br>The resident expired on [DATE].<br><br>On [DATE] at 12:15 p.m., registered nurse (RN) #2 reported a certified nurse aide had informed her on [DATE] the resident had an open area to the resident's bottom. The RN reported the wound was a stage II. The RN reported she had administered barrier cream to the wound without a physician's order. The RN reported she had sent a text to the wound care physician but did not get a response. The RN reported she had not reported the wound to the primary care provider (PCP). The RN reported she should have notified the PCP. The RN reported the pressure ulcer to the left buttock and the right buttock became one wound. The RN reported wound assessments should have been documented in the progress notes.<br><br>On [DATE] at 1:50 p.m., the director of nurses (DON) reported she was not sure why the RN put barrier cream on the wound. The DON reported the physician should have been notified and treatment orders obtained. The DON reported assessments of the wound should be documented in the progress notes. The DON stated, But it's not there. The DON reported the resident was on Bactrim for an infection to the wound. The DON reported the blank documentation should have been completed. She reported if it's not documented it's not done.<br><br>On [DATE] at 3:00 p.m., the wound care physician reported the first she was aware of the wound to the buttocks was on [DATE]. The physician reported if it started out as two wounds it had became one wound when she first observed the wound.<br><br>On [DATE] at 11:35 a.m., the director of nurses (DON) reported the physician should have been notified of the severe weight loss. The DON reported new interventions should have been put into place to prevent further weight loss. The DON reported the resident should have received the Ensure in [DATE] as ordered by the physician. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31949<br><br>On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to assess and intervene in a timely manner to prevent severe weight loss for three residents who had severe weight loss. Resident #10 developed three pressure ulcers. One progressed to a Stage IV, merged with another pressure ulcer and was unstageable due to necrotic tissue. The wound became infected.<br><br>On [DATE] the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.<br><br>At 2:30 p.m., the administrator was notified of the IJ situation.<br><br>At 5:16 p.m., an acceptable plan of removal was provided. The plan of removal was updated on [DATE]. The plan of removal documented:<br><br>.On [DATE] Administrator/designee began an instant in-service with nursing and dietary staff on Policy and Procedures for assessing, monitoring and intervening for weight loss and nutritional status. Emphasis was laid on notifying the physician and the dietitian immediately a resident has weight loss, providing resident with physician ordered supplements and encouraging resident family to partake in getting resident weight back up. To be completed by [DATE]. @ 5:30 PM<br><br>On, [DATE] DON/MDS Coordinator will begin chart review and identify residents that have the potential to be affected by this deficient practice. Care Plans will be reviewed and updated. All weight loses [sic] will be reported to the physician and the dietitian immediately for orders and recommendations. Completed by [DATE] @5:45 PM<br><br>Beginning [DATE] Admin and nurse managers will conduct weekly at-risk meetings to monitor for weight loss. Findings will be reported to physician and dietitian immediately for further review and recommendations .All immediate actions will be completed by 5:45 PM [DATE] and monitoring to continue thereafter .<br><br>The immediate jeopardy was removed on [DATE] at 10:40 a.m., when all components of the plan of removal had been carried out. The deficient practice remained at a pattern of actual harm.<br><br>Based on record review and staff interview, it was determined the facility failed to identify and provide interventions to prevent severe weight loss for three (#10, #12, and #1) of three sampled residents reviewed for weight loss.<br><br>Resident #10 developed a stage II pressure ulcer to the left inner buttock. The resident later developed a pressure ulcer to the right upper buttock that progressed to a Stage IV. Both wounds joined each other creating an unstageable pressure ulcer due to necrosis to the sacrum. The resident was identified with an infection in the wound.<br><br>The facility reported 37 residents resided in the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Findings:<br><br>A nutrition impaired/unplanned weight loss clinical protocol policy documented the threshold for significant unplanned and undesired weight loss would be based on the following criteria: a. 1 month - 5% weight loss considered significant; greater than 5% considered severe, b. 3 months - 7.5% weight loss considered significant; greater than 7.5% considered severe, c. 6 months - 10% weight loss considered significant; greater than 10% considered severe.<br><br>The policy documented the physician and staff would closely monitor residents who had been identified as having impaired nutrition or risk for developing impaired nutrition. The policy documented monitoring may include evaluating the care plan to determine if interventions had been implemented and were effective in attaining established nutritional and weight goals. The policy documented monitoring may include observing for and reporting significant weight gain or loss.<br><br>1. Resident #10 was admitted to the facility on [DATE] with diagnoses which included dementia, initial encounter for closed fracture of left and right femur, and unspecified severe protein-calorie malnutrition.<br><br>A physician's order, dated [DATE], documented for the resident to receive a supplement of Ensure with meals.<br><br>A care plan, dated [DATE], documented the resident had a diagnosis of protein calorie mal-nutrition and was at risk for skin breakdown, weight loss, and poor healing of fractures. The care plan documented a goal was for the resident to have gradual weight gain of at least two pounds weekly. The care plan documented for the staff to monitor, record, and report to the physician signs and symptoms of malnutrition such as significant weight loss of greater than 5% in one month. The care plan documented for the staff to provide supplements as ordered such as Ensure or house supplement with meals.<br><br>A dietary note, dated [DATE] at 3:38 p.m., documented the resident's initial assessment. The note documented the resident weighed 163 pounds. The note documented the resident had a diagnosis of dysphagia. The note documented the resident received Ensure with meals. The note documented the resident's intake was ,d+[DATE]%. The note documented for the staff to monitor intake and weights.<br><br>An admission assessment, dated [DATE], documented the resident was severely impaired with cognition and required extensive assistance with activities of daily living. The assessment documented the resident was independent with eating. The assessment documented the resident was at risk for developing a pressure ulcer. The assessment documented the resident did not have a pressure ulcer upon admission. The assessment documented the resident was frequently incontinent of bowel and bladder. The assessment documented the resident weighed 163 pounds. The assessment documented the resident required a nutrition or hydration intervention to manage skin problems.<br><br>A nurse's note, dated [DATE] at 12:34 p.m., documented, Stage II pressure sore noted to L inner buttock measuring approx 3.5 x 3.0 x 0.1 cm.<br><br>A nurse's note, dated [DATE], documented to change the resident's diet to pureed due to having no teeth.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A physician's order, dated [DATE], documented the resident was to receive a high protein pureed diet.<br><br>A wound care physician's note, dated [DATE], documented a wound on the left heel.<br><br>A nurse's note, dated [DATE] at 12:13 p.m., documented, Telemed with PCP, new orders for Bactrim DS BID x 10 days for infection, new dx (diagnosis) of L heel DTI (deep tissue injury), Stg IV to Right upper buttock, and failure to thrive .<br><br>A dietary note, written by the Registered Dietician, dated [DATE], documented, Wt. [weight] 146# [pounds], down 17# past month. 10% weight loss past month. Recent hip replacement, as well as femur fx. [fracture]. Receives a Regular, Puree diet with intakes of ,d+[DATE]%,. Also receives Ensure with meals. Pressure areas present. Will follow weights for any needed interventions.<br><br>A medication administration record (MAR), dated [DATE], contained no documentation the resident received the supplement of Ensure as ordered by the physician.<br><br>The clinical record contained no documentation the physician had been notified of the severe weight loss. The clinical record contained no documentation the care plan had been updated to reflect the severe weight loss. The clinical record contained no new interventions to prevent further weight loss.<br><br>A wound care telemedicine follow up evaluation, dated [DATE], documented, .He has an unstageable (due to necrosis) sacrum for at least 1 days duration . The evaluation documented the size of the wound was 2.3 x 3. 0 x 2.5 centimeters (cm).<br><br>A monthly weight record, dated [DATE], documented the resident weighed 139.2 pounds.<br><br>The clinical record contained no documentation the physician or dietitian had been notified regarding the continued weight loss.<br><br>A wound care telemedicine follow up evaluation, dated [DATE], documented, .He has an unstageable (due to necrosis) sacrum for at least 5 days duration. There is moderate serous exudate . The evaluation documented the size of the wound was 9.0 x 10.0 x 4.0 cm.<br><br>A wound evaluation management summary, dated [DATE], documented the wound to the sacrum was unstageable due to necrosis. The summary documented the wound size was 10.0 x 3.5 x 2.6.<br><br>The resident expired on [DATE].<br><br>On [DATE] at 11:35 a.m., the director of nurses (DON) reported the physician should have been notified of the severe weight loss. The DON reported new interventions should have been put into place to prevent further weight loss. The DON reported the resident should have received the Ensure in [DATE] as ordered by the physician.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On [DATE] at 11:50 a.m., the DON reported she printed a list of weights from the computer. She provided a list of weights. When asked about some of the resident's on the list who had significant weight loss, and why they had not been identified, she reported she was unsure of what she was looking at.<br><br>2. Resident #12 was admitted to the facility on [DATE] with diagnoses which included muscle wasting and atrophy right hand, spondylosis, and type II diabetes without complications.<br><br>A nutrition care plan, initiated on [DATE], documented the resident had a potential nutritional problem related to history of being underweight. The care plan goal documented the resident would maintain adequate nutritional status as evidenced by maintaining weight within 5% of baseline, would have no signs or symptoms of malnutrition, and would consume at least 50% of at least two meals daily through review date. The care plan documented approaches which included: provide, serve diet as ordered, monitor intake and record each meal, and for the registered dietitian to evaluate and make diet change recommendations as needed.<br><br>A weight summary, dated [DATE], documented the resident's weight was 179.1 pounds.<br><br>A comprehensive assessment, dated [DATE], documented the resident was intact with cognition. The assessment documented the resident reported poor appetite or overeating two to six days of the 14 day look-back period. The assessment documented the resident was independent with eating. The assessment documented the resident weighed 179 pounds. The assessment documented the resident was on a therapeutic diet.<br><br>A weight summary, dated [DATE], documented the resident's weight was 161.0 pounds. This documented an 18.1 pound weight loss for one month. The summary documented this was a 10.1% weight loss in a month.<br><br>A dietary progress note, signed by the Registered Dietician, dated [DATE], documented the resident weighed 161 pounds, down 18 pounds in past month. The note documented ,d+[DATE]% meal intake. The note documented a recommended reweigh. The clinical record did not contain documentation that the resident was reweighed.<br><br>A weight summary, dated [DATE], documented the resident's weight was 165, which indicated a 7.9% weight loss of 14.1 pounds in 90 days.<br><br>A quarterly assessment, dated [DATE], documented the resident was intact with cognition. The assessment documented the resident was independent with eating. The assessment documented the resident weighed 162 pounds. The assessment documented the resident had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a physician prescribed weight loss regimen.<br><br>A weight summary, dated [DATE], documented the resident weighed 161.6 pounds.<br><br>A weight summary, dated [DATE], documented the resident weighed 147.0 pounds, which indicated a 9.0% weight loss of 14.6 pounds in one month, a 13% weight loss of 22 pounds in three months, and a 17.9% weight loss of 32.1 pounds within the past six months.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On [DATE] at 11:35 a.m., the director of nurses (DON) reported the physician should have been notified of the severe weight loss. The DON reported new interventions should have been put into place to prevent further weight loss.<br><br>The care plan contained no interventions to address the severe weight loss.<br><br>43023<br><br>3. Resident #1 was admitted to the facility on [DATE] with diagnoses of closed fracture, insomnia unspecified, malignant neoplasm of prostate, other specified depressive episodes, presence of cardiac pacemaker, repeated falls, restlessness and agitation, and unspecified dementia with behavioral disturbance.<br><br>A care plan, dated [DATE], documented the resident had potential for a nutritional problem related to Alzheimers disease and vitamin deficiency. The care plan documented for the staff to monitor, record, and report to the physician signs and symptoms of malnutrition: emaciation, muscle wasting, significant weight loss: 3lbs in 1 week, greater than 5% in 1 month, greater than 7.5% in 3 months, and greater than 10% in 6 months.<br><br>A physician's order, dated [DATE], documented for the resident to receive a regular diet, regular texture, and regular liquid consistency.<br><br>A monthly weight report, dated [DATE] through [DATE], documented the residents weight as follows:<br><br>[DATE]- 170 lbs.<br><br>[DATE]- 158.4 lbs.<br><br>[DATE]- 150 lbs.<br><br>[DATE]- 176 lbs.<br><br>[DATE]- 160 lbs.<br><br>[DATE]- 141.8 lbs.<br><br>[DATE]- 138.2 lbs.<br><br>A dietary note, dated [DATE], documented, Wt. 158# [pounds] (question last month's weight of 170#. Current weight is more in line with the weights of the past 3 months. Continues to receive a Regular diet with good meal intakes of ,d+[DATE]%. Will continue to follow weights for any needed interventions.<br><br>This documented a one month severe weight loss of 11.6 pounds or 6.8%.<br><br>The clinical record contained no documentation the physician was notified of the severe weight loss. The clinical record contained no documentation of new interventions to prevent further weight loss.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | An annual assessment, dated [DATE], documented the resident was moderately impaired with cognition and required assistance with activities of daily living. The assessment documented the resident required one staff member to assist with meals. The assessment documented the resident weighed 158 pounds. The assessment documented the resident required a mechanically altered and therapeutic diet.<br><br>A dietary note, dated [DATE], documented, Wt. 150#, down 8# past month. 5% weight loss past month. Receives a Regular diet with good meal intakes of ,d+[DATE]%. Recommend give 60cc 2.0 qid [four times a day] with med pass.<br><br>The weight record, dated [DATE], documented the resident weighed 176 pounds.<br><br>The weight record, dated [DATE], documented the resident weighed 160 pounds. The record documented the resident had lost 16 pounds, a 9.1% severe weight loss in one month.<br><br>A dietary note, dated [DATE], documented the resident weighed 160 pounds. The note documented the resident's meal intake was ,d+[DATE]%. The note documented to continue the same routine.<br><br>The clinical record contained no documentation the physician was notified of the severe weight loss. The clinical record contained no documentation of new interventions to prevent further weight loss.<br><br>An updated care plan, dated [DATE], documented the resident had potential for nutritional problem related to Alzheimer's disease and vitamin deficiency. The care plan documented for the staff to monitor, record, and report to the physician signs and symptoms of malnutrition: emaciation, muscle wasting, significant weight loss: 3lbs in 1 week, greater than 5% in 1 month, greater than 7.5% in 3 months, and greater than 10% in 6 months.<br><br>A quarterly assessment dated [DATE], documented the resident was severely impaired with cognition and required assistance with activities of daily living. The assessment documented the resident required extensive assistance of one staff member with meals. The assessment documented the resident weighed 160 pounds. The assessment documented the resident required a mechanically altered diet.<br><br>The weight record, dated [DATE], documented the resident weighed 141.8 lbs. This represented an 11.3% severe weight loss of 18.2 pounds in one month.<br><br>The weight record, dated [DATE], documented the resident weighed 138.2 lbs. This represented an 13.6% severe weight loss of 21.8 pounds in one month.<br><br>On [DATE] at 11:35 a.m., the director of nurses (DON) reported the physician should have been notified of the severe weight loss. The DON reported new interventions should have been put into place to prevent further weight loss. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31949<br><br>Based on observation, interview, and record review, it was determined the facility failed to ensure pharmacy services provided consultation to ensure medications were administered as ordered by the physician for two (#4 and #9) of 10 residents reviewed. The facility reported 37 residents lived in the facility. Findings:<br><br>1. Resident #4 was admitted to the facility on [DATE] with diagnoses which include pulmonary hypertension, seizures, and diabetes mellitus with neuropathic arthropathy.<br><br>A quarterly assessment, dated 02/01/21, documented the resident was cognitively intact and was totally dependent on staff for activities of daily living.<br><br>A combined initial and final state reportable incident report, dated 04/23/20, documented an allegation the director of nursing (DON) had directed staff to administer bio freeze to the resident's testicles with no order. The report documented the nurse practitioner was unaware of the incident and reported they would not give such an order because the bio freeze would be contraindicated for the use of this kind. The report documented the resident reported the bio freeze burned. The report documented the DON was suspended pending the investigation. The report documented the physician, family, adult protective services, the local law enforcement, and the appropriate licensing board were notified.<br><br>An Oklahoma Board of Nursing report of nursing practice incident, dated 04/24/20, documented registered nurse (RN) #1 directed nursing staff to apply an ointment on a resident which was contraindicated and without a physician's order.<br><br>An Oklahoma Board of Nursing report of nursing practice incident, dated 04/24/20, documented licensed practical nurse (LPN) #1 applied topical cream to a resident that was contraindicated without a physician's order at the direction of RN #1.<br><br>On 05/17/21 at 9:20 a.m., the resident was observed lying in bed with his eyes closed.<br><br>On 05/18/21 at 9:55 a.m., the resident reported RN #1 ordered LPN #1 to apply bio freeze to my scrotum. The resident reported it burned like fire for a long time.<br><br>On 05/18/21 at 11:00 a.m., the administrator (ADM) reported he was not the ADM at the time the incident occurred.<br><br>2. Resident #9 had diagnoses which included diabetes, quadriplegia, pain, depression, and anxiety.<br><br>A quarterly assessment, dated 11/03/20, documented the resident required extensive assistance with most of his activities of daily living.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375463 | A. Building<br>B. Wing | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pauls Valley Care Center | 1413 South Chickasaw Street<br>Pauls Valley, OK 73075 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A Medication administration record (MAR), dated 04/01/20 through 04/30/20, documented Baclofen 15 milligram (mg) by mouth four times a day was not given at 8:00 p.m. (2000) on the 18th, 26th, and 29th. Nor was it given at 8:00 a.m. (0800) on the 24th.<br><br>The MAR also documented Gabapentin 300 mg by mouth four times a day was not given at 8:00 p.m. (2000) on the 18th, 26th, and 29th. Nor was it given at 8:00 a.m. (0800) on the 24th.<br><br>The clinical record contained no documentation the resident had refused his medication.<br><br>On 05/18/21 at 2:35 p.m., certified medication aide #1 reported the MAR should have been initialed on those dates and times if given or a 2 for resident refused. |