STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375341	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Estates	Highway 64 East Warner, OK 74469

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43023 Based on record review and interview, the facility failed to ensure residents were offered the right to formulate an advanced directive for five (#6, 12, 14, 31, and #35) of eight sampled residents reviewed for advanced directives. DON #1 identified 70 residents resided in the facility. Findings: 1. Res #6 admitted to the facility on [DATE]. Res #6's medical record did not contain an advanced directive acknowledgement form. 2. Res #14 admitted to the facility on [DATE]. Res #14's medical record did not contain an advanced directive acknowledgement form. 3. Res #31 admitted to the facility on [DATE]. Res #31's medical record did not contain an advanced directive acknowledgement form. 46582 4. Res #12 admitted to the facility on [DATE]. Res #12's medical record did not contain an advanced directive acknowledgement form. 46216 5. Res #35 admitted to the facility on [DATE]. Res #35's medical record did not contain an advanced directive acknowledgment form. On 01/08/25 at 11:07 a.m, the social services director reported they were unable to locate advanced directive acknowledgement forms for Residents #6, 12, 14, 31, and #35.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 46582 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed, a care plan was completed, and a physician order was obtained for the use of a physical restraint for one (#25) of one sampled resident reviewed for physical restraints. The ADON identified one resident who utilized a wheelchair lap seat belt. Findings: An undated Use of Restraints policy, read in parts, All restraints must have a physician's order and an order for evaluation by designee for the least restrictive device that is appropriate for the resident .Restraints shall be used only for safety or postural support of a resident to prevent injury to self or others .An assessment regarding the need of restraint for the resident will be completed and documented .The physician's restraint order must be detailed and specific; the order must include type of device, specific duration of use, reason for use and frequency of release .Informed consent for physical restraint will be obtained from the resident or legal representative .The plan of care will identify the need for restraint use .At least every three months an assessment will be completed by the therapist to determine if the restraint continues to be the only viable option for care .Quarterly updates and care plan entries are the responsibility of the interdisciplinary care plan team. Res #25 had diagnoses which included reduced mobility, impulse disorders, and seizures. An annual assessment, dated 09/26/24, documented the resident was severely cognitively impaired, had impairment in bilateral upper and lower extremities, utilized a wheelchair, and was dependent on staff with transfers. The assessment documented the resident had no physical restraints. On 01/07/25 at 12:27 p.m., Res #25 was observed sitting in a wheelchair with a quick release seat belt fastened across their lap. Res #25 stated they wanted the lap seat belt to help prevent them from sliding out of the wheelchair. Res #25 independently unfastened the quick release belt upon request. On 01/08/25 at 10:30 a.m., Res #25 was observed sitting in a wheelchair with a quick release seat belt fastened across their lap. Res #25 independently unfastened the quick release belt upon request. There was no physician order, assessment, or documentation in the care plan regarding the lap seat belt found in Res #25's medical record. On 01/09/25 at 9:15 a.m., the ADON stated the lap belt was requested by Res #25. They stated Res #25 utilized the lap belt to feel more secure in their wheelchair. On 01/09/25 at 10:09 a.m., the ADON stated they did not know when the lap belt had been implemented for Res #25. They stated physical therapy should have assessed the resident prior to implementation and a physician order should have been obtained. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/09/25 at 10:32 a.m., DON #2 stated the lap seat belt was not documented in the care plan, but should have been. On 01/09/25 at 10:39 a.m., DON #1 stated the facility was unable to provide documentation of a physician order or an assessment prior to the implementation of the lap seat belt for Res #25.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was developed for one (#21) of 18 sampled residents reviewed for comprehensive care plans. DON #1 identified 70 residents resided in the facility. Findings: A facility policy titled Care Planning - Interdisciplinary Team, revised 09/2013, read in parts, Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .A comprehensive care plan for each resident is developed with seven (7) days of completion of the resident assessment (MDS) .The care plan is based on the resident's comprehensive assessment. A facility policy titled Care Plans, Comprehensive Person-Centered, revised 12/2016, read in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Resident #21 admitted on [DATE] with diagnoses which included cerebral palsy and severe intellectual disabilities. Resident #21's admission assessment, dated 11/26/24, documented Resident #21 was dependent upon staff for all aspects of their ADLs. Resident #21's EHR contained no documentation of a comprehensive care plan. On 01/08/25 at 12:05 p.m., DON #1 stated Resident #21 did not have a comprehensive care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43023 Based on record review and interview, the facility failed to update the care plan related to wound/treatment care for one (#6) of 18 sampled residents reviewed for care plans. DON #1 identified 70 residents who resided in the facility. Findings: Res #6 admitted to the facility with diagnoses which included traumatic brain injury, dependence on respirator, and tracheostomy. A physician's order, dated 12/14/24, documented to apply Betadine to scabbed area to left dorsal lateral foot daily until resolved. The resident's record was reviewed and the care plan had not been revised to document the wound to the left foot. On 01/09/25 at 8:40 a.m., DON #2 was asked to review the resident's care plan. They stated it should have been revised to document the area to the left foot.