STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375369	A. Building B. Wing	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagoner Health & Rehab	205 North Lincoln Avenue Wagoner, OK 74467

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 34270 Based on record review and interview the facility failed to ensure section the care plan decision column of the care area assessment section [section V] was completed on an annual assessment for one (#3) of two sampled resident reviewed for care plans. A facility Census List, dated 12/21/23, documented there were 55 residents living at the facility. Findings: A Comprehensive Assessment and the Care Area Process policy, dated 2001 and revised 2023, read in part, .Comprehensive assessment will be conducted to assist in the developing person-centered care plans . Resident #3 had diagnoses which included schizophrenia and recurrent depressive disorder. An annual assessment, dated 08/17/23, documented in the behaviors section [section E] the resident had rejected care one to three times during the look back period. The care planning decision column of section V [the section of the assessment were an interdisciplinary team (IDT) from the facility meet and decide wether to care plan any triggered care areas] was blank. On 12/27/23 at 1052 a.m. the MDS Coordinator stated they had found no documentation Resident #3 had attended a care plan meeting following the last annual assessment. On 12/28/23 at 9:43 a.m., the MDS Coordinator stated the care areas psychotropic medications, psychosocial, and behaviors had triggered on the assessment but they had missed care planning them. They stated section V should have been completed and those areas care planned. They stated the assessment was incomplete. They stated the IDT had not met as required following the completion of the assessment to discuss the resident care plan. They stated there was no system in place they were aware of to trigger an IDT meeting to occur following an comprehensive assessment. At 10:00 a.m. the Administrator stated they would need to put a system in place to ensure the assessment process was thorough.

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
	375369	A. Building B. Wing	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagoner Health & Rehab	205 North Lincoln Avenue Wagoner, OK 74467

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 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. 34270 Based on record review and interview the facility failed to create a comprehensive care plan for one (#3) of two sampled resident reviewed for care plans. A facility Census List, dated 12/21/23, documented there were 55 residents living at the facility. Findings: A Care Plan, Comprehensive Person Centered policy, dated 2001 and revised 2023, read in part, .The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person centered care plan for each resident . Resident #3 had diagnoses which included schizophrenia and recurrent depressive disorder. On 12/21/23 at 11:31 a.m., Resident #3 stated they had not attended a care plan meeting at the facility. On 12/27/23 at 1052 a.m. the MDS Coordinator stated they had found no documentation Resident #3 had attended a care plan meeting. On 12/28/23 at 9:43 a.m., the MDS Coordinator stated the care areas psychotropic medications, psychosocial, and behaviors had triggered on the last annual assessment, dated 08/17/23, but they had missed care planning them. They stated section V of the assessment should have been completed and those areas care planned. They stated the IDT had not met as required following the completion of the assessment to discuss the resident's care plan so the current care plan was not comprehensive. At 9:56 a.m., the SSD stated the IDT team did not meet following Resident #3's annual assessment. They stated they depended on the MDS coordinator or someone from nursing to alert her of the need for an IDT meeting. At 10:00 a.m. the Administrator stated they would need to put a system in place to ensure the IDT meet following the comprehensive assessments. 12/29/23 at 10:41 a.m., the DON stated their expectation is for each care plan to be comprehensive and complete. They stated they have a full time person now to keep track of the care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375369	A. Building B. Wing	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagoner Health & Rehab	205 North Lincoln Avenue Wagoner, OK 74467

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34270 Based on observation, record review, and interview the facility failed to ensure a prescribed medication was available for administration to a resident for one (#109) of seven sampled resident observed for medication administration. Findings: A Pharmacy Services Overview policy, dated 2001 and revised 2023, read in part, Residents have sufficient supply of their prescribed medications (routine, emergency, or as needed) in a timely manner .Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration . Resident #109 had diagnoses which included heart failure and chronic atrial fibrillation. A medication administration record, dated 12/01/23 through 12/31/23, documented the resident had missed two doses of Eliquis 5 mg two tabs twice daily on 12/21/23 and one dose on 12/22/23. On 12/22/23 at 8:00 a.m., CMA #1 was observed preparing medication for resident #109. They stated the resident's Eliquis [a blood thinner] was not in the building. They stated it had not arrived since it was ordered. They stated the resident was to have started the day before and had missed three doses including the one to be given at that time. On 12/22/23 at 8:59 a.m., Resident #109 stated they had not received Eliquis yet but was not sure when it was to start. A controlled drug receipt form, dated 12/22/23, documented Resident #109 received a dose of Eliquis 5 mg two tabs on that date at 11:35 a.m. On 12/29/23 at 7:57 a.m., the nurse manager stated Resident #109's Eliquis arrived the afternoon of 12/22/23. The medications were observed in the medication cart. At 9:52 a.m. CMA #1 stated the policy regarding missing medication was to inform the charge nurse who would contact the pharmacy. 12/29/23 at 10:41 a.m., the DON stated the nursing staff were to follow policy and immediately contact the pharmacy when medications were not available for administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375369	A. Building B. Wing	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagoner Health & Rehab	205 North Lincoln Avenue Wagoner, OK 74467

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 42171 Based on record review and interview, the facility failed to ensure a response was received from the physician for a gradual dose reduction recommendation for one (#7) of five sampled residents reviewed for unnecessary medications. The DON reported the census was 55. Findings: An undated facility policy titled Antipsychotic Medication Use, read in part, .Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review . Resident #7 had diagnoses which included depression and hypokalemia. A quarterly assessment, dated 11/16/23, documented the resident was cognitively intact and was receiving antianxiety and antidepressant medications. A MRR, dated 10/25/23, documented Resident #7 was receiving Vistaril 50 mg by mouth four times a day and Buspirone 10mg by mouth twice a day. The pharmacist asked the physician to consider a gradual dose reduction on these medications. Review of the clinical record did not document the physician had addressed the MRR. On 12/29/23 at 10:35 a.m., the DON stated they were in the process of updating their procedure to ensure the physician was made aware of the pharmacist recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375369	A. Building B. Wing	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagoner Health & Rehab	205 North Lincoln Avenue Wagoner, OK 74467

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34270 Based on record review and interview, the facility failed to ensure gradual dose reductions were attempted for psychotropic medications without an appropriate rationale to continue the current regimen for one (#38) of five sampled resident reviewed for unnecessary medications. A facility Census List, dated 12/21/23, documented there were 55 residents living at the facility. Findings: Resident #38 had diagnoses which included bipolar disorder and depression. A pharmacy note to Resident #38's prescriber documented the resident was prescribed Abilify, Lexapro, Lamictal, and Depakote for bipolar disorder. The pharmacy form further documented a request for the physician to attempt a gradual dose reduction for those medication if appropriate. Physician #1 checked the box for disagree and hand wrote, needs ask staff. On 12/28/23 at 11:46 a.m., physician #1 stated what they wrote said, needs, ask staff and that means they asked the nurses if the resident needed to stay on the four medications as they were. They stated the staff confirmed they need to stay on the medication and they documented as such. 12/29/23 at 10:33 a.m. the DON stated the nurses were the eyes of the physician and they just tell the physician how the resident was acting. They stated they did not questions doctors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375369	A. Building B. Wing	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagoner Health & Rehab	205 North Lincoln Avenue Wagoner, OK 74467

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 42171 Based on record review and interview, the facility failed to ensure laboratory tests were obtained per physician's orders for one (# 2) of five residents reviewed for laboratory services. The administrator reported the census was 55. Findings: An undated policy titled Lab and Diagnostic Test Results - Clinical Protocol, read in part, .The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs . If resident refuses, documentation from lab will be obtained and documented in the medical record . Resident #2 had diagnoses which included a fractured tibia and hypokalemia. A quarterly assessment, dated 09/16/23, documented the resident had severe cognitive impairment and was total dependent on staff for transfers. A physician order, dated 09/28/23, documented a valproic acid level was to be drawn on 10/02/23 and then every month on the first Monday. A review of Resident #1's clinical record did document any VPA levels were drawn for October, November, or December. A review of Resident #1's clinical record did not document the resident had refused any laboratory tests. A review of the lab book documented the resident had refused the VPA level on 12/04/23 but did not document the VPA level had been refused or completed for 10/02/23 or 11/06/23. On 12/29/23 at 10:31 a.m., the DON stated that if lab work had been completed the results should be in the medical record and if a resident refused the lab work it should be documented in the nurse notes and the physician should be notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375369	A. Building B. Wing	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagoner Health & Rehab	205 North Lincoln Avenue Wagoner, OK 74467

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46703 Based on observation and interview the facility failed to ensure the kitchen was maintained to promote food safety and sanitation. The administrator identified 55 residents residing in the facility. Findings: On 12/21/23 at 9:10 a.m., a tour of the kitchen and dining area were conducted. The following observation was made: There were no dates on four partially used gallons of milk in refrigerator #1. On 12/21/23 at 9:20 a.m., the dietary manager stated the four gallons of milk should have open dates on them. The dietary manager removed the milk from the refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375369	A. Building B. Wing	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagoner Health & Rehab	205 North Lincoln Avenue Wagoner, OK 74467

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 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. 34270 Based on record review and interview, the facility failed to maintain records of the quality assurance and performance improvement (QAPI) program. Findings: The facility's QAPI Plan, dated 2019, read in part, .The Administrator, Director of Nursing, and Medical Director are responsible and accountable for developing, leading, and closely monitoring the QAPI program . On 12/29/23 at 9:50 a.m., the Administrator stated QAPI issues were discussed in every morning meeting. They stated the QAPI team meets quarterly. They were asked for documentation the meeting had occurred. At 9:58 a.m., the Administrator stated they could not locate the meeting documentation and that the staff were looking for them. At 10:10 a.m., the staff searched the MDS office. The Administrator stated they could not find the QAPI folder. At 10:30 a.m., the Administrator presented documentation for one meeting that occurred on 11/01/23. They stated the rest of the QAPI documentation was not found.