STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375528	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Suites Healthcare	3501 W Washington Street Broken Arrow, OK 74012

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 46703 Based on observation, interview, and record review, the facility failed to ensure residents were assessed for the use of bed rails prior to installation for one (#11) of one resident who was reviewed for bed rails. The administrator identifed 52 residents using bed rails. Findings: Resident #11 had a diagnosis which included dementia. A review of Resident #11's medical record did not reveal the resident was assessed for the use of bed rails. On 11/06/24 at 2:18 p.m., bed rails were observed to be up on both sides of the resident's bed. On 11/07/24 at 4:07 p.m., the administrator stated the bed rail assessment page did not automatically populate, so the nurses had to manually pull that up. They stated it did not get done for Resident #11.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 30267 Based on record review and interview, the facility failed to administer a cardiac medication as prescribed for one (#50) of 10 residents observed during a medication administration pass. The facility administrator identified 48 residents who were prescribed cardiac medications. Findings: Resident #50 had diagnoses which included atrial fibrillation. A physician's order, dated 09/12/24, documented the resident was to receive 100 milligrams amiodarone (antiarrhythmic medication) daily for atrial fibrillation. The order documented to monitor blood pressure for hypotension and heart rate for increased rate. The September 2024 MAR documented the resident missed six of 18 doses of amiodarone from 09/13/24 through 09/30/24. The October 2024 MAR documented the resident missed 11 of 31 doses of amiodarone. The November 2024 MAR documented the resident missed four of seven doses of amiodarone from 11/01/24 through 11/07/24. On 11/07/24 at 9:55 a.m., CMA #2 did not administer the amiodarone for Resident #50. On 11/07/24 at 1:10 p.m., CMA #2 stated the amiodarone was given to raise the resident's blood pressure and they had been instructed not to give it if the systolic (top or first number in a blood pressure reading) blood pressure was over 100 or the diastolic (lower or second number in a blood pressure reading) blood pressure was over 60. The CMA stated the resident's blood pressure was 115/58. On 11/07/24 at 2:50 p.m., LPN #1 stated they were not familiar with amiodarone, but thought it was a cardiac medication and so they would not administer the medication if the resident's systolic blood pressure was below 120, the diastolic blood pressure was below 60, or the heart rate was below 60 beats per minute. On 11/07/24 at 3:15 p.m., LPN #2 stated amiodarone was an anti-arrhythmia medication and so they would not administer the medication if the resident's systolic blood pressure was below 120, the diastolic blood pressure was below 60, or the heart rate was below 60 beats per minute. On 11/07/24 at 3:30 p.m., the DON stated the order for amiodarone should specify when to hold the medication and did not. The DON stated the physicians usually ordered to hold cardiac medications if the residents systolic blood pressure was below 120, the diastolic blood pressure was below 60, or the heart rate was below 60 beats per minute. The DON stated Resident #50 missing 20 doses of amiodarone from 09/13/24 to 11/07/24 was significant. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/07/24 at 5:15 p.m., the DON stated they contacted the physician, informed them of the missed doses of amiodarone, and received clarification on when to hold the medication. The DON stated they were to hold the amiodarone if the resident's heart rate was below 50 beats per minute. The DON stated the physician did not wish to order the amiodarone to be held if the resident's blood pressure was low.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30267 Based on observation and interview, the facility failed to ensure the physical environment of the kitchen and kitchen equipment were kept clean and maintained in good repair. The administrator identified 83 residents ate meals prepared in the kitchen. Findings: On [DATE] at 10:15 a.m., cook #1 was observed to puree pork. [NAME] #1 placed cut pieces of pork into a bladed container, placed the container on the base, and the lid on top of the container. The container was observed to be cracked and missing sections of the bottom edge which secured the container to the base. On [DATE] at 10:15 a.m., cook #1 stated the container was broken and they had to hold the container down onto the base to get the unit to puree foods. On [DATE] at 10:20 a.m., observations of the kitchen and ice machine were conducted: a. there was standing water on the floor below the dish machine, the drying rack, the walk way in front of the drying rack, and to the dry goods storage room; b. a box fan with a screen was covered in dust. The box fan blew air across the food preparation stations; c. a ceiling return vent was thickly covered in dust; d. the exterior door had visible light penetration along the top and sides of the door, potentially allowing vermin access to the kitchen; e. there was faded yellow to rust colored dried water stains on the ceiling in the main food preparation area and dish machine area; f. there was dried red and brown food stains on the ceiling above the interior kitchen door; g. there was an approximately one inch in diameter hole through the drywall of the ceiling in the dish machine room; h. there was peeling paint from the ceiling in the dish machine room; i. there was missing drywall under the sink immediately to the right of the dish machine; j. there was peeling paint and exposed chips of drywall along the base boards in the main kitchen and dish machine room; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. there was a black substance covering the splash screen beside and behind the dish machine. The substance was easily removed with a finger nail; l. there was a lower cabinet door partially hung from the top hinge and supported on the opposite corner by the floor; m. there was dirt, food particles, and expired insects located along the baseboards in the dry goods room; n. there were streaks of grease and other liquids staining the walls of the dry storage room; o. there was a brown substance smeared on the wall and edge of the electrical outlet cover; p. there was white, black, and brown particles resting on the rails of the bread storage rack; q. there was white, black, brown particles, two large cookie sheets, a dusty white towel, and a caulking gun resting on top of the freezer in the dry goods room; r. there was white, black, brown particles, and dried food staining the wall and baseboards on the exposed areas near trash receptacles in the main kitchen/food preparation area; s. there was black a substance wiped from the interior of the ice storage box; and t. there was a black substance observed around the water reservoir and mechanical structures of the ice maker/ice machine. On [DATE] at 11:20 a.m., DA #1 stated a few months ago, the maintenance person used a broom handle to make a hole in the ceiling to locate the source of a water leak. The DA stated the hole was not repaired. On [DATE] at 11:25 a.m., the DM stated the kitchen staff were routinely assigned to pull out and clean around storage racks and moveable kitchen appliances and food preparation areas. The DM stated they were able to see light around the edges of the exterior door. The DM stated they were aware of the peeling paint, holes, and missing sheetrock in the dish machine room. The DM stated they were aware of the condition of the container used to puree foods but did not have the budget to replace it. The DM stated the drain in the floor in the dish machine room did not drain well and contributed to the standing water on the floor. The DM stated the black substance observed around the water reservoir and mechanical structures of the ice maker/ice machine was mold.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41220 Based on observation, record review, and interview, the facility failed to to adhere to enhanced barrier precautions while providing wound care for one (#187) of one sampled resident reviewed for wound care. The administrator identified 83 residents resided in the facility and eight residents on enhanced barrier precautions. An undated facility Enhanced Barrier Precautions policy, documented high contact resident care activities such as wound care required the use of gown and gloves. Resident #187 had diagnoses which included a sacral pressure ulcer. On 11/07/24 at 10:19 a.m., RN #1 and LPN #3 prepared to treat Resident #187's pressure ulcer. Both sanitized their hands and donned gloves. Before wound care began, RN #1 was asked if there was any other infection control measures to take before starting wound care. RN #1 stated, No. RN #1 and LPN #3 did not don gowns. They proceeded with wound care. On 11/07/24 at 11:06 a.m., LPN #3 stated for regular wound care, they just wore gloves, if MRSA they wore a gown and mask. On 11/07/24 at 11:11 a.m., the administrator stated gowns were to be worn during wound care per the facilities EBP policy.