STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375416	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIRST SHAMROCK CARE CENTER	1415 SOUTH MAIN STREET KINGFISHER, OK 73750

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, interview, and record review, it was determined the facility failed to repair a broken window in a resident room and ensure a safe and homelike environment for one (#13) of ten residents reviewed for environment. The facility reported 44 residents resided in the facility. Findings: On 03/02/20 at 2:20 p.m., resident #13 was interviewed in her room and reported one side of the window in her room had been boarded up since she was admitted to the facility. She reported it would get really cold in her room when the wind was blowing hard and she could feel it leaking air around the board. The resident stated she had reported the window to staff on several occasions but nothing had been done. On 03/03/20 at 10:24 a.m., staff members were interviewed regarding a process for reporting a problem to maintenance. All staff interviewed reported a maintenance log was kept at the nurse's station to write down problems or repairs to be addressed. The maintenance log book was reviewed for the previous 60 days. The log documented no reports related to the resident's window. On 03/04/20 at 10:30 a.m., the resident's window was observed from outside the facility and noted to be boarded from the outside also. On 03/04/20 at 11:00 a.m., the ADM reported a maintenance log was not kept for 2019 and maintenance staff had not kept a record of repairs made in 2019. On 03/04/20 at 2:00 p.m., the DON reported she had noticed the board on the resident's window after she was hired in January 2020. She reported she had asked the maintenance worker about the window and was told the window had been ordered. On 03/04/20 at 2:31 p.m., the corporate nurse reported she contacted one of the maintenance workers and he stated he didn't know the window was broken again. He reported having two invoices where the window had been replaced in the past. The nurse then contacted the other maintenance worker and he said the window had not been ordered and it had not been replaced in the past but it would be ordered immediately. The nurse also reported she went outside and checked the window with the maintenance worker and it was apparent the window had never been replaced.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure a significant change assessment was completed related to hospice services for one (#44) of 10 residents whose records were reviewed for assessments. Findings: Resident #44 had [DIAGNOSES REDACTED]. A physician order, dated 05/01/19, documented to admit the resident to hospice for [MEDICAL CONDITION]'s disease. A quarterly assessment, dated 01/28/20, documented the resident received hospice services. The clinical record was reviewed and contained no significant change assessment for hospice services. On 03/05/20 at 10:49 a.m., the assessment coordinator reviewed the findings and reported a significant change assessment should have been completed within 14 days of initiating hospice services.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were updated related to falls for four (#44, #5, #14, and #34) of 10 residents whose care plans were reviewed. Findings: 1. Resident #44 had [DIAGNOSES REDACTED]. A care plan, dated 09/13/19, documented the resident was at risk for falls. The care plan had not been updated to reflect the resident had experienced multiple falls since September 2019. A quarterly assessment, dated 01/28/20, documented the resident had multiple falls. 2. Resident #5 was admitted with [DIAGNOSES REDACTED]. An assessment, dated 12/12/19, documented the resident's cognition was intact. The assessment documented the resident required supervision with activities of daily living and had experienced one fall. A care plan, updated 02/27/20, did not include goals or interventions for prevention of falls. 3. Resident #14 was admitted with [DIAGNOSES REDACTED]. A care plan, dated 09/05/19, documented the resident was at risk for falls. The care plan had not been updated to reflect the resident had experienced falls. A quarterly assessment, dated 12/04/19, documented the resident's cognition was intact. The assessment documented the resident required limited assistance with transfers and supervision only with ambulating. The assessment documented the resident had experienced two or more falls. 4. Resident #34 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 10/22/19, documented the resident was a fall risk and extremely confused due to dementia. The care plan had not been updated to reflect multiple falls. A quarterly assessment, dated 01/18/20, documented the resident's cognition was severely impaired. The assessment documented behaviors of wandering and the resident ambulated with supervision only. The assessment documented the resident had two or more falls since the last assessment. On 03/03/20 at 1:59 p.m., the DON reported the care plans had not been updated related to interventions to help prevent falls. On 03/04/20 at 1:27 p.m., the MDS coordinator reported she was responsible for resident care plans at this facility but was new to the job. She reported she had just became aware that care plans needed to be updated or reviewed at least quarterly. She reported the care plans should have been reviewed and updated related to falls.
F 0678 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to have a system in place to identify a resident's DNR status and failed to ensure each shift had a certified CPR-trained staff on duty. The facility identified 44 residents resided in the facility. Findings: On [DATE] at 11:15 a.m., LPN # 2 reported a red name label outside the resident's room was for DNR and a green label indicated full code status. She reported the resident's code status could be found in the resident's chart. On [DATE] at 11:50 a.m., CNA #1 reported being unaware until today that the red name label outside of a resident room was for DNR code status and green was for full code status. On [DATE] at 2:49 p.m., LPN #3 reported the name label outside the room was red for DNR and green for full code status. She reported the code status could be found in the electronic medical record and in the resident's hard chart. Clinical records were reviewed for the resident DNR/code status. Four of 18 residents reviewed were found to have inaccurate documentation related to code status. On [DATE] at 8:43 a.m., the DON was asked to provide documentation for staff who were CPR certified. The DON

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0678 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) provided certificates for five staff members. On [DATE] at 9:26 a.m., the DON reported the facility was not able to have a CPR certified staff member on duty for each shift with the limited number of employees currently certified in CPR. The DON reported the facility was working toward getting all employees certified. The DON acknowledged staff training would be required related to the facility's process for identifying a resident's code status.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on interview and record review, it was determined the facility failed to ensure nurse aides could demonstrate competency of skills and techniques to adequately care for resident needs. The facility reported 44 residents resided in the facility. Findings: On 03/03/20 at 3:12 p.m., the DON was asked to provide copies of CNA skills and technique checklists. The DON provided a stack of in-services labeled 2019. The yearly in-service checklist had not been updated for 2019. The DON was asked again to provide specific CNA skills and technique checklists and the corporate nurse reported those were usually kept in the employee file. On 03/03/20 at 3:53 p.m., the DON provided CNA skills checklists from 2017 and 2018. The DON was asked if there were any CNA skills checklists for 2019 and she stated to her knowledge there were none. The DON reported she understood the need for CNAs to demonstrate competency of skills and techniques and this would be completed in the near future.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to obtain laboratory blood tests, per physician orders, for two (#11 and #13) of five residents reviewed for routine laboratory tests. The facility reported 24 residents who had physician orders [REDACTED]. Findings: 1. Resident #11 was admitted with [DIAGNOSES REDACTED]. A care plan, dated 04/08/19, documented to perform lab tests as ordered and notify the physician of lab results. Physician orders, dated 03/01/20 and with a start date of 01/19/18, documented laboratory test to be done yearly, Lipid (cholesterol), CMP, and CBC in January. The orders documented to obtain an A1C, vitamin B12, and [MEDICATION NAME] test every three months. The clinical record was reviewed and contained no documentation of laboratory test results. On 03/04/19 at 3:25 p.m., the consultant nurse reviewed the resident's clinical record and reported the labs had not been obtained for the past year as ordered. 2. Resident # 13 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Physician orders, dated 03/08/19, documented to obtain a CBC and CMP every six months, HGB A1C every three months, and a lipid panel annually. The clinical record was reviewed and documented lab tests were obtained on 03/12/19 and 08/21/19. Lab tests obtained included CMP, CBC, lipid panel, BMP and HGB A1C. There was no documentation to indicate lab tests were performed every three months and six months as ordered by the physician. No other blood work results were documented in the clinical record. On 03/05/20 at 10:00 a.m., RN #1 reviewed the clinical record and reported the ordered lab tests had not been obtained per physician orders.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to identify and correct quality deficiencies, related to having an adequate system in place to identify a resident's code status, and for ensuring each shift had a certified CPR-trained staff on duty. The facility identified 44 residents resided in the facility. Findings: On [DATE], staff members were interviewed regarding a system for identifying a resident's code status. Staff reported a red name label outside a resident's room was for DNR and a green label indicated full code status. Staff reported the resident's code status could be found in the electronic medical record or the resident's hard chart. One staff member reported they had previously not been aware of what the red and green name labels represented. Clinical records were reviewed for the resident DNR/code status. Four of 18 residents reviewed were found to have inaccurate documentation related to code status. On [DATE] at 9:05 a.m., the ADM was interviewed regarding QAA meetings and the facility QAPI plan. The ADM reported she had a binder with guidelines for the QAA committee but stated the facility had not been having quarterly meetings for the past year. There was no documentation to indicate the facility had identified and/or addressed the issue of resident code status and how staff would respond. There was no documentation to indicate the facility had recognized an issue related to lack of CPR certified staff. On [DATE] at 8:43 a.m., the DON was asked to provide documentation for staff who were CPR certified. The DON provided certificates for five staff members. On [DATE] at 9:26 a.m., the DON reported the facility was not able to have a CPR certified staff member on duty for each shift with the limited number of employees currently certified in CPR. The DON reported the facility was working toward getting all employees certified.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on interview and record review, it was determined the facility failed to have a quality assessment and assurance committee in place, with the required members, and failed to ensure the committee met at least quarterly to identify and address quality concerns. The facility reported 44 residents resided at the facility. Findings: On 03/02/20 at 10:27 a.m., during the entrance conference, the ADM reported the QAA committee had not been meeting over the past year. The ADM reported she was new to the position of ADM and the previous ADM had left no documentation of any QAA meetings. On 03/03/20 at 9:05 a.m., the ADM was interviewed again regarding QAA meetings and the facility QAPI plan. The ADM reported she had a binder with guidelines for the QAA committee but stated again the facility had not been having quarterly meetings for the past year. The ADM provided minutes from a meeting held in January 2020, but this appeared to be an in-service related to infection control.