STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375417	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTHAVEN NURSING HOME	**1215 SOUTH WESTERN STILLWATER, OK 74074**

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 0568 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.** Based on record review and interview, it was determined the facility failed to ensure quarterly statements were provided to one (#22) of one sampled resident who had a personal funds account with the facility. The facility identified 21 residents who had trust funds accounts with the facility. Findings: On 03/04/20 at 8:35 a.m., the resident's representative was asked if she received statements for the resident's personal funds account. She stated no. On 03/05/20 at 10:33 a.m., the business office manager was asked how often statements were sent to residents with personal funds accounts. She stated, Monthly. It was documented in her trust book. The business office manager was asked if resident #22 had a personal funds account. She stated yes. She was asked if the resident's representative had received the quarterly statement as required. She stated no.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 observations and interviews, it was determined the facility failed to provide a homelike environment for one (#45) of one sampled resident reviewed for a homelike environment. The facility identified 70 residents who resided in the facility. Findings: On 03/03/20 at 2:07 p.m., five mattresses were observed stacked on the unoccupied bed in the front of the resident's room. The privacy curtains had been partially pulled around the area but the mattresses were still visible. At 2:13 p.m., a staff member was observed to enter the room and remove one of the mattresses which had been stacked on the unoccupied bed. At 2:16 p.m., the staff member was observed to re-enter the resident's room and remove the remaining mattresses from the bed. At 2:17 p.m., the resident was asked how long the mattresses had been stored in the room. She stated two weeks. The resident stated more mattresses and another bed had also been stored in the area but they had been removed. On 03/05/20 at 8:38 a.m., the DON was asked if mattresses, beds and other equipment were ever stored in rooms occupied by the residents. She stated, No, not normally. She was informed of the observations which had been made and asked if the mattresses should have been stored in the resident's room. She stated, No. The DON was asked if using a resident room for storage was maintaining a homelike environment. She stated, No.
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 record review and interview, it was determined the facility failed to ensure significant change assessments were completed as required for one (#46) of one sampled resident who was reviewed for hospice services. The facility identified 70 residents who resided in the facility. Findings: Resident #46 had [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The clinical record did not include a significant change assessment after the resident was admitted to hospice services. A physician's orders [REDACTED]. The clinical record did not include a significant change assessment after the resident was discontinued from hospice services. On 03/09/20 at 10:04 a.m., MDS coordinator #2 was asked if a significant change assessment was to have been completed when a resident was placed on hospice services and discharged from hospice services. She stated, yes. MDS coordinator #2 was asked if she had completed a significant change assessment for the resident when he was admitted to hospice services. She stated a significant change was completed in October 2019, but did not document hospice services. She was asked when the resident was admitted to hospice. She stated on 10/11/19. MDS coordinator #2 was asked if she had completed a significant change assessment for the resident when he was discharged from hospice services. She stated, No. She was asked if a significant change assessment should have been completed. She stated, Yes.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** Based on record review and interview, it was determined the facility failed to complete timely quarterly assessments for one (#13) of three sampled residents reviewed for quarterly assessments. The facility identified 70 residents who resided in the facility. Findings: An admission assessment, dated 10/09/19, was documented as completed for the resident. There was no documentation an assessment had been completed from 10/09/19 through 03/05/20. On 03/05/20 at 3:15 p.m., MDS coordinator #1 was asked who completed the MDS assessments. She stated she and MDS Coordinator #2. She was asked when MDS assessments were completed. She stated by the 14th day after admission, 14 calendar days after discharge from the facility and within 14 days after the determination of a significant change. She stated the entry and death assessments were completed within seven calendar days of the event and there were also quarterly and annual assessments. The MDS coordinator was asked when the last quarterly assessment had been due for resident #13. She stated it was due on 1/23/2020. She asked if the assessment had been completed. She stated, No. She was asked if it had been submitted in the required time frame. She stated, No.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined the facility failed to ensure: ~ expired medications were discarded from two (the hall 100 treatment cart and the hall 200 treatment cart) of two treatment carts reviewed; and ~ medications were appropriately labeled with an expiration date for one (the hall 100 medication cart) of two medication carts reviewed. The facility identified 70 residents who resided in the facility. Findings: On 03/09/20 at 11:47 a.m., the hall 200 treatment cart was observed with LPN #1. The following medications were observed: ~ one bottle of [MEDICATION NAME] HFA Inhalation Aerosol 90 mcg with an expiration date of 10/19; and ~ one box of IcyHot 5% back pads with an expiration date of 02/20. LPN #1 was asked if the medications should have been in the active stock on the treatment cart. She stated, No. At 12:02 p.m., the hall 100 treatment cart was observed with LPN #2. The following medications were observed: ~ two tubes of Inzo Barrier Cream with 5% Dimethicone with an expiration date of 2/20. LPN #2 was asked if the medications should have been in the active stock on the treatment cart. She stated, Probably not. At 12:23 p.m., the hall 100 medication cart was

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 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) observed with ACMA #1. The following medications were observed: ~ one bottle of [MEDICATION NAME]/App 5-325 tablets with no expiration date on the bottle; and ~ one bottle of [MEDICATION NAME] 600 mg ER with no expiration date on the bottle. At 12:35 p.m., the DON was asked how staff would know the expiration dates on the undated bottles. She stated, You would not know.