STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375498	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradford Village Healthcare Center	906 North Blvd Edmond, OK 73034

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to notify the physician when a resident's blood pressure was abnormal for one (#24) of five sampled residents reviewed for unnecessary medication. The administrator identified 81 residents resided in the facility. Findings: Resident #24 had a diagnosis of hypertension. A physician's order, dated 12/01/22, documented valsartan (an antihypertensive) 160 mg, give one tablet by mouth one time a day for hypertension. A physician's order, dated 05/10/23, documented amlodipine besylate (an antihypertensive) 5 mg, give one tablet by mouth one time a day for hypertension. A physician's order, dated 07/24/24, documented to obtain blood pressure and heart rate one time a day for monitoring if systolic blood pressure 170 or greater refer to as needed hydralazine (vasodilator) order. The January 2025 Medication Admin Audit Report documented amlodipine besylate was initialed as given on: a. 01/28/25 at 8:01 a.m., b. 01/30/25 at 7:52 a.m., and c. 01/31/25 at 8:10 a.m. The January 2025 Medication Admin Audit Report documented the valsartan was initialed as given on: a. 01/28/25 at 8:06 a.m., b. 01/30/25 at 7:52 a.m., and c. 01/31/25 at 8:10 a.m. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Blood Pressure Summary documented the following blood pressures: a. 93/49 mmHg on 01/28/25 at 8:06 a.m., b. 88/46 mmHg on 01/30/25 at 7:54 a.m., and c. 91/41 mmHg on 01/31/25 at 8:12 a.m. The February 2025 Medication Admin Audit Report documented the amlodipine besylate was initialed as given on: a. 02/02/25 at 6:36 a.m., and b. 02/03/25 at 7:33 a.m. The February 2025 Medication Admin Audit Report documented the valsartan was initialed as given on: a. 02/02/25 at 6:36 a.m., and b. 02/03/25 at 7:36 a.m. A Blood Pressure Summary documented the following blood pressures: a. 80/52 mmHg on 02/02/25 at 6:40 a.m., and b. 91/53 mmHg on 02/03/25 at 7:42 a.m. There was no documentation the provider was notified antihypertensives were administered with the abnormal blood pressures above. On 02/05/25 at 2:50 p.m., CMA #1 reviewed Resident #24's blood pressures above. They stated the blood pressures above were considered abnormal. They stated their process was to notify the charge nurse and document in the resident's electronic health record the nurse was notified of low blood pressures. On 02/05/25 at 2:54 p.m., CMA #1 stated they could not locate documentation the nurse was notified of the resident's abnormal blood pressures above. On 02/05/25 at 3:03 p.m., LPN #1 stated the CMAs would report to the nurse abnormal blood pressure readings and the nurse would notify the provider for further guidance. On 02/05/25 at 3:07 p.m., LPN #1 reviewed Resident #24's blood pressures and the medication administration record for January and February 2025. They stated the CMA should have reported the blood pressures to them. They stated they were not notified. On 02/05/25 at 3:10 p.m., LPN #1 stated there was no documentation the provider was notified of the blood pressures above. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/25 at 11:34 a.m., the DON reviewed Resident #24's blood pressures and the medication administration record for January and February 2025. They stated the resident's antihypertensive medications did not contain parameters for physician notification. They stated their process was to notify the charge nurse and the provider of abnormal blood pressure readings, and to recheck. On 02/06/25 at 11:45 a.m., the DON stated they could not locate documentation the resident's blood pressure was rechecked on the dates above.

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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** Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed within the required timeframe for one (#170) of 18 sampled residents reviewed for care plans. The administrator identified 81 residents resided in the facility. Findings: Resident #170 admitted to the facility on [DATE]. Resident #170's admission Resident Assessment was dated 01/22/25. There was no comprehensive care plan located in Resident #170's clinical record. On 02/11/25 at 9:45 a.m., the case manager stated they were responsible for MDS resident assessments and care plans for the skilled residents. On 02/11/25 at 9:48 a.m., the case manager stated they put in basic care plans when residents initially admitted to the facility. They stated they would then complete the admission assessment. They stated the comprehensive care plan should be completed no more than 21 days after admission. On 02/11/25 at 9:50 a.m., the case manager stated Resident #170 admitted on [DATE]. They stated the care plan was not completed and had surpassed the 21 days. On 02/11/25 at 10:27 a.m., the DON stated the facility did not have a care plan policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review and interview, the facility failed to: a. ensure expired medications were removed from circulation for three (#8, 46, and #56) of 10 sampled residents reviewed with controlled medications; and b. medications were administered as ordered for one (#24) of five sampled residents reviewed for unnecessary medications. The administrator identified 81 residents resided in the facility. Findings: The MEDICATION ADMINISTRATION-GENERAL GUIDELINES policy, dated 01/2022, read in part, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. 1. Resident #8 had diagnoses which included chronic obstructive pulmonary disease. A Physician Order, dated 05/18/24, documented hydrocodone-acetaminophen (an opioid) tablet 5-325 mg give one tablet by mouth every four hours as needed for pain. An Individual Resident's Narcotics Record, dated 05/18/24, documented the last dose of hydrocodone-acetaminophen 5-325 mg was administered to Resident #8 on January 25th. The remaining count was 62 tablets. On 02/10/25 at 9:59 a.m., CMA #2 stated the facility reordered medications on the computer, usually one to two times a week. On 02/10/25 at 10:06 a.m., CMA #2's medication cart was observed. Resident #8 had two medication cards for hydrocodone-acetaminophen 5/325, one with a count of 17 and the other with a count of 45. Both medications were observed to have an expiration date of 09/22/24. CMA #2 stated, Nobody caught it. They stated what they would do was write up a piece of paper and let the nurse know, and call hospice to get new cards. CMA #2 stated the medication was last administered on 01/25/25 at 9:00 a.m. 2. Resident #56 had diagnoses which included chronic obstructive pulmonary disease and paroxysmal atrial fibrillation. An Individual Resident's Narcotics Record, dated 05/22/24, documented the last dose of lorazepam concentrate 2 mg/ml amount 0.25 ml was administered to Resident #56 on 09/09/24. The remaining count was 8. A Physician Order, dated 09/10/24, documented lorazepam (an antianxiety) oral tablet 0.5 mg give one tablet by mouth two times a day for anxiety. The order summary report provided by the facility did not contain an order for the liquid lorazepam. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Individual Resident's Narcotics Record, dated 05/29/24, documented the last dose of lorazepam concentrate 2 mg/ml amount 0.25 ml was administered to Resident #56 on July 7th. The remaining count was 26. 3. Resident #46 had diagnoses which included chronic kidney disease and paroxysmal atrial fibrillation. The order summary report provided by the facility did not contain an order for the liquid lorazepam. An Individual Resident's Narcotics Record, dated 05/16/24, documented the last dose of lorazepam concentrate 2 mg/ml amount 0.25 ml was administered to Resident #46 on 10/09/24. The remaining count was 24. On 02/10/25 at 10:20 a.m., the following medications were observed in the locked box in the refrigerator in the medication storage room for halls 5, 6, 7, and 8: a. Resident #56's lorazepam concentrate 2 mg/ml amount in each syringe 0.25 ml count 8 with an expiration date of 08/13/24. LPN #1 stated the medication expired on 08/13/24; b. Resident #56's lorazepam concentrate 2 mg/ml amount in each syringe 0.25 ml count 26 with an expiration date of 08/27/24. LPN #1 stated, These are expired; and c. Resident #46's lorazepam concentrate 2 mg/ml amount in each syringe 0.25 ml count 24 with an expiration date of 11/15/24. LPN #1 stated the expiration date was 11/15/24. LPN #1 stated staff usually checked medications weekly for expiration dates through the cart audit. LPN #1 stated staff or the pharmacist would check them in the cubbies and in the carts. LPN #1 stated staff would pull expired and discontinued medications. On 02/10/25 at 12:50 p.m., the DON stated the medication aides were responsible for monitoring the expiration dates on medications. They stated staff would write the medication up with the destruction logs and they would get destroyed. 4. Resident #24 had diagnoses which included generalized anxiety, major depressive disorder, and insomnia. Physician orders, dated 11/21/23, documented buspirone HCl (an antianxiety) 10 mg, give one tablet by mouth one time a day for anxiety at 10:00 p.m. every night; and doxepin HCl (an antidepressant) to give 150 mg by mouth one time a day for insomnia at 10:00 p.m. every night. The December 2024 MAR documented blanks at 10:00 p.m. for buspirone and doxepin on the 5th, 6th, 13th, 20th, 21st, 25th, 26th, 28th, 29th, and 30th. The January 2025 MAR documented blanks at 10:00 p.m. for buspirone and doxepin on the 4th, 16th, 19th, 21st, 23rd, 25th, 27th, and 29th. On 02/05/25 at 2:48 p.m., CMA #1 reviewed Resident #24's December 2024 and January 2025 MAR. They stated the blanks meant the medications were not administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/25 at 11:33 a.m., the DON stated the process for administering medications was to punch, initial, give, and to notify the nurse if a resident refused medication. On 02/06/25 at 11:36 a.m., the DON reviewed Resident #24's December 2024 and January 2025 MAR. They stated the blanks on the MAR could mean the medication was not administered or the staff forgot to initial as given.