CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		375098	B. WING		08/09/2013
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 000	INITIAL COMMEN	ſS	F 000		
	conducted from 08/	licensure survey was 06/13 through 08/09/13. 42796 was investigated in e survey.			
	The following is a lis through out this doo	st of abbreviations used cument.			· .
	@ - at ADL - activities of d ADON - assistant d CNA - certified nurs	irector of nursing		1	
	Dc ' d - discontinue DON - director of n HS - hour of sleep	ursing		1	
	I/O - input and outp I's and O's - inpu LPN - licensed prac	t and output		1	
	Mg/ml - milligrams Ml - milliliter npo - nothing by mc	per milliliter			
	peg - percutaneous po - by mouth	endoscopic gastrostomy in time/international			
	q/Q - every R/T - related to rt - right			•	
	sats - saturation Tabs - tablets 483.10(c)(1) RIGHT	TO MANAGE OWN	F 158	2	
SS=E	financial affairs, and	RS e right to manage his or her I the facility may not require their personal funds with the			
ABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 375098 B. WING 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110 (X3) DATE SURVEY COMPLETED			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 08/26/2013 M APPROVED D. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MANORCARE HEALTH SERVICES-MIDWEST CITY Z300 PARKLAWN DRIVE MANDE OF PROVIDER'S FLAN OF CORRECTION (EACH OERICENCY MUST BE PRECEDED BY FULL TAG D PREFX SUMMARY STATEMENT OF DEFICIENCIES (EACH OERICETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D F 158 Continued From page 1 facility. F 158 This REQUIREMENT is not met as evidenced by: Based on trust account ledger review, and interviews, it was determined the facility failed to ensure resident swho held their money in the resident frust account had access to their funds at night and on the weekends for three (#5, 11 and #18) of three sampled residents who had their money held in the resident frust account. F Findings: A review of the resident shad coccurs. A review as conducted on 08/09/13 at 9:15 a.m., with the accounts payable. She was asked where the petty cash was located for the resident sub lot bid their money in the resident trust account. She stated, "It's in the [Payroll] safe." An interview was conducted on 08/09/13 at 9:15 a.m., with the accounts payable. She was asked where the petty cash was located for the resident sub of bid their money in the resident	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	25			(X3) DA	TE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE, ZIP CODE MANORCARE HEALTH SERVICES-MIDWEST CITY 200 PARKLAWN DRIVE MIDWEST CITY, OK 73110 (X4) ID PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE RECEICED BY FUIL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREX TAG PROVIDER OF ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X3) DATE F 158 Continued From page 1 facility. F 158 F 158 This REQUIREMENT is not met as evidenced by: Based on trust account ledger review, and interviews, it was determined the facility failed to ensure residents who held their money in the resident trust account ledger review, and their money held in the resident trust account. The business office manager identified seventeen residents whose personal money was held in the resident trust account. Findings: A review of the resident trust account. The duriness office manager identified seventeen resident trust account. A review of the resident frust account. The business office manager identified seventeen resident whose personal money was held in the resident whose personal money was held in the resident was conducted on 08/09/13 at 9:15 a.m., with the accounts payable. She was asked where the petty cash was located for the resident's who held their money in the resident trust account. She stated, "It's in the [PayrolI] safe."			375098	B. WING			08	3/09/2013
MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX (EACH OCRECTION (EACH OCRECTION DEFICIENCY) (N) DEFICIENCY F 158 Continued From page 1 facility. F 158 F 158 PROVINCE (EACH OCRECTION) (N) DATE Deficiency Based on trust account ledger review, and interviews, it was determined the facility failed to ensure resident swho held their money in the resident trust account access to thre (#5, 11) and #18) of three sampled residents who had their money held in the resident trust account. The business office manager identified seventeen resident trust account. Findings: F indings: A review of the resident trust account ledgers for resident #5, 11 and #18 did not contain documentation the weekends. An interview was conducted on 08/09/13 at 9:15 a.m., with the accounts payable. She was asked where the petty cash was located for the resident should be idi ther resident trust account. She stated, "It's in the [Payroll] safe."	NAME OF F	PROVIDER OR SUPPLIER				TO CONTRACT THE PERSONNEL PERS		
Pričejik TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE construction of the construction of the table of the table of the table of t	MANORO	CARE HEALTH SERV	CES-MIDWEST CITY					
facility. This REQUIREMENT is not met as evidenced by: Based on trust account ledger review, and interviews, it was determined the facility failed to ensure residents who held their money in the resident trust account had access to their funds at night and on the weekends for three (#5, 11 and #18) of three sampled residents who had their money held in the resident trust account. The business office manager identified seventeen residents whose personal money was held in the resident trust account. Findings: A review of the resident trust account ledgers for resident #5, 11 and #18 did not contain documentation the residents' had access to funds at night and on the weekends. An interview was conducted on 08/09/13 at 9:15 a.m., with the accounts payable. She was asked where the petty cash was located for the resident's who held their money in the resident trust account. She stated, "It's in the [Payrol1] safe."	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
by: Based on trust account ledger review, and interviews, it was determined the facility failed to ensure residents who held their money in the resident trust account had access to their funds at night and on the weekends for three (#5, 11) and #18) of three sampled residents who had their money held in the resident trust account. The business office manager identified seventeen residents whose personal money was held in the resident trust account. Findings: A review of the resident trust account ledgers for resident #5, 11 and #18 did not contain documentation the residents' had access to funds at night and on the weekends. An interview was conducted on 08/09/13 at 9:15 a.m., with the accounts payable. She was asked where the petty cash was located for the resident's who held their money in the resident trust account. She stated, "It's in the [PayrolI] safe."	F 158		ge 1	F 1	58			
when resident's requested. She indicated it was herself and [payroll clerk]. She was asked what hours she worked. She stated, "8:00 a.m. through 5:00 p.m." She was asked how residents' could access funds after 5:00 p.m. and on the weekends. She		by: Based on trust acc interviews, it was de ensure residents wh resident trust accou at night and on the and #18) of three sa their money held in The business office residents whose per resident trust accou Findings: A review of the resider resident #5, 11 and documentation the at night and on the An interview was co a.m., with the accou where the petty cas resident's who held trust account. She safe." She was asked who when resident's req herself and [payroll She was asked who stated, "8:00 a.m. th	ount ledger review, and etermined the facility failed to no held their money in the int had access to their funds weekends for three (#5, 11 ampled residents who had the resident trust account. manager identified seventeen rsonal money was held in the int. dent trust account ledgers for #18 did not contain residents' had access to funds weekends. onducted on 08/09/13 at 9:15 ints payable. She was asked h was located for the their money in the resident stated, "It's in the [Payroll] o had access to the funds uested. She indicated it was clerk]. at hours she worked. She prough 5:00 p.m." o residents' could access					

Facility ID: NH5512

If continuation sheet Page 2 of 55

		AND HUMAN SERVICES			-		FORM	: 08/26/2013 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION			E SURVEY IPLETED
		375098	B. WING				08/	/09/2013
NAME OF F	PROVIDER OR SUPPLIER		0.		STREET ADDRESS, CITY, STATE, ZIP	CODE		
MANORO	CARE HEALTH SERV	ICES-MIDWEST CITY	2 -		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 158	Continued From pa	ae 2	F 1	158	8			
	stated, "I don't know	v I'm not here. She then ents] know to come by before	[
	ensure residents ha	ere was a system in place to ad access to their money at ekends. She stated, "I'm not ']			
	a.m., with the payro residents' would acc	onducted on 08/09/13 at 9:19 Il clerk. She was asked how cess money in the evenings ds. She stated, "There is no yable] is not here."						
	a.m., with resident # her money from the asked if money was weekends. She sta	onducted on 08/09/13 at 9:55 #23 regarding accessibility of a trust account. She was a available at night and on the tted, "You are unable to get tokkeeper is not here. You ow ahead of time."						
	a.m., with resident # her money from the asked if money was weekends. She sta the evening and on	CILITY MANAGEMENT OF	F 1	59				
	facility must hold, sa account for the pers	ization of a resident, the afeguard, manage, and sonal funds of the resident acility, as specified in 3) of this section.						

Facility ID: NH5512

If continuation sheet Page 3 of 55

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		375098	B. WING			08/0	09/2013
NAME OF	PROVIDER OR SUPPLIER	nt H.	<u> </u>	STREET ADDRESS, CITY,			
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 7			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPF FICIENCY)	BE	(X5) COMPLETION DATE
F 159	The facility must def funds in excess of a account (or accoun the facility's operati all interest earned of account. (In pooled separate accountin The facility must ma funds that do not ex- bearing account, in petty cash fund. The facility must ear that assures a full a accounting, accordi accounting principle funds entrusted to the behalf. The system must p resident funds with of any person other The individual finan through quarterly st the resident or his of The facility must no Medicaid benefits w resident's account in SSI resource limit for section 1611(a)(3)(1) amount in the according the resident's other reaches the SSI resource for the section the resident's other	age 3 eposit any resident's personal \$50 in an interest bearing ts) that is separate from any of ng accounts, and that credits on resident's funds to that d accounts, there must be a g for each resident's share.) aintain a resident's personal kceed \$50 in a non-interest terest-bearing account, or stablish and maintain a system and complete and separate ing to generally accepted es, of each resident's personal the facility on the resident's reclude any commingling of facility funds or with the funds than another resident. cial record must be available tatements and on request to or her legal representative. tify each resident that receives when the amount in the reaches \$200 less than the or one person, specified in B) of the Act; and that, if the unt, in addition to the value of nonexempt resources, source limit for one person, the eligibility for Medicaid or SSI.		59			

Event ID: K32O11 Facility ID: NH5512

If continuation sheet Page 4 of 55

		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES	(X2) MULT		1	0938-0391
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			PLETED
		375098	B. WING		08/	09/2013
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	ARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
	SUMMARY STA	TEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N	(86)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	3 <u>31-11-1</u> -1	······	· · · · · · · · · · · · · · · · · · ·			
F 159	Continued From pa	ge 4	F 15	59		
				1		
1		NT is not met as evidenced				ĩ
	by: Based on record re	eview and interviews, it was				
		lity failed to ensure residents		1		1.
		alances within two hundred				1
		rce limit for two (#11 and #18)				
		funds greater then the				
	resource limit of \$2			:		
	The business office	monogor identified coventeen				ĺ
		e manager identified seventeen rsonal money was held in the				
1	resident trust accou			ĺ		
	The discourse					
	Findings:					
	The "Resident Trus	t Fund Authorization"				
		receive Medicaid benefits,				
		when the amount in my wo Hundred and 00/100				
		than the social security				
I	income (SSI) resou	rce limit for one person, and		1		
1		n the account, in addition to				
		er nonexempt resources, source limit for one person, I				
		or Medicaid and SSI"				
 	A America Cit					1
		esident trust account ledger cumented the resident had a				
	balance of \$2,209.7					
1						r T
		mentation the facility provided their family a notice when they				
	were within \$200 of			1		ε
		1				Ĩ
Ē		esident trust account ledger cumented the resident had a				
	balance of \$2,531.0					e I
	· · · · · · · · · · · · · · · · · · ·	<u> </u>				1

Facility ID: NH5512

If continuation sheet Page 5 of 55

		AND HUMAN SERVICES				FOR	D: 08/26/2013 M APPROVED O. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 N N		CONSTRUCTION		ATE SURVEY OMPLETED
		375098	B. WING			0	8/09/2013
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY			00 PARKLAWN DRIVE DWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 159	Continued From pa	ge 5	F	159			
		mentation the facility provided their family a notice when they the resource limit.					
	a.m., with the busin asked if the facility or their family a not	onducted on 08/09/13 at 9:53 ess office manager. She was provided resident #11 and #18 ice when they were within					
F 160	have not given notion that."	resource limit. She stated, "I ces, I didn't know I had to do EYANCE OF PERSONAL	F	60			
	FUNDS UPON DEA						
	deposited with the f within 30 days the r accounting of those	acility, the facility must convey esident's funds, and a final funds, to the individual or					
	probate jurisdiction estate.	administering the resident's					
	by:	NT is not met as evidenced trust account ledger review		- 100 - 100			
	and interviews, it was failed to convey mo account, within 30 c	as determined the facility ney held in the resident trust lays, for two (#19 and #21) of		8			
	had money held in t	de la face de la construir a construir de la construir de		ī			
		manager identified seventeen rsonal money was held in the int.		l			
	Findings:						
		Obselete Event ID: K22011		-			

Facility ID: NH5512

If continuation sheet Page 6 of 55

	T OF DEFICIENCIES OF CORRECTION	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		375098	B. WING		30	8/09/2013
	PROVIDER OR SUPPLIER	/ICES-MIDWEST CITY		STREET ADDRESS, CITY, STATE, ZIP 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLETIO DATE
F 160	Continued From p	ane 6	F 16	SO		
	The "Resident Tru documented, "I a discharge or death	st Fund Authorization" acknowledge that upon my a the balance of my account leased to the private party or				
	a.m., with the busi active residents or asked to identify a no longer resided a	conducted on 08/09/13 at 8:15 ness office manager regarding the trust account. She was nyone on the trust account who at the facility. She identified and #21 as no longer being at				
		hey had expired or moved to ne stated they had all expired.				
		en the residents had expired. following dates the residents				
	Resident #19: 06/2 Resident #20: 07/1 Resident #21: 07/0	9/13;				l ī
		resident trust account ledger cumented the resident had 07 on 08/05/13.		1		
1	The resident expire to the review of the	ed on 06/21/13, 49 days prior e trust account.				Ī
		resident trust account ledger cumented the resident had on 08/01/13.				
	The resident expire to the review of the	ed on 07/02/13, 39 days prior	1	İ		

Facility ID: NH5512

If continuation sheet Page 7 of 55

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/26/2013 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	121 121		E CONSTRUCTION		E SURVEY IPLETED
		375098	B. WING		···	08	/09/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	ARE HEALTH SERVI	CES-MIDWEST CITY			900 PARKLAWN DRIVE IIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 160	Continued From pa		F 1	60			
	9:53 a.m., with the l was asked how long	was conducted on 08/09/13 at ousiness office manager. She g the facility had to convey the ents' estate. She stated,					
	account being open	PORT	F 2	25			
	been found guilty of mistreating resident had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness for	t employ individuals who have abusing, neglecting, or s by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment ppropriation of their property; vledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ies.					
	involving mistreatme including injuries of misappropriation of immediately to the a to other officials in a	sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the rtification agency).					
	violations are thorou	ve evidence that all alleged ughly investigated, and must ntial abuse while the ogress.					

If continuation sheet Page 8 of 55

	a suscession of the second sec	AND HUMAN SERVICES				FORM	APPROVED
	(1997) (1997) (1997)	& MEDICAID SERVICES	[. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		375098	B. WING			08	/09/2013
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-MIDWEST CITY			00 PARKLAWN DRIVE DWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	< 	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 8	F 22	25]
	to the administrator representative and with State law (inclu- certification agency incident, and if the a appropriate correction This REQUIREMENT by:	vestigations must be reported or his designated to other officials in accordance uding to the State survey and) within 5 working days of the alleged violation is verified ve action must be taken. NT is not met as evidenced e file review and interview, it					
	was determined the former employer ref employee files revie	e facility failed to complete ference checks for 11 of 11 ewed. This had the potential ents who resided at the					
	1. A review of the e	employee file for licensed ocumented she was hired on					
		mentation to indicate the mployer reference checks.]			
		mployee file for licensed ocumented she was hired on					
		mentation to indicate the mployer reference checks.					
		employee file for licensed ocumented she was hired on					

Facility ID: NH5512

If continuation sheet Page 9 of 55

		I AND HUMAN SERVICES				FOR	D: 08/26/2013 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 I I I			(X3) D/	ATE SURVEY OMPLETED
		375098	B. WING	i		0	8/09/2013
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERV	ICES-MIDWEST CITY		et - 1911111	00 PARKLAWN DRIVE IDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 9	F	225			
		mentation to indicate the mployer reference checks.					
		employee file for certified mented she was hired on		I x I			
		mentation to indicate the mployer reference checks.	r I				
		employee file for certified mented she was hired on		ļ			
		mentation to indicate the mployer reference checks.		[
		employee file for certified mented she was hired on		,			
		mentation to indicate the mployer reference checks.	Ì				
		employee file for cook #1 s hired on 03/28/13.					
		mentation to indicate the mployer reference checks.					
		employee file for cook #2 as hired on 07/26/13.					
		mentation to indicate the mployer reference checks.		1			
		employee file for the speech inted she was hired on					

Event ID: K32O11

Facility ID: NH5512

If continuation sheet Page 10 of 55

		AND HUMAN SERVICES				RINTED: 08/26/2013 FORM APPROVED MB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		375098	B. WING _			08/09/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 7311	0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD	BE COMPLETION
F 225	Continued From pa 07/19/13.	age 10	F 22	5]
		mentation to indicate the mployer reference checks.	1]
		e employee file for certified documented she was hired on]			
	r	mentation to indicate the mployer reference checks.]
	11. A review of the housekeeper #1 do 07/15/13.	employee file for ocumented she was hired on]
		mentation to indicate the mployer reference checks.	I I			
	a.m., with the admin director and regionaregarding reference the facility had com on the new hires lis	onducted on 08/07/13 at 9:40 nistrator, human resource al human resource director e checks. They were asked if pleted the reference checks ited above. The regional rector stated, "That's correct lone."				
	483.13(c) DEVELO ABUSE/NEGLECT		F 22	6		
	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.				
		NT is not met as evidenced				
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: K32O1	1 F	acility ID: NH5512	If continuation	on sheet Page 11 of 55

.

If continuation sheet Page 11 of 55

TATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CC	MPLETED
		375098	B. WING		08	3/09/2013
NAME OF I	PROVIDER OR SUPPLIER	2	<u> </u>	STREET ADDRESS, CITY, STATE, Z		
MANOR	CARE HEALTH SERV	VICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	Tion should be The appropriate	(X5) COMPLETION DATE
F 226	Continued From p	age 11	F 22	26		
	by: Based on employ	ee file review and interview, it	1			
	was determined th	ne facility failed to implement	I			
	reference checks	for completed former employer for 11 of 11 employee files				
	reviewed. This ha residents who resi	id the potential to affect all 81 ided at the facility.				1
	Findings:		1	Ĩ		1
		and procedure documented,				: I
	prospective emplo	ening: The center evaluates a wee's experience in working		ĺ		1
		have specific conditions and to identify and verify history of				
ļ	abuse, neglect, or	misappropriation of patient ter screens prospective				
1	employees to redu	ice the risk that no one is hired	ł			ļ
	utilizes the employ	use patients. The center vee screening process to	1			I
	identify information employers"	n from: previous and current	Ĩ			
		employee file for licensed	l			
	practical nurse #3 05/31/13.	documented she was hired on	1			
		umentation to indicate the employer reference checks.				
		employee file for licensed documented she was hired on				
		umentation to indicate the employer reference checks.				
]		e employee file for licensed documented she was hired on				

If continuation sheet Page 12 of 55

		AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		375098	B. WING		08/09/2013
te statementer of elevation of	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 226	Continued From pa 02/25/13.	ge 12	F 22	26	
	- Description Sector (Sector (mentation to indicate the mployer reference checks.		l i	
		employee file for certified mented she was hired on		((
		mentation to indicate the mployer reference checks.	 	[
		employee file for certified mented she was hired on			
]		mentation to indicate the mployer reference checks.			
		employee file for certified mented she was hired on]] 1	
		mentation to indicate the mployer reference checks.			
		employee file for cook #1 s hired on 03/28/13.	l		
		mentation to indicate the mployer reference checks.			
		employee file for cook #2 as hired on 07/26/13.	I I		
		mentation to indicate the mployer reference checks.			
	9. A review of the e	employee file for the speech	1	 	

Event ID: K32O11

Facility ID: NH5512

If continuation sheet Page 13 of 55

	0071	AND HUMAN SERVICES			FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		375098	B. WING		08	/09/2013
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		STREET ADDRESS, CITY, STATE, ZIP CC 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 252	07/19/13. There was no docu facility completed e 10. A review of the medication aide #1 07/15/13. There was no docu facility completed e 11. A review of the housekeeper #1 do 07/15/13. There was no docu facility completed e An interview was co a.m., with the admin director and regionar regarding reference the facility had com on the new hires list human resource dir they haven't been d They were asked if procedure was follo checks. The region resource director bo followed." 483.15(h)(1)	ented she was hired on mentation to indicate the mployer reference checks. employee file for certified documented she was hired on mentation to indicate the mployer reference checks. employee file for cumented she was hired on mentation to indicate the mployer reference checks. onducted on 08/07/13 at 9:40 histrator, human resource al human resource director e checks. They were asked if pleted the reference checks ted above. The regional ector stated, "That's correct	F 25			
				I		

Facility ID: NH5512

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		& MEDICAID SERVICES		• • • • • • •		0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		375098	B. WING		08	/09/2013
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
MANORO	ARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 731	10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 252	the resident to use to the extent possible This REQUIREMEN by: Based on observat determined the faci- environment was sa- evidenced by stained and torn chairs, sta marked and scuffed loose and cracked 300) of four halls, a the dining room) of the potential to affe ambulated indepen 35 who used a whe assistance for mob Findings: On 08/06/13 at 10:3 was conducted. The made: 1. On hall 100, a. In room 104, b. In room 114, 2. On hall 300,	ovide a safe, clean, omelike environment, allowing his or her personal belongings ole. NT is not met as evidenced tion and interview, it was lity failed to ensure the anitary and in good repair as ed and frayed carpet, stained ined and torn couches, d end tables and corroded, faucets on two (Halls 100 and ind one (the lounge area by four public areas. This had ct seven residents who dently without assistance and eel chair or walker without		252		
	3. In the lounge are were four gold chai	ea by the dining room, there rs that were stained n with scratches and scuff				x

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		I AND HUMAN SERVICES				FORM	08/26/2013 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		375098	B. WING			08/	09/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERV	ICES-MIDWEST CITY			00 PARKLAWN DRIVE IDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 252	Continued From pa	ae 15	/ E3	252			
		There were two couches that	1	.02			[
		hout and torn with scratches the legs. There were two end	I				
		nted and scratched on the		÷			
	table tops and legs in this area was sta	of the end tables. The carpet		Ī			1
			Į.	1			*
		0 p.m., the Maintenance rviewed. He was shown the					
	findings of the envir	ronmental tour. He stated he		I			Ì
F 280	would take care of i 483.20(d)(3), 483.1		F	280			
SS=E	- a we have be shared in the second	NNING CARE-REVISE CP					[
		e right, unless adjudged		ĩ			
	incompetent or othe incapacitated under	erwise found to be r the laws of the State, to		ł			
	participate in planni	ing care and treatment or					
	changes in care an	d treatment.		×			
		are plan must be developed					×
,		he completion of the sessment; prepared by an		l.			
ĺ	interdisciplinary tea	m, that includes the attending					
		red nurse with responsibility doubted and the staff in		1			
	disciplines as deter	mined by the resident's needs,		ļ			
		racticable, the participation of sident's family or the resident's		ĺ			1
	legal representative	; and periodically reviewed					
	and revised by a tea each assessment.	am of qualified persons after		ſ			
				l.			
		i					
		IT is not mat as subtract		ŕ			
	by:	NT is not met as evidenced		L			
					·····		

Facility ID: NH5512

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STATEMEN	T OF DEFICIENCIES DF CORRECTION	KANNER SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		375098	B. WING		08	/09/2013	
	PROVIDER OR SUPPLIER	/ICES-MIDWEST CITY	2	TREET ADDRESS, CITY, STATE, ZIP 900 PARKLAWN DRIVE 11DWEST CITY, OK 73110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 280	interviews, it was d address on the car due to compression a lumbar corsett for residents with an or director of nursing residents who had lumbar corsett. Findings: Resident #3 was and diagnoses to include A 'Radiology Report documented, "Ref is evident. Mild def evidenced by osted T9 modest compre 1/11/13 lumbar spi intact T9conclusi compression fractu L3notify family of compression fractu A care plan dated (06/24/13, document due to history of fall of antidepressant at Goals: minimize riss Interventions: Assu socks in roomoffer rising, before and at	tion, record review, and etermined the facility failed to e plan a resident's back pain in fractures and the need to use r one (#3) of one sampled rder for a lumbar corsett. The identified no additional back pain and an order for a dmitted to the facility with the left hip and femur fracture. rt" dated 04/25/13, esults: T9 modest compression generative change is seen as ophytic spurring. Conclusion: ission fracture. New since ne images which showed an on: Unchanged L1 old marked are with more compressed somewhat progressed L3 ire" 01/09/13 and last updated neted, "Focus: At risk for falls ls, generalized weakness, use and antianxiety medication ek for injury r/t [due to] falls are the patient wears non skid er frequent toielting- upon after meals, and before bed. ansfer as needed. Provide					

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PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

ID PLAN OF CORRECTION IE		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		375098	B. WING			08/09/2013		
	ROVIDER OR SUPPLIER	CES-MIDWEST CITY		STREET ADDRESS, CITY, S 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE		
F C C C C C C C C C C C C C C C C C C C	broblems with comported in the president of the rest o	ot address the resident's back oression fractures and the use nent dated 08/01/13, sident's speech was clear, uld be understood and had n. ian's orders for July 2013, oar Corsett on when up in n in bed." The order was first 40 a.m., the resident was m in a low bed. There was no le in the room. the noon and evening meal served at the dining room nair chair. The resident did Corsett in place at the time of 8/08/13, the resident was ing breakfast and noon meal pom. The resident was again	F 2					
v	vas asked why the	a.m., the director of nursing resident required a Lumbar ted it was for back pain.						
b		at the diagnoses was when the red. She indicated she would the doctor and see.						
1		ere the Lumbar Corsett was en it was placed on the	1					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING **B** WING 375098 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 18 F 280 resident. She left and returned stating, 'I've been told by the certified nurse aides the resident never had it." She then stated, "I don't know why central supply didn't get it." She also stated if the resident used the Lumbar Corsett it would be on the resident's task list. She left and returned providing a task list and stated, "It's not on there." She was asked if the care plan addressed the resident's back pain and the use of a lumbar corsett. She looked through the care plan and stated it had not been addressed. On 08/08/13 at 2:52 p.m., the director of nursing stated the physician had wrote the order for back pain due to the compression fractures. 483.25 PROVIDE CARE/SERVICES FOR F 309 F 309 SS=E HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined the facility failed to ensure a resident had a lumbar corsett in place while up in her wheel chair for one (#3) of one sampled resident with orders for a lumbar corsett due to compression fractures and back pain. The

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NH5512

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		AND HUMAN SERVICES				FC	ED: 08/26/2013 RM APPROVED NO: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	17 170				DATE SURVEY COMPLETED
		375098	B. WING				08/09/2013
NAME OF F	PROVIDER OR SUPPLIER	<u>y</u>			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
MANORO	CARE HEALTH SERV	ICES-MIDWEST CITY			2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION E DATE
F 309	Continued From pa	ae 19	F 3	na			Ĩ
		dentified no other residents			l f		
	Findings:		ſ				I L
		lmitted to the facility with e left hip and femur fracture.			t L		
	is evident. Mild deg evidenced by osteo	t" dated 04/25/13, sults: T9 modest compression generative change is seen as phytic spurring. Conclusion: ssion fracture. New since			 		
	1/11/13 lumbar spir intact T9conclusic compression fractur	ne images which showed an on: Unchanged L1 old marked re with more compressed somewhat progressed L3					
	documented the res	nent dated 08/01/13, sident's speech was clear, uld be understood and had n.			 		
	documented, "Lumb	ian's orders for July 2013, oar Corsett on when up in n in bed." The order was first					
	the resident was ob The wheel chair wa	Ir of the facility on 08/06/13 served in her room in bed. s observed and the room was ar corsett was observed in the					
		0 a.m., the resident was m in a low bed. There was no le in the room.			 		

If continuation sheet Page 20 of 55

	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MU				D. 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					MPLETED
		375098	B. WING			08	8/09/2013
NAME OF I	PROVIDER OR SUPPLIER	- <u> </u>			ET ADDRESS, CITY, STATE, ZIP CO	DDE	
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY			PARKLAWN DRIVE VEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 20	F 3	 809			
	On 08/06/13 during	the noon and evening meal					
		bserved at the dining room	l	и Г			
		hair chair. The resident did Corsett in place at the time of					
	the observation.		r F				
	On 08/07/13 and 0	8/08/13, the resident was	I.	Ĩ			l.
	again observed du	ring breakfast and noon meal	ļ	I			
	in the main dining r without the Lumbar	room. The resident was again r Corsett.	I				
		onducted on 08/08/13 at 8:25					
		nurse aide #1. She was askec any braces or supports while	Î	i I			
		air She stated, "There are no	[
	Ani interview was c	conducted on 08/08/13 at 8:40	Ĩ				
		nurse aide #2. She was asked	r I				6
	and how often it wa	's Lumbar Corsett was located as placed on the resident. She , she never had one."	[[
	An interview was c	onducted on 08/08/13 at 9:10	i i	l			l
	Construction of the second second	ent. She was asked if she had	ļ				
	a back brace she v a back brace."	vore. She stated, "I don't wear					
		onducted on 08/08/13 at 9:25					1
		tor of nursing. She was asked quired a Lumbar Corsett. She back pain		ļ	x		
				Ĭ			5
	brace was first orde	at the diagnoses was when the ered. She indicated she would the doctor and see.					
		ere the Lumbar Corsett was ten it was placed on the					

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Alternation of the		E & MEDICAID SERVICES			OMB NO. 0938	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 - 68	IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		375098	B. WING		08/09/20	013
NAME OF I	PROVIDER OR SUPPLIEF	λ		STREET ADDRESS, CITY, STATE, ZIP	· · · · · · · · · · · · · · · · · · ·	
MANOR	CARE HEALTH SER	VICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWÈST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE COM	(X5) PLETIO DATE
F 309	Continued From p	age 21	F 30)9		
		and returned stating, 'I've been				
		d nurse aides the resident neve		1		
		stated, "I don't know why	ř.	1	c Í	
	central supply didr	n't get it."	i.	1	I.	
	Charalas stated if i				l.	
		the resident used the Lumbar on the resident's task list. She		1		
		roviding a task list and stated,	-			
	"It's not on there."	· · · · · · · · · · · · · · · · · · ·	1			
]			
		52 p.m., the director of nursing	1]	1	
		an had wrote the order for back	1	1	1	
E 215		mpression fractures.	F 31	F	1	
SS=E		THETER, PREVENT UTI,	· FO		1	
33-L			1		ļ	
	Based on the resid	dent's comprehensive]			
1		acility must ensure that a]	1		
1		rs the facility without an	1	1		
1		r is not catheterized unless the condition demonstrates that		I	1	
ĺ		s necessary; and a resident	1	1	1	
1		of bladder receives appropriate		1		
1		vices to prevent urinary tract	1		1	
,		estore as much normal bladder	1			
I	function as possib	le.		1		
ļ					j	
	This REQUIREME	NT is not met as evidenced		1		
l	by:			1	ł	
İ		eview, and interviews, it was		1	1	
Ĭ		cility failed to assess a	a 	i i	1	
I		ence for a toileting program d bladder program for one (#3)	, I			
1		sidents with urinary		1		
		experienced reoccurring falls	1	1		
	while attempting to	self toilet. The resident				
		ion report, dated 08/06/13,	1			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 375098 **B. WING** 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 315 Continued From page 22 F 315 documented 40 residents were occasionally or frequently incontinent of urine. Findings: Resident #3 was admitted to the facility with diagnoses to include over active bladder, left hip and femur fracture. An incident report, dated 01/06/13 at 10:25 p.m., documented, "pt [patient] found by cna [certified nurse aide] no injuries noted vital signs and nero [sic] checks started " There was no documentation on the incident report or in the nurse's notes as to what occurred and what the resident had been doing prior to the incident. An incident report, dated 01/09/13 at 5:00 p.m., documented, "Pt was found on the floor in front of bathroom. Pt stated she needed to go to the bathroom. Pt stated she hit her elbow. Skin tear noted to right elbow ... " There was no documentation in the nurses' notes about the resident's fall while attempting to self toilet. An incident report, dated 01/25/13 at 8:00 p.m., documented, "Patient found on the floor on the side of the bed, states she was coming from the bathroom and lost balance d/t socks...describe care...routine Lortab given, assessment, and reassurance " There was no documentation in the nurses' notes about the resident's fall while attempting to self toilet. An incident report, dated 03/07/13 at 9:45 p.m.,

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TATEMEN	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) [O. 0938-039 ATE SURVEY OMPLETED
		IDENTIFICATION NOWDER.	A. BUILD	ING			
		375098	B. WING				8/09/2013
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZI	P CODE	
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY	-		0 PARKLAWN DRIVE DWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 315	Continued From pa	age 23	F 3	15			l
	documented, Pt fo front of bathroom of bed no injuries"	und sitting in floor on bottom in loorassessed and assisted to		1 1 1			[[]
	There was no documentation in the nurses' notes about the resident's fall while attempting to self toilet.			1			(
		ined four falls from 01/06/13 while attempting to self toilet.		ļ			L L
	assessed the resid	umentation to show the facility lent's incontinence for a leduled bladder program.] [1	i i i			
	06/24/13, documer due to history of fa	01/09/13 and last updated hted, "Focus: At risk for falls lls, generalized weakness, use and antianxiety medication	 				
	Goalsminimize ri	sk for injury r/t falls	1	ĺ			I.
	socks in roomoff rising, before and a	are the patient wears non skid er frequent toileting- upon after meals, and before bed. ansfer as needed. Provide t toileting	 				
1		ontinence related to impaired mitations and cognitive	- 	 1			
	Goals: will have no incontinence	o complications due to					
ļ	Interventionsprov	vide assistance with toileting"		ļ			ſ
	A Radiology Repor	t, dated 04/25/13, esults: T9 modest compression	1	l			

If continuation sheet Page 24 of 55

CENTERS FOR MEDICARE & MEDICALD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROJUGER OR SUPPLICA JOB PLAN OF CORRECTION X1) PROJUGER OR SUPPLICA JOB PLAN OF CORRECTION 375098 NAME OF PROVIDER OR SUPPLICA STREET ADDRESS. CITY STATE. 20P CODE MANONCARE HEALTH SERVICES MIDWEST CITY STREET ADDRESS. CITY STATE. 20P CODE MANONCARE HEALTH SERVICES MIDWEST CITY STREET ADDRESS. CITY STATE. 20P CODE MANONCARE HEALTH SERVICES MIDWEST CITY PROVIDER OR SUPPLICA MANONCARE HEALTH SERVICES CODE Y FULL PREFIX MANONCARE HEALTH SERVICES MIDWEST CITY PREFIX PREFIX CONTINUED FOR CORRECTION OF CORRECTION MANONCARE HEALTH SERVICES AND WEST BENEFICIENCES PROVIDER SECOND FOR STRUCT OF CORRECTION PREFIX CONTINUED FOR CORRECTION IN THE PROVIDER SECOND FOR CONCENT OF CORRECTION TAG SUMMARY STATEMENT OF DEFICIENCES IF 315 Continued From page 24 F 315 IF sevident. Mild degenerative change is seen as evidenced by osteophytic spuring. Conclusion: PROVIDER SEVICES OF THE APPROPRIATE DOPERSION TRACTURE. New Since 1/11/13 Lumbar spine images which showed an intract The .conclusion: IF 315 Continued From page 24 F 315 IF and develop the cound state of CORR	DEPART	MENT OF HEALTH	I AND HUMAN SERVICES					APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED 375098 B WING 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08/09/2013 (M) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, OK 73110 08/09/2013 (M) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS OR SUPPLIAR CORRECTIVE AT 100 SHOULD BE COMPLETED TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS OR CORRECTIVE AT 100 SHOULD BE COMPLETED TAG RECOUNTORY OR LSC DENTIFYING INFORMATION PROVIDERS OR CORRECTIVE AT 100 SHOULD BE COMPLETED TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS OR CORRECTIVE AT 100 SHOULD BE COMPLETED TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS OR TRACK AND RRIVE CORRECTIVE AT 100 SHOULD BE COMPLETED TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS OR CORRECTIVE AT 100 SHOULD BE COMPLETED TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS OR CORRECTIVE AT 100 SHOULD BE COMPLETEN TAG SUMMARY STATEMENT OF DEFICIENCIES ID ID COMPLETENCH	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(2 0 CE 1 C C C C	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MANORCARE HEALTH SERVICES-MIDWEST CITY STREET ADDRESS, CITY, STATE, ZIP CODE (cd) ID SUMMARY STATEMENT OF DEFICIENCIES ID (rtr) REGULATORY OR LSC IDENTIFYING INFORMATION PREV TAG PREV PROVIDERS PLAN OF CORRECTION PERIOD (rtr) REGULATORY OR LSC IDENTIFYING INFORMATION PREV TAG Street ADDRESS, CITY, STATE, ZIP CODE Concerning Street ADDRESS, CITY, STATE, ZIP CODE (rtr) REGULATORY OR LSC IDENTIFYING INFORMATION PREV TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREV TAG Street ADDRESS, CITY, STATE, ZIP CODE Concerning Street ADDRESS, CITY, STATE, ZIP CODE TAG SUMMARY OR LSC IDENTIFYING INFORMATION PREV TAG Street ADDRESS, CITY, STATE, ZIP CODE Concerning Street ADDRESS, CITY, STATE, ZIP CODE TAG Street ADDRESS, CITY, STATE, ZIP CODE Concerning Street ADDRESS, CITY, STATE, ZIP CODE TAG Street ADDRESS, CITY, STATE, ZIP CODE Concerning Street ADDRESS, CITY, STATE, ZIP CODE TAG Street ADDRESS, CITY, STATE, ZIP CODE Concerning Street ADDRESS, CITY, STATE, ZIP CODE TAG Street ADDRESS, CITY, STATE, ZIP CODE Concerning Street ADDRESS, CITY, STATE, ZIP CODE TAG Street ADDRESS, CITY, STATE, ZIP CODE				2 S.				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY 2000 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MOWEST CITY, OK 73110 2000 PARKLAWN DRIVE MANDRY DRIVESTICHTOR DEFICIENCIES ID PROVIDER FLAN OF CORRECTION DEFICIENCIES ID PREFIX ICACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER CITON SHALL DEFICIENCIES ID Is evident. Mild degenerative change is seen as evidenced by osteophytic spuring. Conclusion: T9 modest compression fracture. New since 111/1/3 lumbar spine images which showed an intact 79conclusion: Unchanged L1 old marked compression fracture" F 315 F 315 A significant change assessment, dated 105/03/13, documented the resident could underste impairment with cognitive skills for daily decision making. The resident required extensive assistance with transfers, dressing and tollet use and was occasionally incontinent of bladder and was not on a tolleting program. An incident report, dated 07/07/13 at 5:00 a.m., documented, "Resident may ab served sitting on the floor on her bottom in front of the bathroom when she fell against the room door, sid down the door and landing on her bottom-denies hitting head-of (complains of) soreness to back" A nurse's noted, dated 07/07/13 at 7:29 a.m.,			375098	B. WING	;	· · · ·	08	/09/2013
MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 (A) 10 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10 PROVIDERS FLAN OF CORRECTION CONSECTION (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10 PROVIDERS FLAN OF CORRECTION CONSECTION (EACH DEFICIENCY) 00 PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY) F 315 Continued From page 24 Is evident. Mild degenerative change is seen as levidenced by osteophytic spurting. Conclusion: T9 modest compression fracture. New since (1/11/13 lumbar spine images which showed an lintact T9conclusion. Unchanged L1 old marked compression fracture" F 315 A significant change assessment, dated 05/03/13, documented the resident could understand and be understood, and had moderate impairment with cognitive skills for daily decision making. The resident required extensive assistance with transfers, dressing and toilet use and was occasionally incontinent of bladder and was not on a toileting program. An incident report, dated 07/07/13 at 5:00 a.m., documented, "[Resident] was observed sitting on lthe floor on her bottom in front of the bathroom-she states she was walking to the bathroom-she states she was walking to the bathroom-she states she was walking to the bathroom-she states she was walking to the bathroom-she states she was walking to the bathroom-denies hitting head-c/o [complains of] is orneass to back @escribe care assess for injuries-assist to bathroom and to bed call light pinned to bed and asked her to demo [demostrate] to use the call light. pinned to bed and asked her to demo [demostrate] to use the call light.	NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 315 Continued From page 24 F 315 is evident. Mild degenerative change is seen as evidenced by osteophytic spurring. Conclusion: T9 modest compression fracture. New since 1/1/1/13 lumbar spine images which showed an intact T9conclusion: Unchanged L1 old marked compression fracture. F 315 A significant change assessment, dated 05/03/13, documented the resident could understand and be understood, and had moderate impairment with cognitive skills for daily decision making. The resident required extensive assistance with transfers, dressing and toilet use and was occasionally incontinent of bladder and was not on a toileting program. An incident report, dated 07/07/13 at 5:00 a.m., documented, "Resident] was observed sitting on the bottom infort of the bathroom-she states she was walking to the bathroom when she fell against the room door, slid down the door and landing on her bottom-denies hitting head-c/o (complains of) soreness to backdescribe careassess for injuries-assist to bathroom and to bed call light pinned to bed and asked her to demo (demonstrate) to use the call light- medicated for pain and soreness of the back"	MANORO	CARE HEALTH SERV	ICES-MIDWEST CITY		I			
 is evident. Mild degenerative change is seen as evidenced by osteophytic spurring. Conclusion: T9 modest compression fracture. New since 1/11/13 lumbar spine images which showed an intact T9conclusion: Unchanged L1 old marked compression fracture with more compressed L3notify family of somewhat progressed L3 compression fracture" A significant change assessment, dated 05/03/13, documented the resident could understand and be understood, and had moderate impairment with cognitive skills for daily decision making. The resident required extensive assistance with transfers, dressing and toilet use and was not on a toileting program. An incident report, dated 07/07/13 at 5:00 a.m., documented. "[Resident] was observed sitting on the floor on her bottom in front of the bathroom-she states she was walking to the bathroom-she states she was walking to the bathroom-denies hitting head-c/o [complains of] soreness to backdescribe caresees for injuries-assist to bathroom and to bed call light pinned to bed and asked her to demo Idemonstrate] for use the call light pinned to bed call light pinned to bed and asked her to demo Idemonstrate] to use the call light pinned to bed call light pinned to bed and asked her to demo 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
documented, "[Resident] was observed scooting on the floor in sitting position- patient states she was walking to the bathroom when she fell- leaning on the door and slid to the floor on her bottom- denies hitting head, does c/o [complains of] sore back-medicated for pain and ask her to demo [demonstrate] the use of call light and at		is evident. Mild deg evidenced by osteo T9 modest compres 1/11/13 lumbar spir intact T9conclusic compression fractu L3notify family of compression fractu A significant change 05/03/13, documen understand and be moderate impairme decision making. T assistance with tran and was occasional was not on a toiletin An incident report, of documented, "[Resi the floor on her bott bathroom-she state bathroom when she slid down the door a bottom-denies hittin soreness to backo injuries-assist to bar pinned to bed and a [demonstrate] to us pain and soreness of A nurse's noted, dat documented, "[Resi on the floor in sitting was walking to the t leaning on the door bottom- denies hittin of] sore back-medic	generative change is seen as phytic spurring. Conclusion: ssion fracture. New since he images which showed an on: Unchanged L1 old marked re with more compressed somewhat progressed L3 re" The assessment, dated ted the resident could understood, and had ent with cognitive skills for daily the resident required extensive hefers, dressing and toilet use lly incontinent of bladder and ng program. The dated 07/07/13 at 5:00 a.m., ident] was observed sitting on iom in front of the s she was walking to the e fell against the room door, and landing on her ig head-c/o [complains of] describe careassess for throom and to bed call light asked her to demo e the call light- medicated for of the back" ted 07/07/13 at 7:29 a.m., ident] was observed scooting g position- patient states she pathroom when she fell- and slid to the floor on her ing head, does c/o [complains cated for pain and ask her to	F 3	315			

Facility ID: NH5512

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 375098 **B** WING 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 315 Continued From page 25 F 315 the time she states she understands the ... purpose of the light ... " An incident report, dated 07/12/13 at 11:00 a.m., documented, "Patient attempting to self transfer without assistance lost balance and slid into floor. fall witnessed by roommate ... " There was no documentation why the resident was attempting to self transfer when she fell. A quarterly assessment, dated 08/01/13, documented the resident's speech was clear, the resident understood and could be understood and had mild occasional pain. The resident required extensive assistance with transfers, dressing and toilet use. The resident was occasionally incontinent of urine and was not on a toileting program. The assessment also documented the resident had one fall without injury since the last assessment. The resident's task list documented, "Bowel and Bladder: provide assistance with toileting. Provide incontinent care as needed." The resident sustained two additional falls while attempting to self toilet from 03/07/13 through 07/12/13 There continued to be no documentation the facility assessed the resident's incontinence and placed her on toileting program. On 08/08/13 at 8:25 a.m., certified nurse aide #1 was asked if the resident was on a toileting schedule or program. She indicated the resident

FORM CMS-2567(02-99) Previous Versions Obsolete

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TATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		TE SURVEY IPLETED
		075000					
	PROVIDER OR SUPPLIER	375098	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE	08	/09/2013
		ICES-MIDWEST CITY		2900	PARKLAWN DRIVE WEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 315	Continued From pa	age 26	F 3	15			
	was able to make h the staff know.	ner needs known and would let		1]]]
ii t a	indicated the reside	ne resident had falls. She ent had falls while attempting stated the resident was not on					l I
	was asked if the re program. She state always want the he	0 a.m., certified nurse aide #2 sident was on a toileting ed, "She can tell us but doesn't lp. She was asked if the Ills. She indicated the resident g to the bathroom.					
	was asked if there	5 a.m., the director of nursing was a pattern with the falls the ned. She stated, "I do see a om."					
	assessed and if sh program. She indic at the resident task	he resident incontinence was e was placed on a bladder cated she would have to look t list located on the computer. a copy and stated, "It's not on not."					
	been assessed for	ne resident's incontinence had a scheduled bladder program. e resident had not been					
		ne resident would be a good eting program. She stated, "I wouldn't be good."					
	01/06/13 and 07/12	out the incident report dated 2/13. She was asked how the e stated the resident had					

Facility ID: NH5512

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **B** WING 375098 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 315 Continued From page 27 F 315 attempted to go to the bathroom and fell. F 318 483.25(e)(2) INCREASE/PREVENT DECREASE F 318 SS=E | IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, review of policy/procedures, and resident and staff interviews, it was determined the facility failed to ensure restorative nursing services were provided for one (#9) of four sampled residents who were reviewed for range of motion. This had the potential to affect nine residents identified by the facility who had physician orders for restorative care. Findings: A facility policy, titled Braces/Splints documented, Purpose: To maintain functional range of motion, decrease muscle contractures and provide support and alignment for weakened limbs through use of braces and/or splints. Equipment: Orthotic device such as: hand splint, ankle splint or brace.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K32O11

Facility ID: NH5512

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PRINTED: 08/26/2013 FORM APPROVED

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		375098	B. WING		- 08	/09/2013		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-MIDWEST CITY				STREET ADDRESS, CITY, ST 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 318	wearing schedule c physician"	fy physician's order9. Follow butlined by therapist or	F 3 [.]	18 				
	diagnoses which in obstructive pulmon	dmitted to the facility with cluded hypertension, chronic ary disease, hemiplegia, acute cerebral vascular accident, nd dysphagia.						
í		d 04/26/13, documented, loss of range of motion r/t				[[[
]	Goals Will tolerate device when worn	application of splint/orthotic	l l					
]	InterventionsAppl ordered"	ly splint to rt hand as	È.	Ĩ		ļ [[
	documented the re- and understands of independence in co- making. She had li impairment on one	ment, dated 06/08/13, sident was usually understood thers. She had modified ognitive skills for daily decision mited range of motion side in both upper and lower as frequently incontinent of						
	documented, " R	ns order, dated August 2013, ESTORATIVE CARE nt to right hand at 9 am [a.m.] m.] to prevent hand]]]					
		30 a.m., the resident was d without a hand splint on her]					

If continuation sheet Page 29 of 55

TATEMEN	OF DEFICIENCIES	K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
375098		B. WING		08/09/2013	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-MIDWEST CITY				STREET ADDRESS, CITY, STATE, ZIF 2900 PARKLAWN DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	MIDWEST CITY, OK 73110 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLÉTION
F 318	Continued From pa	age 29	F 3	18	
	The same observa 3:30 p.m. and 4:45	tion was made at 12:00 p.m., p.m.	I		I
		00 a.m., the resident was d without a hand splint on her			
		resident was observed in her I splint on her right hand.	Ĩ		
		esident was observed in her I splint on her right hand.			
]		00 a.m., the resident was d without a hand splint on her		 	
		esident was observed in her I splint on her right hand.			4
	The second	esident was observed in her I splint on her right hand.]	
]	hand splints when She stated, "The C then asked if the st	ON was asked who applied ordered for restorative care. NA's do restorative." She was taff is rotated on the halls. She we a consistent staffing pattern			
	of the resident rout was then asked if t orders. She stated was doing therapy arm brace. It goes	#1 was asked if she took care inely. She stated, "Yes." She he resident had any restorative I, "None that I'm aware of. She but they dc'd it. She has an on at night and we take it off hink they are doing that still."			

Facility ID: NH5512

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		AND HUMAN SERVICES				FORM	D: 08/26/2013 APPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		375098	B. WING	;		08	/09/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERV	ICES-MIDWEST CITY			900 PARKLAWN DRIVE /IDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	was then asked if th orders. She stated and arms." She was restorative care for pillow under her arr asked if there was a She stated, "No bra one on her right har At 9:15 a.m., LPN # had any restorative "She wears a brace morning. I believe to morning." At 9:25 a.m., the DC clinical record it was to perform the appli splint. She stated, ' At 10:15 a.m., the DC with a Task printout documented, "AD *ADAPTIVE DEVIC extremity put on at 9 483.25(h) FREE OF HAZARDS/SUPER'	 Inely. She stated, "Yes." She he resident had any restorative, "No, except moving her legs is then asked is she had any her right hand. She stated, "A in to elevate it." She was a splint to apply to her hand. And the eor splint. They were putting ind." If was asked if the resident care ordered. She stated, e at night and off in the the aides took it off this ON was asked where in the state the aides took it off the mere is a cation and removal of the "I'm sure its in the task." ON provided the survey team the for the resident. The printout I's/Restorative Care is apply splint to rt upper 9pm [9:00 p.m.]" ACCIDENT VISION/DEVICES sure that the resident 		318			
	as is possible; and e	ns as free of accident hazards each resident receives on and assistance devices to					

Event ID: K32O11

Facility ID: NH5512

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	COMPLETED
		375098	B. WING		- 08/09/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	
MANORO	CARE HEALTH SER	VICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 731	10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETIO D TO THE APPROPRIATE DATE DIENCY)
F 323	Continued From p	age 31	E 2	323	
		ENT is not met as evidenced			ļ
	Based on record i determined the fac	review, and interviews, it was cility failed to assess a	î.	Í Í	I
[one (#3) of one sa	le attempting to self toilet for mpled residents who curring falls while attempting to	1	[l
	self toilet. The res	sident census and condition 6/13, documented 51 residents a from one or two staff for toile			
]	Findings:		[l	
		admitted to the facility with de over active bladder, left hip a.	I I I		
	documented, "pt [p	dated 01/06/13 at 10:25 p.m., patient] found by cna [certified ries noted vital signs and nero d"	l L		
	report or in the nur	umentation on the incident se's notes as to what occurrec ent had been doing prior to the			
	documented, "Pt w bathroom. Pt state	dated 01/09/13 at 5:00 p.m., vas found on the floor in front c ed she needed to go to the ed she hit her elbow. Skin tear w"	1		
		umentation in the nurses' notes 's fall while attempting to self	5 		

Facility ID: NH5512

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		I AND HUMAN SERVICES				FORM	08/26/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		(X3) DATE SURVEY COMPLETED		
		375098	B. WING			08/	09/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	MANORCARE HEALTH SERVICES-MIDWEST CITY				900 PARKLAWN DRIVE NIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	side of the bed, star bathroom and lost to careroutine Lortal reassurance" There was no docu about the resident's toilet. An incident report, of documented, Pt fou front of bathroom do bed no injuries" There was no docu about the resident's toilet. The resident sustain through 03/07/13, w There was no docu assessed the reside a toileting and or so attempts to prevent A care plan, dated 0 06/24/13, documen due to history of fall of antidepressant at Goalsminimize riss Interventions: Assur- socks in roomoffer rising, before and at	ent found on the floor on the tes she was coming from the balance d/t socksdescribe b given, assessment, and mentation in the nurses' notes a fall while attempting to self dated 03/07/13 at 9:45 p.m., and sitting in floor on bottom in oorassessed and assisted to mentation in the nurses' notes a fall while attempting to self hed four falls from 01/06/13 while attempting to self toilet. mentation to show the facility ent's falls and incontinence for heduled bladder program in	F 3				
	socks in roomoffer rising, before and a	r frequent toileting- upon fter meals, and before bed. Insfer as needed. Provide			·		

Facility ID: NH5512

If continuation sheet Page 33 of 55

ĒF	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN			TE SURVEY MPLETED	
375098		B. WING				08/09/2013		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-MIDWEST CITY					S 2 N			
	EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		MIDWEST CITY, OK 73110 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
tii	inued From p	page 33		F 32	23			
il		continence related to impaire limitations and cognitive	d I]		ļ
	s: will have n itinence	no complications due to]]		
v	ventionspro	ovide assistance with toileting	l"					1
Ir	mented, "R	ort, dated 04/25/13, Results: T9 modest compress egenerative change is seen a				j 1		
1	odest compre	eophytic spurring. Conclusion ression fracture. New since pine images which showed ar	1			ļ]
n t	T9conclus pression fract notify family o	sion: Unchanged L1 old mark ture with more compressed of somewhat progressed L3]
	pression fract	ige assessment, dated	I			1]
3 er	3/13, docume rstand and be	ented the resident could e understood, and had nent with cognitive skills for d	aily					
st	tance with tra vas occasion	The resident required extens ansfers, dressing and toilet u nally incontinent of bladder an ting program.	se					
r	mented, "[Re oor on her bo	, dated 07/07/13 at 5:00 a.m. esident] was observed sitting ottom in front of the				· ·		
do	oom when sh own the door m-denies hitti	he fell against the room door, r and landing on her ting head-c/o [complains of]						
	not on a toilet cident report, mented, "[Re- bor on her bo oom-she stat oom when sh own the door m-denies hitti ness to back	ting program. c, dated 07/07/13 at 5:00 a.m. esident] was observed sitting ottom in front of the tes she was walking to the he fell against the room door, r and landing on her	, on 					

Facility ID: NH5512

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200 20 2		I AND HUMAN SERVICES				FOR	D: 08/26/2013 MAPPROVED D: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY
		375098	B. WING			08	8/09/2013
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERV	ICES-MIDWEST CITY			900 PARKLAWN DRIVE MDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ae 34	/ F3	323			
	pinned to bed and a [demonstrate] to us	asked her to demo e the call light- medicated for					
1	pain and soreness	of the back"			1		
		ted 07/07/13 at 7:29 a.m.,					
		ident] was observed scooting g position- patient states she					
İ	0	bathroom when she fell-					
		and slid to the floor on her ng head, does c/o [complains					1
	of] sore back-medic	cated for pain and ask her to			1		
	the time she states	e] the use of call light and at she understands		1			3
	the purpose of the	light"		1			
	An incident report,	dated 07/12/13 at 11:00 a.m.,	l]			
	documented, "Patie	ent attempting to self transfer					1
	fall witnessed by ro	lost balance and slid into floor, ommate"]
		mentation why the resident elf transfer when she fell.					
	A quarterly assessr	nent, dated 08/01/13,					
	documented the res	sident's speech was clear, the		1			
		and could be understood and pain. The resident required					
	extensive assistance	e with transfers, dressing and					
1		dent was occasionally and was not on a toileting					1
	program.			1			1
	The resident's task	list documented, "Bowel and		Ì			
	Bladder: provide as	sistance with toileting.					7
	Provide incontinent	care as needed."					
Í		ned two additional falls while					
	attempting to self to 07/12/13.	ilet from 03/07/13 through					
			···· // //-			_	

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES		Fr	FORM APPROVEI		
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-039		
Contraction and contraction	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	375098		B. WING	-	08/09/2013		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MANORO	ARE HEALTH SERVI	CES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110			
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(¥5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 323	Continued From pa	ge 35	F 32	3			
	facility assessed the	be no documentation the e resident's incontinence and ng program to prevent			t t		
	was asked if the res schedule or program	5 a.m., certified nurse aide #1 sident was on a toileting m. She indicated the resident er needs known and would let					
	indicated the reside	e resident had falls. She nt had falls while attempting stated the resident was not on					
	was asked if the res) a.m., certified nurse aide #2 sident was on a toileting ed, "She can tell us but doesn't p.					
		e resident had any falls. She nt had falls while going to the					
	was asked if there v	a.m., the director of nursing vas a pattern with the falls the ned. She stated, "I do see a m."					
	assessed and if she program to aide in t falls. She indicated resident task list loc	e resident incontinence was was placed on a bladder he prevention of recurrnce of she would have to look at the ated on the computer. She y and stated, "It's not on the					

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TATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		D. 0938-039 ATE SURVEY MPLETED
			A. BUILDIN	IG		
		375098	B. WING _			8/09/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 36	F 32	3]
	•	ne resident's incontinence had	i coastro			
		a scheduled bladder program.	r.			
	She stated, "No, th assessed."	e resident had not been				
			Ĩ.			C.
		out the incident report dated	l. [1		1
		2/13. She was asked how the stated the resident had	De .	1		
		the bathroom and fell.	1	1		ł
	483.35(c) MENUS	MEET RES NEEDS/PREP IN	F 36	3		
SS=D	ADVANCE/FOLLO	WED	14			
	Menus must meet	the nutritional needs of		1		
	residents in accord	ance with the recommended	-]		
		of the Food and Nutrition	1			Ĩ
		nal Research Council, National ces; be prepared in advance;	i î	Ĩ		1
	and be followed.		1 3 1			ļ
	This REQUIREME	NT is not met as evidenced]]
	by: Record on obconvo	tion report roview and	ĩ			
		tion, record review, and etermined the facility failed to	1			
	ensure the pureed	meal was prepared and	3			
		ce with the menu for one (the	1			
		6/13) of two meals observed. er identified eleven residents	1			1
ļ		ed meals. Findings:	1			
	The "Menu Overvie	ew" documented, "repetition				
	of the same or nea	rly same menu helps]			
	•	ation procedures and gives the]			ĺ
		ortunity to become more peated use of familiar	}			ļ
	The pureed menu					1

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		375098	B. WING		08	/09/2013
	PROVIDER OR SUPPLIER	/ICES-MIDWEST CITY		STREET ADDRESS, CITY, STATE, 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 363	Continued From pa	age 37	F 36	53]
	resident was to rec	ieve the following items:	1			
	one pureed shaped #40 scoop of pinea #8 scoop of Au Gr #8 scoop of green #16 scoop of bread ice cream.	apple, ratin potatoes, s,				
	meal documented served the following	nu for Tuesday 08/06/13, noon the resident's were to be g items: slice of ham with eens, Au Gratin potatoes, ice f choice.				
	documented, "Pu of pineapple slices pineapple in proces	ed Ham with Pineapple Ring ireed pineapple: place number or equivalent of crushed ssor and blendServe #40 neapple with pureed ham."				
		eal service on 08/06/13 from 12:20 p.m., cook #3 was ne meal.				
 	The cook was obse with the following m	erved serving the pureed meal nenu items:	 			Ĩ
	one pureed shaped #8 scoop of Au Gr #8 scoop of greens ice cream.	atin potatoes,				
	pineapple to the res	erve any pureed bread and sidents. He was observed plates with the same.	Í.			
		ts who received pureed meals suming their meal without the				Î

Facility ID: NH5512

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 375098 **B** WING 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 363 Continued From page 38 F 363 bread and pineapple. An interview was conducted on 08/07/13 at 1:35 p.m., with cook #3. He was asked about the pureed bread and pineapple not being served to the residents. He stated, "The pureed bread is to be put on the tray by someone else." He was asked about serving the pureed pineapple. He stated, "I didn't do that. I didn't realize I had to" He was asked if the pureed menu was served according to the menu. He indicated it had not. F 371 F 371 483.35(i) FOOD PROCURE, SS=F STORE/PREPARE/SERVE - SANITARY The facility must -(1) Procure food from sources approved or considered satisfactory by Federal. State or local authorities: and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview, it was determined the facility failed to ensure the kitchen food storage and preparation was maintained in a sanitary manner as evidenced by exposed food in the freezer, unlabeled sliced tomatoes, dirty grimy can opener, unclean microwave and workers with facial hair who had no guards on. This had the

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1		OMB NO. 0938-039
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		375098	B. WING	· · · · · · · · · · · · · · · · · · ·	08/09/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE COMPLÉTION HE APPROPRIATE DATE
F 371	Continued From pa	ge 39	F 3	71	l.
	potential to affect 7 meals from the kitc	7 of 81 residents who received hen.			, j
	Findings:		1]
		edure- Microwave Oven" be up all spills as they occur"]		
	Bench Type" docun by lifting the shaft o detergent solution, may be sanitized by	edure- Can Opener, Manual nented, "remove the opener ut of the basewash in rinse and sanitizethe shaft / running through the dish]]]		
		edure- Pots and Pans" drystacked once completely	1	i I	
	During the initial tou	ur of the kitchen on 08/06/13 at ving observations were made:	 		
		were observed working in the ea with facial hair. The re a guard on.			i I
		es was open in the small osing the food to ice and cold		i 	
i		with french toast was open french toast was freezer] 		
	A container of slice refrigerator undated	d tomatoes was in the I and labeled.			
	A package of lettuc refrigerator.	e was brown in the			

Facility ID: NH5512

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		AND HUMAN SERVICES & MEDICAID SERVICES				FC	NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION) DATE SURVEY COMPLETED
		375098	B. WING				08/09/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MANOR	CARE HEALTH SERV	CES-MIDWEST CITY			2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION E DATE
F 371	Continued From pa	ge 40	F 3	871	1		ĺ
		ned liquids from Sysco was of the dry storage room.					[
	Twenty eight desert Three of them were	cups were stacked wet. still soiled.					
	The microwave had the inside tray and v	l dried brown substance on walls.	 				1
	A bag of vanilla waf to the air.	ers were open and exposed					
	The can opener had grime.	d a build up of dried food and]
	11:35 a.m. through observed serving th observed placing co desert cups and ser	eal service on 08/06/13 from 12:20 p.m., cook #3 was e meal. The cook was boked greens into three soiled rving them to the residents. hair which was not covered					
	An interview was co p.m., with the dietar observations listed	onducted on 08/06/13 at 3:05 y manager regarding the above. She was asked about the freezers. She stated they					
		out the cases of thickened e floor. She stated, "They are n milk crates."			i]		
	cups, microwave, a acknowledged all th	re of the stacked wet desert nd can opener. She le observations and stated of them when she walked in					

Facility ID: NH5512

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 375098 B. WING 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 SUMMARY STATEMENT OF DEFICIENCIES **PROVIDER'S PLAN OF CORRECTION** ID (X5) COMPLETION (X4) ID (FACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 371 Continued From page 41 F 371 She was asked about the workers wearing guards when they have facial hair. She stated, "I know it's a problem." F 441 483.65 INFECTION CONTROL, PREVENT F 441 SS=E SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens

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		HAND HUMAN SERVICES			FORM	: 08/26/201 APPROVE . 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	
		375098	B. WING		08	/09/2013
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
	Continued From page 42 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.		F 441 			
	by: Based on observa	NT is not met as evidenced tion, record review and staff termined the facility failed to				
	prevent cross conta sampled residents care. This had the identified by the fac	was provided in a manner to amination for one (#9) of three observed during incontinent potential to affect 40 residents cility census and condition ontinent of bowel and/or	 			
	for 11 (LPN#3, LPN #5, CNA #6, Cook Pathologist #1, CM 11 employees who	tests were performed on hire N #4, LPN #5, CNA #4, CNA #1, Cook #2, Speech A #1 and housekeeper #1) of se personnel files were d the potential to affect all 81 ded in the facility.				
-	Findings:			1		
	diagnoses which in obstructive pulmon	s admitted to the facility with cluded hypertension, chronic ary disease, hemiplegia, acute cerebral vascular accident, nd dysphagia.				
	documented the re	ment, dated 06/08/13, sident was usually understood thers. She was modified				

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		375098	B. WING _			08/	09/2013
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERV	CES-MIDWEST CITY					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	making. The reside assistance from stat toilet use and bathin on staff for locomot dressing, eating and range of motion imp upper and lower ex- incontinent of bowe A care plan, initiated "Focus Urinary ind process CVA, impa- limitations Goals Will have no incontinence InterventionsProv- needed" On 08/07/13 at 1:30 observations were of provided incontinen CNA #2 and CNA # soap and water and CNA #2 provided pet then rolled her over changing her soiled buttocks and rectal soiled brief under the brief under the resid rolled onto her back	nitive skills for daily decision ent required extensive ff with bed mobility, transfers, ng. She was totally dependent ion on and off the unit, d hygiene. She had limited bairment on one side in both tremities. She was frequently I and bladder. d 04/01/13, documented, continence related to disease ired mobility, physical complications due to ide incontinent care as 0 p.m., the following observed as the resident was t care. 3 sanitized their hands with then donned gloves. eri care to the resident and onto her side. Without cloves she then cleansed her area. She then tucked the te resident and rolled a clean tent. The resident was then	F 44				
	CNA #3 then remov	ed the soiled brief from under #3 then removed her gloves					

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		AND HUMAN SERVICES				FORM APP	ROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SUF COMPLET	RVEY
		375098	B. WING			08/09/2	013
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY,			
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPP EFICIENCY)	BE CON	(X5) IPLETION DATE
F 441	hands and replaced At 2:00 p.m., CNA a have done anything contamination durin stated, "I would hav after every two or th TB test: The "Infection Cont Screening and Imm Screening" page 1. Screening Guideling increasing risk of or tuberculosisInitial Employees receive screening upon hire 1. A review of the e practical nurse #3 c 05/31/13. There was no docu facility completed T skin test upon hire. 2. A review of the e practical nurse #4 c 05/24/13.	oves without sanitizing her d the resident's sheet. #2 was asked if she would g differently to prevent cross ing the provision of care. She ve changed my gloves more, hree wipes. I was nervous." trol Manual Chapter 9- nunization Tuberculosis 46 documented, "Employee e: Healthcare workers face an ccupational exposure to screening procedures; baseline tuberculosis e" employee file for licensed documented she was hired on mentation to indicate the 'B (Tuberculosis Screening) employee file for licensed documented she was hired on	F 44				
	facility completed T3. A review of the	mentation to indicate the B skin test upon hire. employee file for licensed]				
	practical nurse #5 c 02/25/13.	documented she was hired on			16		45 - 555
FURINI CIVIS-25	67(02-99) Previous Versions	Obsolete Event ID: K32O1	1 B	Facility ID: NH5512	ir continuati	on sheet Page	45 01 55

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION). 0938-039 TE SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		MPLETED
		375098	B. WING		08	/09/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	age 45	F 44	1		
		umentation to indicate the FB skin test upon hire.]			1
		employee file for certified imented she was hired on				1 1 1
		umentation to indicate the FB skin test upon hire.				1
		employee file for certified imented she was hired on				
	· · · · · · · · · · · · · · · · · · ·	mentation to indicate the B skin test upon hire.	Ĭ			
		employee file for certified imented she was hired on]] :			1
		mentation to indicate the B skin test upon hire.				1]
		employee file for cook #1 is hired on 03/28/13.				
	. 885 E	mentation to indicate the B skin test upon hire.	1			
9 11 12 12 12 12 12 12 12 12 12 12 12 12		employee file for cook #2 as hired on 07/26/13.				
		mentation to indicate the B skin test upon hire.				
9		employee file for the speech ented she was hired on				1

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/26/2013 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		375098	B. WING	;		08	/09/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	· · · · ·	
MANOR	CARE HEALTH SERV			1	2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 46	F4	44 [.]	1		[
		mentation to indicate the B skin test upon hire.					 •]
		employee file for certified documented she was hired on					
		mentation to indicate the B skin test upon hire.					[[
	11. A review of the housekeeper #1 do 07/15/13.	employee file for cumented she was hired on					
		mentation to indicate the B skin test upon hire.]
	a.m., with the admir director and regiona regarding TB skin to asked if employees	onducted on 08/07/13 at 9:40 histrator, human resource al human resource director est upon hire. They were were being administered the ire. The administrator stated, doing TB test."					
F 465 SS=E	resource director bo done, we have iden 483.70(h)	n resource director and human oth stated, "They haven't been tified that as a problem." L/SANITARY/COMFORTABL	F 4	465	5		
		ovide a safe, functional, rtable environment for the public.					

Facility ID: NH5512

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	CONSTRUCTION		TE SURVEY MPLETED
		375098	B. WING		08	8/09/2013
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	290	REET ADDRESS, CITY, STATE, 00 PARKLAWN DRIVE DWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 465	 by: Based on observation determined the facility exterior grounds free large trash bags, of trash, debris, a user recliner, an old when old table and an old This had the potention identified by the facility With ambulation and Findings: An exterior environ 08/07/13 at 8:00 a. If observed: Numerous cigar southeast patio. On the northeast were 11 large trash There were sever ground. There was an old Southeast numbers of the southwere was a used nursing There was an old 	NT is not met as evidenced tion and interview, it was lity failed to maintain the ee of debris, cigarette butts, d pallets, an old fan base, d nursing glove, an old eelchair, old gate panels, an	F 465			

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG	CO	MPLETED
	12.70	375098	B. WING		08	8/09/2013
NAME OF	PROVIDER OR SUPPLIER	·	1	STREET ADDRESS, CITY, STATE, ZIP (ODE	
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 465	Continued From pa	age 48	 . F4	65		į
		ne Maintenance Supervisor.				
	He was asked how	often rounds were completed]	J		
		ding grounds for trash, debris,]]		j.
		ment and equipment that is no He stated the grounds were	1]		1
		ay. He stated he would take	1	1		1
	care of it.		1			1
F 502	483.75(j)(1) ADMIN	NISTRATION	F 5	02		1
SS=E	The facility must pr	ovide or obtain laboratory				1
	services to meet th	e needs of its residents. The]			
		le for the quality and timeliness	5			
	of the services.	x]			2 [
	This REQUIREME	NT is not met as evidenced				
	by:					
		eview and interview, it was]	1]
		ility failed to provide laboratory d by the physician for one (#2)				
		b had orders for daily PT INR	1	1		1
	. ,	sampled residents who had a		i		
		outine orders for laboratory 2 had 17 PT INR laboratory	1			
		#1 had one laboratory draw]	1		
	missed. The direct	tor of nursing identified 81 of	1	1		
		esided in the facility had rdered from 05/01/13 through	I.			1
	08/09/13.	dered from 05/0 f/15 through	i I			l
	Findings:					1
			x x 1			
		diagnoses which included ailure, and acute kidney	i I			
	failure.	andre, and acute ridney				
	A physician's telep	none order dated 07/18/13,				I I
		ck] UA [urinalysis] c [with] C &	1			

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		& MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION		0. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		375098	B. WING		08	/09/2013
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP C	ODE	
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		900 PARKLAWN DRIVE NDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 502	Continued From pa	age 49	F 502			
		sitivity] if ind [indicated]"				1
		pratory results were were no laboratory results for ted on 07/18/13.]
	about the lab result	5 p.m., the ADON was asked to for the urinalysis. She that it had not been done.				
	diagnoses which in pulmonary disease	is admitted to the facility with cluded chronic obstructive , hypertension, chronic pain, a and gastroesophageal reflux				
	A physicians' order "PT/INR every da	, dated 06/23/13, documented, ıy"] 1
	There were no labo completed on 06/20 07/04/13, 07/05/13 07/10/13, 07/19/13	pratory results was conducted. pratory results for a PT/INR 6/13, 07/01/13, 07/03/13, , 07/06/13, 07/07/13, 07/08/, , 07/20/13, 07/21/13, 07/24/13, , 07/29/13 and 08/03/13.				
	there were any othe	D a.m., <mark>the DON was asked if</mark> er lab results for the resident. st missed those labs. There				
	483.75(I)(1) RES RECORDS-COMP LE	LETE/ACCURATE/ACCESSIB	F 514			
	resident in accorda standards and prac	aintain clinical records on each nce with accepted professiona tices that are complete; nted; readily accessible; and				

Facility ID: NH5512

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 375098 **B. WING** 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 514 Continued From page 50 F 514 systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain complete and accurate clinical records for three (#3, 9 and #10) of 14 sampled residents whose clinical records were reviewed. The resident census and conditions report documented 81 residents resided in the facility. Findings: A facility policy, titled Ongoing Management Strategies documented, "...Skin Evaluations Patients at risk for skin breakdown have a head-to-toe skin evaluation weekly by a licensed nurse...Documentation of the evaluation is located in the Treatment Administration Record or progress note ... " 1. Resident #9 was admitted to the facility with diagnoses which included hypertension, chronic obstructive pulmonary disease, hemiplegia, acute respiratory failure, cerebral vascular accident. cognitive deficits and dysphagia. A monthly intake and output flow sheet, dated April 2013 documented, seven of the 33 input and output opportunities were blank.

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		I AND HUMAN SERVICES				FO	ED: 08/26/2013 RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
375098		375098	B. WING		08/09/2013		
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
MANOR	CARE HEALTH SERV				00 PARKLAWN DRIVE DWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ae 51	F 5	11			
	A MAR, dated April 2013 documented, four of four skin assessment updates were blank.		13				
		nd output flow sheet, dated nted, 21 of the 36 input and s were blank.	Í				
	A MAR, dated May skin assessment up	2013 documented, two of four odates were blank.	Ĩ	Ì			
		nd output flow sheet, dated nted, 12 of the 33 input and s were blank.		1			
		2013 documented, two of ont updates were blank.					
		nd output flow sheet, dated ited, 22 of the 36 input and s were blank.		ļ			
		2013 documented, one of four odates were blank and six of ons were blank.					
		nd output flow sheet, dated nented, six of the 18 input and s were blank.					
	one skin assessme	ust 2013 documented, one of nt updates were blank and saturations were blank.					
	documented, "03/ feeder03/31/13 up	ns order, dated August 2013 31/13 NPO - tube odate skin sheets weekly on check 02 sats every shift"					
	On 08/08/13 at 9:15	a.m., LPN #1 was asked who		E T			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

TATEMENT ND PLAN OF	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			000 0		
	FCORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		375098	B. WING		- 0	8/09/2013	
	ROVIDER OR SUPPLIER	ICES-MIDWEST CITY		STREET ADDRESS, CITY, STA 2900 PARKLAWN DRIVE MIDWEST CITY, OK 731			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	(X5) COMPLETIO DATE	
	saturations. She si it in the MAR." On 08/09/13 at 8:30 which residents req recorded in the clin "Everyone with a Pl then asked who wa the input, output an stated, "Nurses." S in the input, output asked if there were documentation. Sh why not documente At 8:40 a.m., the Du had input and output record. She stated indwelling urinary c (intravenous) or a fi asked who was res input, output and ox the nurses. 2. Resident #10 wa diagnoses which in- failure, diabetes me disease and hyperli A nurse's note, date documented, "Pa	D a.m., LPN #2 was asked puired input and output to be ical record. She stated, EG is on I's and O's. She was is responsible for documenting id oxygen saturations. She She was then shown the gaps and oxygen saturations and any reasons for the gaps in he stated, "There's no reason ed." ON was asked which residents ut recordings in the clinical , any residents with an atheter, peg tube, IV luid restriction. She was then ponsible for documenting the kygen saturations. She stated, as admitted to the facility with cluded, congestive heart ellitus type II, Alzheimer's	 				

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Facility ID: NH5512

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		H AND HUMAN SERVICES			FORM): 08/26/201 1 APPROVE). 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		375098	B. WING		08	/09/2013
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	29	REET ADDRESS, CITY, STATE, ZIP COE 00 PARKLAWN DRIVE IDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 514	Continued From pa	age 53	F 514			
	"Remeron 30 mg	ust 2013 documented, po @ HS may give 2 15mg to tabs are gone 8/7/13 9pm				
	clinical record and	55 a.m., RN #1 was shown the asked where the order was d, "That's a mistake, I will find				
	Megace, it was Rei	#1 stated, "OK, it was not meron. The Megace order is a ne staff who wrote it."				
		s admitted to the facility with le over active bladder, left hip				
	documented, "pt [p	dated 01/06/13 at 10:25 p.m., atient] found by cna [certified ries noted vital signs and nero I"	: 			ал
	report or in the nurs	imentation on the incident se's as to what occurred and ad been doing prior to the				
	documented, "Pt w bathroom. Pt state	lated 01/09/13 at 5:00 p.m., as found on he floor in front of d she needed to go to the d she hit her elbow. Skin tear y".				
		mentation in the nurse's notes fall while attempting to self				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 375098 **B** WING 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY **MIDWEST CITY, OK 73110** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 514 Continued From page 54 F 514 An incident report dated 01/25/13 at 8:00 p.m. documented, "Patient found on the floor on the side of the bed, states she was coming from the bathroom and lost balance d/t socks...describe care...routine Lortab given, assessment, and reassurance " There was no documentation in the nurse's notes about the resident's fall while attempting to self toilet. An incident report dated 03/07/13 at 9:45 p.m., documented. Pt found sitting in floor on bottom in front of bathroom door....assessed and assisted to bed no injuries " There was no documentation in the nurse's notes about the resident's fall while attempting to self toilet. An incident report dated 07/12/13 at 11:00 a.m., documented, "Patient attempting to self transfer without assistance lost balance and slid into floor, fall witnessed by roommate ... " There was no documentation why the resident was attempting to self transfer when she fell on the incident report and in the nurse's notes. An interview was conducted on 08/08/13 at 9:25 a.m., with the director of nursing. She was asked if the resident's incident reports and nurse's accurately reelected what happened. She stated, "It's not accurate."

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Event ID: K32O11

Facility ID: NH5512

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