STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. BUILDING _____ B. WING _____	05/17/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEVISTA REHABILITATION AND SKILLED CARE	7604 QUANAH PARKER TRAILWAY LAWTON, OK 73505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to notify a family member of a change in a resident's condition for one (#4) of 21 sampled residents. This had the potential to affect all residents. The facility had a census of 81 residents. Findings: Resident #4 has [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 04/10/13, documented her cognitive status was severely impaired. She required extensive assistance with transfers, dressing, hygiene and bathing. She could feed herself with setup help and was frequently incontinent of bowel and bladder. She could self propel around in her wheelchair. A nurses's note, dated 01/19/13, documented, Obtained final results of U/A C&S (urine analysis and culture and sensitivity). DR (doctor) (name omitted), notified, received N.O. (new order) for Bactrim DS (and antibiotic, double strength) one P.O. (by mouth) daily X (for) 10 days. res is with confusion noted, resident encouraged to increase P.O. fluid intake, resident offered fluids between meals. No documentation was found in the nurses note to indicate a family member had been notified. On 05/16/13 at 11:45 a.m., the DON was asked if the family member should have been notified. She stated, Yes.
F 0174 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide access to a telephone for resident to use in private.** Based on observation and interviews, it was determined the facility failed to ensure residents were provided a place to use the telephone that was private. There were 81 residents residing in the facility at the time of the survey. Findings: On 05/14/13 at 3:30 p.m., a group meeting was conducted with 17 cognitively aware residents in attendance. The group was asked if they were provided a private place while making telephone calls in the facility. The residents responded, No. On 05/15/13 10:00 a.m., the Administrator was asked where residents can make private phone calls. She stated, They can come into any of the offices to make a phone call.
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/15/13 at 4:30 p.m., an immediate jeopardy (IJ) situation was identified related to the failure of the facility to protect all residents after a resident made an allegation of a certified nurse aide (CNA #1) being abusive. The facility failed to have an effective plan in place to supervise and monitor the CNA to ensure all the residents were safe from abuse. At 4:35 p.m., the existence of an IJ was verified with the Oklahoma State Department of Health (OSDH). At 4:45 p.m., the facility administrator and director of nursing (DON) were notified of the existence of an IJ pertaining to the failure to protect all residents from abuse. At 5:30 p.m., the plan of removal was received and accepted. The facility's Plan of Removal documented: The facility will follow its policy on Abuse and Neglect. Specifically the suspension of an alleged perpetrator (staff), conduct an complete investigation, and provide retraining as deemed necessary prior to the alleged perpetrator returning to assigned duties. The administrator was removed as the Abuse Coordinator. The Director of Nursing was appointed Interim Abuse Coordinator. The Management Company's Director of Clinical Services and Regional Director of Operations conducted an in-service on May 15, 2013 at 5:30 p.m. on the facility Abuse Policy to all facility management team. At 5:40 p.m., the administrator and DON were informed the IJ was removed. The deficient practice remained at a level of actual harm that was not immediate jeopardy, at a pattern. On 05/17/13 at 9:35 a.m., the OSDH was called and verified the need to reinstitute the IJ due to the facility's failure to protect all residents and follow their abuse policy as documented on their plan of removal, received on 05/15/13 at 5:30 p.m. At 9:45 a.m., the DON and the regional consultant were informed the IJ was reinstituted and why. At 10:30 a.m., the plan of removal for the reinstituted IJ was received and accepted. The Plan of Removal documented the CNA (#1) was terminated from the facility. The IJ was removed effective 05/17/13 at 10:30 a.m. The deficient practice remained at a level of no actual harm with a potential for more than minimal harm, at a pattern. Based on observations, record review and interviews, it was determined the facility failed to protect all residents after one (#3) of twelve sampled residents made an allegation of a CNA (#1) being abusive. The facility failed to have an effective plan in place to supervise and monitor the CNA to ensure all the residents were safe from abuse. This had the potential to affect all 81 residents. Findings: The facility's policy, 'Abuse Prohibition Management Program-Identification, Investigation and Reporting Policy', documented, All personnel, residents, family members, visitors, etc., are encouraged to report actual or suspected incidents of Resident Abuse or inappropriate behavior that may lead to resident abuse. Such reports may be made without fear of retaliation from the facility or its staff. The facility will provide feedback to residents and family members and others regarding concerns that have been expressed to facility staff, in a timely manner. Procedures: Identification: 1. To assist our facility's staff members, residents, families and visitors to our facility in recognizing incidents of Resident Abuse, the following definitions are provided: a. Abuse is defined as the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. b. Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families. c. Sexual abuse. d. Physical abuse. e. Mental or psychological abuse includes, but not limited to, humiliation, harassment and threats of punishment or deprivation. Investigation: 3. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the Abuse Coordinator or his/her designee will investigate the alleged incident. 5. The individual conducting the investigation will, at a minimum (and as appropriate): a. Review the completed Resident Abuse Report Form: b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview the resident's attending physician to determine the resident's current mental status, if appropriate; g. Interview staff members (on all shifts) who had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members and visitors; i. Interview other residents to whom the accused employee provides care or services; j. Review all events leading up to the alleged incident; and. 26. Social Services follow-up: a. As part of the investigation, the Social Worker will conduct a Safe Survey. The Social Worker will interview all other cognitive residents possible affected by this incident. b. this action is to evaluate their perspective or their feeling of being safe and if they are aware of how to report an incident. Protection of Residents During Abuse Investigations Policy: Our facility will protect residents from harm during investigations of abuse allegations. Procedures: 1. During abuse investigations, residents will be protected from harm by the following measures: a. Employees accused of participation in the alleged abuse

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. BUILDING _____ B. WING _____	05/17/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEVISTA REHABILITATION AND SKILLED CARE	7604 QUANAH PARKER TRAILWAY LAWTON, OK 73505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) will be immediately suspended until the administrator has reviewed the findings of the investigation. Resident #3 had [DIAGNOSES REDACTED]. The quarterly assessment, dated 05/13/12, documented his cognition was moderately impaired. He was dependant on the staff with transfers, dressing and personal hygiene. He required extensive assistance with eating and bathing. An Incident Report Form reported to the OSDH by the administrator, dated 05/01/13, documented, Resident alleged that a CNA fed him roughly. He stated that she 'fed me like a dog.' Reported to ADON (assistant director of nurses) that CNA informed him that his door had to be closed while he was being fed, when he did not want the door closed. Resident also reported that CNA was watching TV while feeding him. Resident does have cognitive impairment. Investigation complete. Resident interviewed confirmed CNA (name withheld) was feeding him in an angry manner making him feel as he put it, 'like a dog' CNA terminated. resident informed of investigation result. He stated he was satisfied. A typed letter by the administrator, dated 05/01/13, documented the administrator and the assistant administrator went to visit with the resident. .He (the resident) was very pleasant and when asked about his meal, he became agitated. He stated (name withheld) made him feel like a dog when she was 'shoving' food in his mouth. He stated she was mad when she came in and wanted to watch television more than help me eat. He stated he did not want her in his room again. I apologized that this had happened and that this was not they (the) way we treat people. I informed him that (name withheld) was sent home. He stated he was glad. I also informed him that I was making a report to the State health department. He stated he did not understand why she was treating him (this) way and that she should not be helping people. I thanked him for his time and advised him I would let him know when I concluded the investigation. The CNA's (CNA #1) employee file contained A Notice of Warning form, dated 05/07/13. It documented the CNA was given a written warning for unsatisfactory performance for .assisting feeding a resident in an angry manner Resident felt he was being treated like a 'dog'. She would return to work with education. The corrective plan of action was for her to complete training on sensitivity, resident dignity and proper feeding procedures. The file contained five certificates of completion: proper feeding procedures, making a positive difference every day, resident rights: the right thing to do, the professional CNA and resident rights, dated 05/08/13. The Employee Time Sheet Report for CNA #1, documented she worked on 05/07/13, 05/08/13, 05/11/13, 05/12/13, 05/13/13 and 05/14/13, after the incident had occurred. On 05/14/13 at 6:05 p.m., the surveyor observed CNA #1 assisting the resident with his dinner meal in his room. On 05/15/13 at 3:45 p.m., the resident's clinical record was reviewed by the surveyor. At 4:12 p.m. resident #3 was interviewed. He stated he was a little bit afraid of the CNA that had fed him angrily and that he would prefer her to not take care of him anymore. She forces me to eat. At 4:45 p.m., the administrator was asked why CNA #1 was assisting the resident. She stated she did not know the CNA was assisting the resident. I had no idea she was working on the other side (of the building), I had no clue. The surveyor asked the administrator why the incident report sent to the OSDH documented CNA #1 was terminated. She stated she had talked to corporate and they had encouraged her not to terminate the CNA. She stated the CNA was sent home immediately pending the investigation and was suspended for three days. The CNA was required to complete training and was only to work on the opposite side of the building from the resident's room. The surveyor asked the administrator who she assigned to monitor the CNA's work performance. She stated the Assistant Director of Nursing (ADON). The administrator was asked if other residents had been interviewed pertaining to CNA #1. She stated social services should have done a 'Safe Survey.' There was no documentation provided to show a 'Safe Survey' had been conducted during the investigation. On 05/16/13 at 2:00 p.m., the ADON was asked if she had been monitoring the CNA's work performance after her suspension. She stated she did not know the CNA had been suspended and did not know she was supposed to be monitoring her. On 05/17/13 at 8:30 a.m., a hand written letter signed by the DON, CNA #1, the administrator and the Regional Director of Operations was presented to the survey team. It documented a meeting they had together that morning at 7:00 a.m. It documented the CNA had assisted the resident because she .was afraid just to leave his tray outside or just leave it in his room, since state was here. I didn't want to just leave his food & not assist as I didn't want to get into trouble for that. The letter documented the CNA was re-educated that when she had been informed she was unable to work with a specific resident then she would not be able to do so for absolutely any reason. Also explained that when we spoke with resident upon completion of that investigation that he was informed that you would not be working with him ever again and that is what he agreed to. The documentation did not contain who would monitor the CNA's work performance to ensure the safety of other residents. There was no documentation other residents had been interviewed concerning the performance of CNA #1.
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/15/13 at 4:30 p.m., an immediate jeopardy (IJ) situation was identified related to the failure of the facility to fully investigate an allegation of abuse reported by a resident in regard to certified nurse aide (CNA #1), and the failure to take appropriate actions to protect all residents. At 4:35 p.m., the existence of an IJ was verified with the Oklahoma State Department of Health (OSDH). At 4:45 p.m., the facility administrator and director of nursing (DON) were notified of the existence of an IJ pertaining to the failure to fully investigate and protect all residents from abuse. At 5:30 p.m., the plan of removal was received and accepted. The facility's Plan of Removal documented: The facility will follow its policy on Abuse and Neglect. Specifically the suspension of an alleged perpetrator (staff), conduct an complete investigation, and provide retraining as deemed necessary prior to the alleged perpetrator returning to assigned duties. The administrator was removed as the Abuse Coordinator. The Director of Nursing was appointed Interim Abuse Coordinator. The Management Company's Director of Clinical Services and Regional Director of Operations conducted an in-service on May 15, 2013 at 5:30 p.m. on the facility Abuse Policy to all facility management team. At 5:40 p.m., the administrator and DON were informed the IJ was removed. The deficient practice remained at a level of actual harm that was not immediate jeopardy, at a pattern. On 05/17/13 at 9:35 a.m., the OSDH was called and verified the need to reinstitute the IJ due to the facility's failure to protect all residents and follow their abuse policy as documented on their plan of removal, received on 05/15/13 at 5:30 p.m. At 9:45 a.m., the DON and the regional consultant were informed the IJ was reinstituted and why. At 10:30 a.m., the plan of removal for the reinstituted IJ was received and accepted. The Plan of Removal documented the CNA (#1) was terminated from the facility. The IJ was removed effective 05/17/13 at 10:30 a.m. The deficient practice remained at a level of no actual harm with a potential for more than minimal harm, at a pattern. Based on observations, record review and interviews, it was determined the facility failed to fully investigate an allegation of abuse reported by one (#3) of twelve sampled residents in regard to CNA (#1), and take appropriate actions to protect all residents. This had the potential to affect all 81 residents. Findings: The facility's policy, 'Abuse Prohibition Management Program-Identification, Investigation and Reporting Policy', documented, All personnel, residents, family members, visitors, etc., are encouraged to report actual or suspected incidents of Resident Abuse or inappropriate behavior that may lead to resident abuse. Such reports may be made without fear of retaliation from the facility or its staff. The facility will provide feedback to residents and family members and others regarding concerns that have been expressed to facility staff, in a timely manner. Procedures: Identification: 1. To assist our facility's staff members, residents, families and visitors to our facility in recognizing incidents of Resident Abuse, the following definitions are provided: a. Abuse is defined as the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. b. Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families. c. Sexual abuse. d. Physical abuse. e. Mental or psychological abuse includes, but not limited to, humiliation, harassment and threats of punishment or deprivation. Investigation: 3. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the Abuse Coordinator or his/her designee will investigate the alleged incident. 5. The individual conducting the investigation will, at a minimum (and as appropriate): a. Review the completed Resident Abuse Report Form: b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview the resident's attending physician to determine the resident's current mental status, if appropriate; g. Interview staff members (on all shifts) who had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members and visitors; i. Interview other residents to whom the accused employee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. BUILDING _____ B. WING _____	05/17/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEVISTA REHABILITATION AND SKILLED CARE	7604 QUANAH PARKER TRAILWAY LAWTON, OK 73505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) provides care or services; j. Review all events leading up to the alleged incident; and. 26. Social Services follow-up: a. As part of the investigation, the Social Worker will conduct a Safe Survey. The Social Worker will interview all other cognitive residents possible affected by this incident. b. this action is to evaluate their perspective or their feeling of being safe and if they are aware of how to report an incident. Protection of Residents During Abuse Investigations Policy: Our facility will protect residents from harm during investigations of abuse allegations. Procedures: 1. During abuse investigations, residents will be protected from harm by the following measures: a. Employees accused of participation in the alleged abuse will be immediately suspended until the administrator has reviewed the findings of the investigation. Resident #3 had [DIAGNOSES REDACTED]. The quarterly assessment, dated 05/13/12, documented his cognition was moderately impaired. He was dependant on the staff with transfers, dressing and personal hygiene. He required extensive assistance with eating and bathing. An Incident Report Form reported to the OSDH by the administrator, dated 05/01/13, documented, Resident alleged that a CNA fed him roughly. He stated that she 'fed me like a dog.' Reported to ADON (assistant director of nurses) that CNA informed him that his door had to be closed while he was being fed, when he did not want the door closed. Resident also reported that CNA was watching TV while feeding him. Resident does have cognitive impairment. Investigation complete. Resident interviewed confirmed CNA (name withheld) was feeding him in an angry manner making him feel as he put it, 'like a dog' CNA terminated. resident informed of investigation result. He stated he was satisfied. A typed letter by the administrator, dated 05/01/13, documented the administrator and the assistant administrator went to visit with the resident. .He (the resident) was very pleasant and when asked about his meal, he became agitated. He stated (name withheld) made him feel like a dog when she was 'shoving' food in his mouth. He stated she was mad when she came in and wanted to watch television more than help me eat. He stated he did not want her in his room again. I apologized that this had happened and that this was not they (the) way we treat people. I informed him that (name withheld) was sent home. He stated he was glad. I also informed him that I was making a report to the State health department. He stated he did not understand why she was treating him (this) way and that she should not be helping people. I thanked him for his time and advised him I would let him know when I concluded the investigation. The CNA's (CNA #1) employee file contained A Notice of Warning form, dated 05/07/13. It documented the CNA was given a written warning for unsatisfactory performance for .assisting feeding a resident in an angry manner Resident felt he was being treated like a 'dog'. She would return to work with education. The corrective plan of action was for her to complete training on sensitivity, resident dignity and proper feeding procedures. The file contained five certificates of completion: proper feeding procedures, making a positive difference every day, resident rights: the right thing to do, the professional CNA and resident rights, dated 05/08/13. The Employee Time Sheet Report for CNA #1, documented she worked on 05/07/13, 05/08/13, 05/11/13, 05/12/13, 05/13/13 and 05/14/13, after the incident had occurred. On 05/14/13 at 6:05 p.m., the surveyor observed CNA #1 assisting the resident with his dinner meal in his room. On 05/15/13 at 3:45 p.m., the resident's clinical record was reviewed by the surveyor. At 4:12 p.m. resident #3 was interviewed. He stated he was a little bit afraid of the CNA that had fed him angrily and that he would prefer her to not take care of him anymore. She forces me to eat. At 4:45 p.m., the administrator was asked why CNA #1 was assisting the resident. She stated she did not know the CNA was assisting the resident. I had no idea she was working on the other side (of the building), I had no clue. The surveyor asked the administrator why the incident report sent to the OSDH documented CNA #1 was terminated. She stated she had talked to corporate and they had encouraged her not to terminate the CNA. She stated the CNA was sent home immediately pending the investigation and was suspended for three days. The CNA was required to complete training and was only to work on the opposite side of the building from the resident's room. The surveyor asked the administrator who she assigned to monitor the CNA's work performance. She stated the Assistant Director of Nursing (ADON). The administrator was asked if other residents had been interviewed pertaining to CNA #1. She stated social services should have done a 'Safe Survey.' There was no documentation provided to show a 'Safe Survey' had been conducted during the investigation. On 05/16/13 at 2:00 p.m., the ADON was asked if she had been monitoring the CNA's work performance after her suspension. She stated she did not know the CNA had been suspended and did not know she was supposed to be monitoring her. On 05/17/13 at 8:30 a.m., a hand written letter signed by the DON, CNA #1, the administrator and the Regional Director of Operations was presented to the survey team. It documented a meeting they had together that morning at 7:00 a.m. It documented the CNA had assisted the resident because she .was afraid just to leave his tray outside or just leave it in his room, since state was here. I didn't want to just leave his food & not assist as I didn't want to get into trouble for that. The letter documented the CNA was re-educated that when she had been informed she was unable to work with a specific resident then she would not be able to do so for absolutely any reason. Also explained that when we spoke with resident upon completion of that investigation that he was informed that you would not be working with him ever again and that is what he agreed to. The documentation did not contain who would monitor the CNA's work performance to ensure the safety of other residents. The facility's abuse policy was not followed in regard to all of the interviews that should have been conducted as the policy directed. The only interviews conducted were with the resident, CNA #1 and two other residents. Also, the abuse policy was not followed in regard to Social Services not conducting a 'Safe Survey.'
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 05/15/13 at 4:30 p.m., an immediate jeopardy (IJ) situation was identified related to the failure of the facility to follow their abuse policy after a resident made an allegation of a certified nurse aide (CNA #1) being abusive. At 4:35 p.m., the existence of an IJ was verified with the Oklahoma State Department of Health (OSDH). At 4:45 p.m., the facility administrator and director of nursing (DON) were notified of the existence of an IJ pertaining to the failure to protect all residents from abuse. At 5:30 p.m., the plan of removal was received and accepted. The facility's Plan of Removal documented: The facility will follow its policy on Abuse and Neglect. Specifically the suspension of an alleged perpetrator (staff), conduct an complete investigation, and provide retraining as deemed necessary prior to the alleged perpetrator returning to assigned duties. The administrator was removed as the Abuse Coordinator. The Director of Nursing was appointed Interim Abuse Coordinator. The Management Company's Director of Clinical Services and Regional Director of Operations conducted an in-service on May 15, 2013 at 5:30 p.m. on the facility Abuse Policy to all facility management team. At 5:40 p.m., the administrator and DON were informed the IJ was removed. The deficient practice remained at a level of actual harm that was not immediate jeopardy, at a pattern. On 05/17/13 at 9:35 a.m., the OSDH was called and verified the need to reinstitute the IJ due to the facility's failure to protect all residents and follow their abuse policy as documented on their plan of removal, received on 05/15/13 at 5:30 p.m. At 9:45 a.m., the DON and the regional consultant were informed the IJ was reinstituted and why. At 10:30 a.m., the plan of removal for the reinstituted IJ was received and accepted. The Plan of Removal documented the CNA (#1) was terminated from the facility. The IJ was removed effective 05/17/13 at 10:30 a.m. The deficient practice remained at a level of no actual harm with a potential for more than minimal harm, at a pattern. Based on observations, record review and interviews, it was determined the facility failed to follow their abuse policy after one (#3) of twelve sampled residents made an allegation of a CNA (#1) being abusive. This had the potential to affect all 81 residents. Findings: The facility's policy, 'Abuse Prohibition Management Program-Identification, Investigation and Reporting Policy', documented, All personnel, residents, family members, visitors, etc., are encouraged to report actual or suspected incidents of Resident Abuse or inappropriate behavior that may lead to resident abuse. Such reports may be made without fear of retaliation from the facility or its staff. The facility will provide feedback to residents and family members and others regarding concerns that have been expressed to facility staff, in a timely manner. Procedures: Identification: 1. To assist our facility's staff members, residents, families and visitors to our facility in recognizing incidents of Resident Abuse, the following definitions are provided: a. Abuse is defined as the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. b. Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families. c. Sexual abuse. d. Physical abuse. e. Mental or psychological abuse includes, but not limited to, humiliation, harassment and threats of punishment or deprivation. Investigation: 3. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the Abuse Coordinator or his/her designee will investigate the alleged incident. 5. The individual conducting the investigation will, at a minimum (and as appropriate): a. Review the completed Resident Abuse Report Form: b. Review the resident's medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. BUILDING _____ B. WING _____	05/17/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEVISTA REHABILITATION AND SKILLED CARE	7604 QUANAH PARKER TRAILWAY LAWTON, OK 73505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview the resident's attending physician to determine the resident's current mental status, if appropriate; g. Interview staff members (on all shifts) who had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members and visitors; i. Interview other residents to whom the accused employee provides care or services; j. Review all events leading up to the alleged incident; and. 26. Social Services follow-up: a. As part of the investigation, the Social Worker will conduct a Safe Survey. The Social Worker will interview all other cognitive residents possible affected by this incident. b. this action is to evaluate their perspective or their feeling of being safe and if they are aware of how to report an incident. Protection of Residents During Abuse Investigations Policy: Our facility will protect residents from harm during investigations of abuse allegations. Procedures: 1. During abuse investigations, residents will be protected from harm by the following measures: a. Employees accused of participation in the alleged abuse will be immediately suspended until the administrator has reviewed the findings of the investigation. Resident #3 had [DIAGNOSES REDACTED]. The quarterly assessment, dated 05/13/12, documented his cognition was moderately impaired. He was dependant on the staff with transfers, dressing and personal hygiene. He required extensive assistance with eating and bathing. An Incident Report Form reported to OSDH by the administrator, dated 05/01/13, documented, Resident alleged that a CNA fed him roughly. He stated that she 'fed me like a dog.' Reported to ADON (assistant director of nurses) that CNA informed him that his door had to be closed while he was being fed, when he did not want the door closed. Resident also reported that CNA was watching TV while feeding him. Resident does have cognitive impairment. Investigation complete. Resident interviewed confirmed CNA (name withheld) was feeding him in an angry manner making him feel as he put it, 'like a dog' CNA terminated. resident informed of investigation result. He stated he was satisfied. A typed letter by the administrator, dated 05/01/13, documented the administrator and the assistant administrator went to visit with the resident. .He (the resident) was very pleasant and when asked about his meal, he became agitated. He stated (name withheld) made him feel like a dog when she was 'shoving' food in his mouth. He stated she was mad when she came in and wanted to watch television more than help me eat. He stated he did not want her in his room again. I apologized that this had happened and that this was not they (the) way we treat people. I informed him that (name withheld) was sent home. He stated he was glad. I also informed him that I was making a report to the State health department. He stated he did not understand why she was treating him (this) way and that she should not be helping people. I thanked him for his time and advised him I would let him know when I concluded the investigation. The CNA's (CNA #1) employee file contained A Notice of Warning form, dated 05/07/13. It documented the CNA was given a written warning for unsatisfactory performance for .assisting feeding a resident in an angry manner Resident felt he was being treated like a 'dog'. She would return to work with education. The corrective plan of action was for her to complete training on sensitivity, resident dignity and proper feeding procedures. The file contained five certificates of completion: proper feeding procedures, making a positive difference every day, resident rights: the right thing to do, the professional CNA and resident rights, dated 05/08/13. The Employee Time Sheet Report for CNA #1, documented she worked on 05/07/13, 05/08/13, 05/11/13, 05/12/13, 05/13/13 and 05/14/13, after the incident had occurred. On 05/14/13 at 6:05 p.m., the surveyor observed CNA #1 assisting the resident with his dinner meal in his room. On 05/15/13 at 3:45 p.m., the resident's clinical record was reviewed by the surveyor. At 4:12 p.m. resident #3 was interviewed. He stated he was a little bit afraid of the CNA that had fed him angrily and that he would prefer her to not take care of him anymore. She forces me to eat. At 4:45 p.m., the administrator was asked why CNA #1 was assisting the resident. She stated she did not know the CNA was assisting the resident. I had no idea she was working on the other side (of the building), I had no clue. The surveyor asked the administrator why the incident report sent to the OSDH documented CNA #1 was terminated. She stated she had talked to corporate and they had encouraged her not to terminate the CNA. She stated the CNA was sent home immediately pending the investigation and was suspended for three days. The CNA was required to complete training and was only to work on the opposite side of the building from the resident's room. The surveyor asked the administrator who she assigned to monitor the CNA's work performance. She stated the Assistant Director of Nursing (ADON). The administrator was asked if other residents had been interviewed pertaining to CNA #1. She stated social services should have done a 'Safe Survey.' There was no documentation provided to show a 'Safe Survey' had been conducted during the investigation. On 05/16/13 at 2:00 p.m., the ADON was asked if she had been monitoring the CNA's work performance after her suspension. She stated she did not know the CNA had been suspended and did not know she was supposed to be monitoring her. On 05/17/13 at 8:30 a.m., a hand written letter signed by the DON, CNA #1, the administrator and the Regional Director of Operations was presented to the survey team. It documented a meeting they had together that morning at 7:00 a.m. It documented the CNA had assisted the resident because she .was afraid just to leave his tray outside or just leave it in his room, since state was here. I didn't want to just leave his food & not assist as I didn't want to get into trouble for that. The letter documented the CNA was re-educated that when she had been informed she was unable to work with a specific resident then she would not be able to do so for absolutely any reason. Also explained that when we spoke with resident upon completion of that investigation that he was informed that you would not be working with him ever again and that is what he agreed to. The documentation did not contain who would monitor the CNA's work performance to ensure the safety of other residents. The facility's abuse policy was not followed in regard to all of the interviews that should have been conducted as the policy directed. The only interviews conducted were with the resident, CNA #1 and two other residents. Also, the abuse policy was not followed in regard to Social Services not conducting a 'Safe Survey.'
F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure each resident receives an accurate assessment by a qualified health professional** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to accurately assess one (#14) of 21 sampled residents. This had the potential to affect all 81 residents residing in the facility. Findings: Resident #14 had [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 05/07/13, documented the resident's cognitive status was severely impaired, had behaviors daily of wondering, required extensive assistance with all activities of daily living, wheeled self throughout the facility in a wheelchair and was always incontinent of bowel and bladder. The assessment also documented the resident had not received an antipsychotic for the seven day look back period of the assessment. The physician's orders [REDACTED]. The resident had physician orders [REDACTED]. The minimum data set coordinator was shown the resident's quarterly assessment and was asked if the antipsychotic medication should have been coded that the resident received the medication for the past seven days. She stated, Yes.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to ensure a comprehensive care plan had been developed for 1 (#6) of 23 sampled residents whose care plans were reviewed. The resident's potential for depression had not been care planned. 81 residents resided in the facility. Findings: Resident #6 had [DIAGNOSES REDACTED]. The admission assessment, dated 04/11/13, documented the resident was cognitively intact, showed little interest or pleasure in doing things; feeling down, depressed, or hopeless; had trouble falling or staying asleep, or sleeping to much; and feeling tired or having little energy. On 05/16/13 at 3:40 p.m., an interview was conducted with the resident. The resident stated he had begun [MEDICAL TREATMENT] three weeks ago. He stated he was waiting to have eye surgery and that he could not see very well. The surveyor asked him if he felt depressed. He stated, Wouldn't you? The resident's care plan was reviewed. The resident did not have a care plan that addressed depression. On 05/15/13 at 12:30 p.m., the surveyor showed the skilled minimum data set (MDS) coordinator the resident's care plan and MDS and asked if the resident had a care plan addressing depression. She responded, No.
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide necessary care and services to maintain the highest well being of each resident** **Provide necessary care and services to maintain the highest well being of each resident**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. BUILDING _____ B. WING _____	05/17/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEVISTA REHABILITATION AND SKILLED CARE	7604 QUANAH PARKER TRAILWAY LAWTON, OK 73505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review it was determined the facility failed to ensure the physician's orders were followed for two (#10 and #11) of 21 sampled residents. This had the potential to affect all 81 residents. Findings: 1. Resident #10 had [DIAGNOSES REDACTED]. The quarterly assessment, dated 04/07/13, documented her cognition was severely impaired. She was dependent on the staff for transfers, dressing, eating, personal hygiene and bathing. A telephone order, dated 05/03/13, documented the resident was to have a right, upper extremity splint to her hand at all times. The splint was only to be removed for a skin check on the 7 a.m. to 3 p.m. shift. On 05/14/13 at 8:15 a.m., the resident was observed laying in her bed in her room. There was no splint to her right arm. A Band-Aid was observed on the resident's right, second toe. The wound care nurse removed the Band-Aid and stated, Someone applied zinc to this. The physician's orders for May 2013 documented the resident's right, second toe was to be cleansed with normal saline and be left open to the air. At 9:25 am., the wound care nurse was asked if the physician's order for the treatment of [REDACTED]. She stated the order had not been followed and that someone had just done the treatment without a physician's order. At 11:00 a.m., the resident was observed laying in her bed in her room. There was no splint to her right arm. Licensed practical nurse # was in the resident's room and was asked by the surveyor if the physician's order was being followed in regards to the resident's splint being on her right arm. She stated, No. She located the splint on the resident's nightstand and put it on her right arm. 2. Resident #11 had [DIAGNOSES REDACTED]. The admission assessment, dated 10/16/12, documented the resident had severe cognitive impairment, required total assistance with dressing/hygiene and received nutrition through a feeding tube. A careplan, dated 10/13/12, documented N.O. (new order) restart tube feeding @ (at) 35 cc, ^ (increase) H2O (water) flush 200 cc Q (every) 6 (hours), daily ^ feeds 10 cc until 65 cc/hr, 45 (degrees). A physician's order, dated 10/14/13, documented, 45 (degrees) bed. (indicating the head of the bed should be elevated to 45 degrees). A physician's order, dated 10/15/13, documented, ^ increase tube feed to 55 cc (cubic centimeters) today, 60 cc 10/16 and 65 cc 10/17. A nurse's note, dated 10/19/12, documented HOB (head of bed) ^ up 35 (degrees). A nurse's note dated, 10/29/12, documented fibersource continious (continuous) @ (at) 60 cc/hr (cc per hour). A nurse's note, dated 11/12/12, documented HOB up 30 degrees. A nurse's note, dated 11/07/12, documented HOB up 35 degrees. On 05/16/13 at 11:10 a.m., the director of nursing was shown the physician's orders and the nurses' notes and was asked if the physician's orders were followed. She responded, According to the documentation I would assume the orders were not followed.
F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to ensure residents were not treated with antibiotics unless they had symptomatic urinary tract infections for four (#2, 4, 9 and #10) of 21 sampled residents. This had the potential to affect five other residents who had urinary tract infections, according to the facility's Roster/Sample Matrix. 1. Resident #2 had [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 03/16/13, documented she was cognitively intact; required extensive assistance with transfer, dressing, hygiene/bathing; did not walk and had an indwelling urinary catheter. A physician's orders [REDACTED]. There was no documentation in the nurse's notes of the resident having a fever or chills, new flank pain, change in character of urine or changes in mental or functional status prior to the order. A physician's orders [REDACTED]. A nurse's note dated 03/20/13 at 2:00 p.m., documented resident continues on ABT (antibiotic) [MEDICATION NAME] in urine. On 05/15/13 at 10:45 a.m., the director of nurses was shown the resident's clinical record and asked if symptoms were documented to support the initiation of an antibiotic. She responded, I'm going to educate the staff on that. 2. Resident #4 has [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 04/10/13, documented her cognitive status was severely impaired, she required extensive assistance with transfers, dressing, hygiene and bathing. She could feed herself with setup help, frequently incontinent of bowel and bladder and could self propel around in her wheelchair. A nurses's note, dated 01/19/13, documented, Obtained final results of U/A C&S (urine analysis and culture and sensitivity). DR (doctor) (name omitted), notified, received N.O. (new order) for Bactrim DS (double strength) one P.O. (by mouth) daily X (times) 10 days. res is with confusion noted, resident encouraged to increase P.O. fluid intake, resident offered fluids between meals. No documentation was found in the nurses' notes from 10/14/12 through 01/19/13 to indicated the resident had signs and symptoms of a urinary tract infection. On 05/16/13 at 11:45 a.m., the DON was asked if there was sufficient documentation in the clinical record to indicate the resident had signs and symptoms of a urinary tract infection. She stated, No. 3. Resident #9 had [DIAGNOSES REDACTED]. The resident's admission assessment, dated 04/19/13, documented the resident's cognitive status was intact. He required extensive assistance with ambulation, dressing, hygiene, and bathing. He was frequently incontinent of bowel and bladder. A physician's telephone order, dated 04/20/13, documented, [MEDICATION NAME] 100 mg (milligrams) 1 po (by mouth) BID (twice a day) x (times) 10 days. Indication - DX (diagnosis) UTI (urinary tract infection). There was no documentation in the nurses' notes of the resident having a temperature, any pain or changes with urination, changes in character of urine or changes in mental or functional status prior to the above telephone order. On 05/16/13 at 4:30 p.m., the ADON (assistant director of nurses) was given the resident's clinical record to review to see if there was any documentation to support starting the resident on an antibiotic. She stated, No. Resident #10 had [DIAGNOSES REDACTED]. The quarterly assessment, dated 04/07/13, documented her cognition was severely impaired. She was dependent on the staff for transfers, dressing, eating, personal hygiene and bathing. A nurse's note, dated 01/31/13, documented a urine was obtained for a urinalysis with a culture and sensitivity test. The note documented the resident's urine had odor and was cloudy with sediment present. There was no documentation of the resident's temperature or if she was exhibiting signs of discomfort. A urine culture lab result, dated 02/03/13, documented the residents urine did have [MEDICAL CONDITION] bacteria. A nurse's note, dated 02/07/13, documented the resident was to start on Bactrim DS (an antibiotic) twice a day via her feeding tube for a UTI (urinary tract infection). On 05/14/13 at 10:55 a.m., the director of nurses was asked by the surveyor if the resident exhibited enough symptoms to prompt a urinalysis to be obtained and for the resident to be treated with an antibiotic. She stated, No.
F 0318 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined the facility failed to ensure residents with a limited range of motion received services to increase range of motion and/or to prevent decline in range of motion for four (#19, #21-#23) of 21 sampled residents. This had the potential to affect 26 other residents identified by the facility's Roster/Sample Matrix who were at risk for a decline in range of motion. Findings: 1. Resident # 19 had [DIAGNOSES REDACTED]. The quarterly assessment, dated 02/20/13, documented she had severe cognitive impairment and required extensive assist with transfer and dressing. She did not walk and had limited range of motion to her lower extremities. On 05/16/13, the resident's clinical record was reviewed. There was no documentation to indicate she was receiving specialized rehabilitation or restorative nursing. The quarterly assessment, dated 02/20/13, was reviewed. There was no documentation in the assessment to indicate the resident received physical therapy, occupational therapy or restorative nursing. On 05/16/13 at 12:00 p.m., the director of rehabilitative services was asked if the resident was receiving rehabilitation services. She replied No. On 05/16/13 at 11:50 a.m., the restorative nursing assistant was asked if the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. BUILDING _____ B. WING _____	05/17/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEVISTA REHABILITATION AND SKILLED CARE	7604 QUANAH PARKER TRAILWAY LAWTON, OK 73505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0318 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) receiving restorative nursing services. She replied No, I have not received anything from the physical therapy department. 2. Resident #21 has [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 04/10/13, documented the resident's cognitive status was intact, required total assistance of two staff for transfers, extensive assistance with dressing, bathing and hygiene and could feed herself with setup help. The assessment documented the resident had impaired range of motion on both sides of the lower extremities. There was no restorative nursing program documented in the clinical record. On 05/17/13 at 12:35 p.m., the director of nursing was interviewed regarding restorative nursing program for the resident. She was asked should there have been a restorative program in place. She stated, Yes. On 05/17/13 at 12:45 p.m., the director of the therapy department was interviewed. She was asked when the resident was on physical therapy. She stated, The last time was from 02/06/13 through 03/21/13. She was asked if the resident was discharged with a restorative nursing program. She stated, No. 3. Resident #22 has [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 03/17/13, documented the resident's cognition was intact, required extensive assistance with all activities of daily living, except she could feed herself. It also documented the resident had limited range of motion on one side of her lower extremities and propelled herself in a wheelchair. There was no restorative nursing program documented in the clinical record. On 05/17/13 at 12:35 p.m., the director of nursing was interviewed regarding a restorative nursing program for the resident. She was asked should there have been a restorative program in place. She stated, Yes. 4. Resident #23 had [DIAGNOSES REDACTED]. Her annual assessment, dated 04/06/13, documented she was cognitively intact, required total assist with transfers and had limited range of motion to her upper and lower extremities on one side of her body. On 05/16/13 the resident's clinical record was reviewed. A facility form titled Restorative Nursing Treatment Record was reviewed. The section of the form titled Program documented the resident was in grp (group) activities and asst'd (assisted) dining. The documentation on the form indicated the resident had received the group activities on 05/07/13, 05/08/13, 05/09/13, 05/10/13 and 05/13/13. Documentation for 05/01/13 - 05/06/13 and 05/11/13-05/12/13 was blank. The documentation for the assisted dining was the same as for the group activities. The annual assessment, dated 04/06/13, was reviewed. There was no documentation in the assessment to indicate the resident received physical therapy, occupational therapy or restorative nursing. On 05/16/13 at 11:50 a.m., the restorative nursing assistant was asked what services were provided to the resident from 05/01/13- 05/0613 and 05/11/13 - 05/12/13. She replied, None. She was asked if the services provided were enough to maintain present status or prevent further decline. She replied, No. On 05/16/13 at 3:15 p.m., the Nurse Consultant was provided with the findings. She replied We are working on the program. She was asked if the services provided were enough to maintain present status or prevent further decline. She replied, No.
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, it was determined the facility failed to provide adequate assistance with a transfer for one (#16) of 21 sampled residents. This had the potential to affect any resident requiring assistance with transfers. There were 81 residents residing in the facility. Findings: Resident #16 was admitted with [DIAGNOSES REDACTED]. The resident's comprehensive assessment, dated 2/13/13, documented the resident's cognitive status was moderately impaired. On 5/16/13 at 9:54 a.m., CNA #2 was observed transferring the resident from her bed to her wheelchair with a gait belt. The surveyor asked if the resident was a one or two person assist with transfers. The CNA stated she was a one person assist. The resident's care plan dated, 3/20/13, documented the resident was to be 2-person assist with a gait belt for transfers. A monthly summary sheet, dated 4/27/13, documented the resident required the assistance of two staff members for transferring. On 5/16/13 at 4:30 p.m., the director of nurses was asked if the resident should have been assisted by only one certified nurses aide with the transfer. She stated No.
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to ensure residents were not receiving unnecessary drugs for three (#4, #10 and #13) of twenty-one sampled residents. This had the potential to affect any resident residing in the facility. There were 81 residents residing in the facility. Findings: 1. Resident #4 has [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 04/10/13, documented her cognitive status was severely impaired, she required extensive assistance with transfers, dressing, hygiene and bathing. She could feed herself with setup help, frequently incontinent of bowel and bladder and could self propel around in her wheelchair. A nurses's note, dated 01/19/13, documented, Obtained final results of U/A C&S (urine analysis and culture and sensitivity). DR (doctor) (name omitted), notified, received N.O. (new order) for Bactrim DS (double strength) one P.O. (by mouth) daily X (for) 10 days. res is with confusion noted, resident encouraged to increase P.O. fluid intake, resident offered fluids between meals. No documentation was found in the nurses' notes from 10/14/12 through 01/19/13 to indicate the resident had signs and symptoms of a urinary tract infection. On 05/16/13 at 11:45 a.m., the DON was asked if there was sufficient documentation in the clinical record to indicate the resident had signs and symptoms of a urinary tract infection that needed treatment with an antibiotic. She stated, No. 2. Resident #10 had [DIAGNOSES REDACTED]. The quarterly assessment, dated 04/07/13, documented her cognition was severely impaired. She was dependent on the staff for transfers, dressing, eating, personal hygiene and bathing. A nurse's note, dated 01/31/13, documented a urine was obtained for a urinalysis with a culture and sensitivity test. The note documented the resident's urine had odor and was cloudy with sediment present. There was no documentation of the resident's temperature or if she was exhibiting signs of discomfort. A urine culture lab result, dated 02/03/13, documented the residents urine did have [MEDICAL CONDITION] bacteria. A nurse's note, dated 02/07/13, documented the resident was to start on Bactrim DS (an antibiotic) twice a day via her feeding tube for a UTI (urinary tract infection). On 05/14/13 at 10:55 a.m., the director of nurses was asked by the surveyor if the resident exhibited enough symptoms to prompt a urinalysis to be obtained and for the resident to be treated with an antibiotic. She stated, No. 3. Resident #13 had [DIAGNOSES REDACTED]. The resident's annual assessment, dated 03/12/13, documented the resident's cognitive status was severely impaired. She did not ambulate and was totally dependent on the staff for all activities of daily living. The resident had an order for [REDACTED]. On 05/16/13 the resident's clinical record was reviewed, there were no recommendations from the pharmacist to the physician for a gradual dose reduction of this medication. The Nursing 2013 Drug Handbook Edition 33, documents indications for the use of [MEDICATION NAME] are [MEDICAL CONDITION], manic episodes of [MEDICAL CONDITION] I disorder, depression associated with [MEDICAL CONDITION] disorder or obsessive - compulsive disorder. A black box warning documents the drug is not indicated for use in elderly patients with dementia - related [MEDICAL CONDITION] because of increased risk of death. On 05/16/13 at 3:15 p.m., the consultant pharmacist was shown a consultant report dated 08/15/12, which informed the physician the resident was taking two antipsychotic medications, including [MEDICATION NAME] and two antidepressants. The physician discontinued one antipsychotic medication and one antidepressant at that time. He was asked if there were any other consultant reports to the physician requesting a dose reduction of the [MEDICATION NAME] since the one dated 08/15/12. He printed copies from 12/01/12 to 05/16/13 for the surveyor. There were no recommendations for a dose reduction of the [MEDICATION NAME] in the copies. The pharmacist stated he would speak to the resident's physician concerning this medication.
F 0365 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide food in a way that meets a resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to prepare pureed food to meet the residents' nutritional needs for three (#1, #3, #26) of three sampled residents with physician ordered pureed diets. These were the only residents with physician orders [REDACTED]. On 05/13/13 at 10:50 a.m., the surveyor observed dietary aid #1 preparing pureed food ordered for three residents. The aid did not follow the recipe on the can of thicket while preparing the food. She was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. BUILDING _____ B. WING _____	05/17/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEVISTA REHABILITATION AND SKILLED CARE	7604 QUANAH PARKER TRAILWAY LAWTON, OK 73505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0365 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) putting 4 portions of chicken fried steak into the food processor. She then started pouring tap water into the processor without measuring the amount of water. She never looked at the recipe on the can and did not measure the water. She preceded to measure approximately 4 tablespoons of the thicket into the mixture of food. The consistency of the meat was liquefied. She poured the meat mixture into the molds and it filled six molds. On 05/15/13 at 10:20 a.m., the dietary manager was interviewed regarding the observation made on 05/13/13 by the surveyor. She was asked if the dietary aid should have followed the recipe on the can of thicket when preparing the pureed food. She stated, Yes, she knows better than that. She is supposed to follow the recipe on the can of thicket. She was asked if the three residents were getting the amount of protein they needed. She stated, No.
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Store, cook, and serve food in a safe and clean way** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to prepare pureed food in a sanitary manner for three (#1, #3 and #26) of three residents with physician ordered pureed diets. These were the only residents with physician orders [REDACTED]. On 05/13/13 at 10:50 a.m., the surveyor observed dietary aid #1 preparing pureed food ordered for three residents. The aid was observed putting 4 portions of chicken fried steak into the food processor. She was observed opening the lid of the processor 4 separate times and would use her gloved hand and put her index finger down into the food and then close the lid. At 10:54 a.m., she held her index finger over the opened can of thicket and the liquefied food dripped from her finger into the can of thicket. On 05/15/13 at 10:20 a.m., the dietary manager was interviewed regarding the observation made on 05/13/13 by the surveyor. She was asked if the dietary aid should have kept sticking her gloved finger into the mixture and then using the same hand to handle the can of thicket and allowing the food to drip into the can. She stated, No, she knows better than that.
F 0387 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that doctors visit residents regularly, as required.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to ensure physician visits were timely for one (#10) of 21 sampled residents. The facility's census was 81. Findings: Resident #10 had [DIAGNOSES REDACTED]. The quarterly assessment, dated 04/07/13, documented her cognition was severely impaired. She was dependent on the staff for transfers, dressing, eating, personal hygiene and bathing. The clinical record contained physician progress notes [REDACTED]. On 05/14/13 at 10:30 a.m., the director of nurses was asked if the physician had seen the resident since 02/20/13. She stated that he had not.
F 0406 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give or get specialized rehabilitative services per the patient's assessment or plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to provide specialized rehabilitation therapy for one (#2) of 21 sampled residents that required specialized rehabilitation therapy. This had the potential to affect any resident requiring specialized rehabilitation. There were 81 residents residing in the facility. Findings: Resident #2 had [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 03/16/13, documented she was cognitively intact; required extensive assistance with transfer, dressing, hygiene/bathing; and did not walk. The facility's Resident Screening Form, dated 02/26/13, documented A: Observations/Findings 2. The nursing staff has indicated the resident is experiencing a change in function that may require therapy intervention. Yes was circled and PT (physical therapy) and OT (occupational therapy) was circled to indicate the resident required the interventions of those services. B: Recommendations 1. Skilled therapy evaluation is indicated. Yes was circled to indicate the resident required the skilled services. PT and OT was circled to indicate the resident required both services. Documented on the form on the section entitled Recommendations: Pt (patient) may benefit from OT/PT services to (arrow pointing up) increase (I with a circle around it) independence c (with) ADL's (activities of daily living). The quarterly assessment, dated 03/16/13, was reviewed. There was no documentation in the assessment to indicate the resident received physical therapy, occupational therapy or restorative nursing. The facility's Physical Therapy Plan of Care and Occupational Plan of Care was initiated and dated 04/25/13. On 05/15/13 at 11:45 a.m., the resident commented, I feel so much better since they started exercising me. I feel stronger. On 05/16/13 at 12:00 p.m., the physical therapy director was asked about the delay in services for the resident. She responded The resident refused. The physical therapist was unable to provide documentation of the resident's refusal of services.
F 0425 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to ensure a resident received medications as ordered by the physician for one (#13) of twenty-one sampled residents. This had the potential to affect 81 residents residing in the facility. Findings: Resident #13 had [DIAGNOSES REDACTED]. The resident's annual assessment, dated 03/12/13, documented the resident's cognitive status was severely impaired. She did not ambulate and was totally dependent on the staff for all activities of daily living. A physician's telephone order, dated 04/29/13, documented, .Increase Lisinopril (anti-hypertensive medication) order from 20 mg (milligrams) to 40 mg po (by mouth) Q (every) day. Increase Norvasc (anti-hypertensive medication) 5 mg po Q day. The 05/01/13 physician's orders [REDACTED]. These medications were not documented. On 05/16/13 at 3:00 p.m. the consultant nurse was shown the above telephone order and MAR. She stated, What happened was the MARs for May were reviewed on 04/27/13 and the orders didn't get transcribed to the new MARs for May. I will fill out a medication error form and notify the resident's doctor.
F 0428 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the drug regimen reviews failed to identify the possible use of an unnecessary medication for one (#4) of 21 sampled residents. Also, the facility failed to follow-up on recommendations from the drug regimen reviews for one (#14) of 21 sampled residents. This had the potential to affect all 81 residents residing in the facility. Findings: 1. Resident #4 had [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 04/10/13, documented her cognitive status was severely impaired, she required extensive assistance with transfers, dressing, hygiene and bathing. She could feed herself with setup help, was frequently incontinent of bowel and bladder and could self propel around in her wheelchair. The drug regimen reviews for the resident were reviewed for the past six months. No recommendation to the physician had been made in regard of the continued use of Ditropan 5 mg daily (a medication for bladder control) when the resident was frequently incontinent. On 05/16/13 at 3:00 p.m., the licensed pharmacist was asked if a recommendation should have been sent to the physician for the continued use of the Ditropan. He stated, Yes. 2. Resident #14 had [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 05/07/13, documented the resident's cognitive status was severely impaired, had behaviors daily of wandering, required extensive assistance with all activities of daily living, wheeled self throughout the facility in a wheelchair and was always incontinent of bowel and bladder. The physician's orders [REDACTED]. The resident was ordered and received Haldol (an antipsychotic medication) 0.25 mg every 12 hours for psychosis with agitation. The pharmacist's Consultation Reports dated 11/15/12 and 04/04/13, were reviewed. Both reports documented a recommendation to the physician for a gradual dose reduction of Haldol 0.25 mg q (every) 12 hrs. to Haldol 0.25 mg at bedtime. The 11/15/12, report was a repeat from a recommendation dated 09/24/12. There was no documentation to show the physician had answered the recommendation or that the facility acted on the recommendation. On 05/16/13 at 11:45 a.m., the DON was interviewed regarding the drug reviews. She was asked if the facility had acted upon the recommendation. She stated, No. On 05/16/13 at 3:00 p.m., the licensed pharmacist was asked if he questioned the facility regarding the lack of follow-up on the recommendations. He stated, No, I just look in the chart and if there is no response found, I send out another letter to the physician.
F 0490 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Be administered in an acceptable way that maintains the well-being of each resident .**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. BUILDING _____ B. WING _____	05/17/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEVISTA REHABILITATION AND SKILLED CARE	7604 QUANAH PARKER TRAILWAY LAWTON, OK 73505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 7) Based on observation, record review and interview, it was determined the facility failed to be administered in a manner that would ensure residents were protected from being abused. On 05/15/13 at 4:30 p.m., an immediate jeopardy (IJ) situation was identified related to the failure of the facility to fully investigate, follow their abuse policy and protect all residents from abuse. Please refer to deficiencies F223, F225, and F226.
F 0504 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure medically necessary lab services/tests are ordered by the attending physician.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to provide laboratory services for one (#2) of 23 sampled residents. There were 81 residents residing in the facility at the time of the survey. Findings: 1. Resident #2 had [DIAGNOSES REDACTED]. The resident's quarterly assessment, dated 03/16/13, documented she was cognitively intact, required extensive assistance with transfer, dressing, hygiene/bathing; did not walk and had an indwelling urinary catheter. A physician's orders [REDACTED]. The resident's clinical record was reviewed. There was no documentation to indicate the lab had been obtained. On 05/13/13 at 4:20 p.m., the nurse consultant was asked if the lab had been obtained. She responded, I called the lab and they have no record of the lab being received.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined the facility failed to maintain clinical records with complete and accurate documentation for three (#4, 9, and #16) of 21 sampled residents. This had the potential to affect 81 residents residing in the facility. Findings: 1. Resident #4 has diagnoses to include depression, [MEDICAL CONDITION] and [MEDICAL CONDITION]. The resident's quarterly assessment, dated 04/10/13, documented her cognitive status was severely impaired, she required extensive assistance with transfers, dressing, hygiene and bathing. She could feed herself with setup help, frequently incontinent of bowel and bladder and could self propel around in her wheelchair. On 05/13/13 and 05/14/13, the resident's current physician orders [REDACTED]. The resident was currently receiving [MEDICATION NAME] 60 mg. two times daily. There was no diagnosis found for the use of the [MEDICATION NAME]. On 05/16/13 at 11:45 a.m., the DON was asked if a diagnosis should have been given by the physician for the use of the [MEDICATION NAME]. She stated, Yes. 2. Resident #9 had diagnoses to include muscle weakness, abnormal gait, diabetes mellitus and [MEDICAL CONDITION]. The resident's admission assessment, dated 04/19/13, documented the resident's cognitive status was intact. He required extensive assistance with ambulation, dressing, hygiene, and bathing. A physician's telephone order, dated 05/13/13, documented, Bactrim DS (antibiotic medication) 1 po (by mouth) x (times) 7 days STAT (immediately). There was no documentation in the resident's clinical record to explain the reason for the order for an antibiotic. A physician's telephone order, dated 05/15/13, documented, Send to (name omitted) (local hospital) ER (emergency room) for eval (evaluation) and treatment. There was no documentation in the resident's clinical record to explain the reason for sending the resident to the emergency room . 3. Resident #16 was admitted with diagnoses to include, cerebral vascular disease, hypertension, diverticulitis, and [MEDICAL CONDITION]. The resident's comprehensive assessment, dated 02/13/13, documented the resident's cognitive status was moderately impaired. An Accident/Incident report, dated 3/20/13, documented resident slid and hit floor while being transferred from bed to chair. There was no record of the fall documented in the nurse's note for this date. On 5/16/13 at 2:50 p.m. the DON was asked if the resident's medical record was complete and accurate. She stated No, there is no documentation of the fall.