STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 03/17/14 - 03/21/14, a recertification and relicensure survey was conducted. Complaints #OK00043794, #OK00043922 and #OK00043980 were investigated in conjunction with the survey. The following is a list of possible abbreviations used in this document: (ADD) adduction (ADM) Administrator (a) a.m. (@) At (&) and (ac) before meals (abd) abdomen (ABD) abduction (ABT) antibiotic (ADON) Assistant Director of Nurses (ADL) activities of daily living (AEB) as evidenced by (AKA) above the knee amputation (AROM) active range of motion (approx) approximately (B&B) bowel and bladder (BID) two times a day (bil, bilat) bilateral (BKA) below the knee amputation (BLE) bilateral lower extremities (bld) blood (BM) bowel movement (B/P) blood pressure (B/S) bedside (c) with (CABG) coronary artery bypass graft (CAD) coronary artery disease (cap) capsule	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
MOSES AGUKO	INTERIM ADMINISTRATOR	4/10/14

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 IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

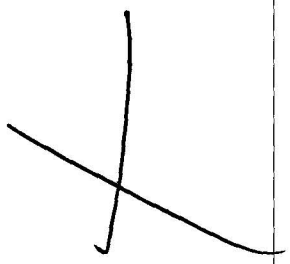
(cc) cubic centimeter
(CDI) clean, dry, intact
(CHF) congestive heart failure
(CHHA) certified home health aide
(c/l) call light
(cm) centimeter
(CMA) Certified Medication Aide
(CNA) Certified Nurse Aide
(c/o) complains of
(cont, con't) continue
(COPD) chronic obstructive pulmonary disease
(CP) care plan
(CPR) cardio pulmonary resuscitation
(CVA) cerebral vascular accident
(dau, dtr) daughter
(DAT) diet as tolerated
(DBP) diastolic blood pressure
(DC) discharge/discontinue
(decub) decubitus
(DF) dorsal flexion
(dig) Digoxin
(d/l) deciliter
(DM) dietary manager
(DO) doctor's order
(doc) documented / documentation
(DON) Director of Nurses
(DR) doctor, dining room
(drsg) dressing
(DVT) deep vein thrombus
(Dx) diagnosis
(eval) evaluation
(ext) extension
(F) Fahrenheit
(Flex) flexion
(freq) frequently
(FSBS) finger stick blood sugar
(FSS) food service supervisor
(g/c) geri-chair
(gm) gram

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2	F 000		

(grn) green
(HHN) hand held nebulizer
(hr) hour
(HIPAA) health insurance portability and accountability act
(IDDM) insulin dependent diabetes mellitis
(inh) inhaler
(i) one
(ii) two
(L), (lt) left
(L) Liter
(LE) lower extremity
(lg) large
(lib) liberal
(LOC) level of consciousness
(LPM) liters per minute
(LPN) Licensed Practical Nurse
(LTC) long term care
(MAE) moves all extremities
(MAR) Medication Administration Record
(max) maximum
(mcg) micrograms
(MD) medical doctor
(MDS) Minimum Data Set
(mg) milligram
(MI) miocardial infarction
(min) minimum
(MIN) minute or minutes
(ml) milliliter
(MR) mentally retarded
(MW) merry walker
(NA) nurse aide
(NAS) no added salt
(NAT) nurse aide in training
(N/C) nasal canula
(NCS) no concentrated sweets
(NF) nursing facility
(N.O.) new order
(NS) normal saline



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 3 (O2) oxygen (OD) right eye (oint) ointment (OOB) out of bed (OSDH) Oklahoma State Department of Health (OS) left eye (OU) both eyes (OT) occupational therapy (PASRR) pre-admission screening and resident review (p) p.m. (P) pulse (pc) after meals (PCC) patient care coordinator (PCP) primary care provider (PEG) percutaneous endoscopic gastrostomy tube (peri-care) perineal care (PF) plantar flexion (po) by mouth (POA) power of attorney (PRN) as needed (PROM) passive range of motion (PT) physical therapy (pt) patient (PT/INR) prothrombin time/international noramlized ratio (Q) every (Q AM) every morning (Q PM) every evening (QD) every day (QID) four times a day (QOD) every other day (R), (rt) right (R) respirations (RA) restorative aide (RNA) restorative nurse aide (req) request (R) resident	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 4 (res) resident (RD) registered dietitian (RN) registered nurse (ROM) range of motion (R/T) related to (s) without (SBA) stand by assistance (SBP) systolic blood pressure (sl) slightly (SNF) skilled nursing facility (S/P) status post (SQ) subcutaneous (SS) social service (S/S) sliding scale (s/t) skin tear (tab) tablet (TB) tuberculosis (tech) technician (temp) temperature (TF) tube feeding (TID) three times a day (trach) tracheostomy (tx) treatment (U) units (UE) upper extremity (V/S) vital signs (w/c) wheelchair (WNL) within normal limits (W/P) whirlpool (x) times (yo) year old (^) increased, up	F 000		
F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5 or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: On 03/18/14, an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to notify the physician in a timely manner when a resident who was on Coumadin had black tarry stools. The Oklahoma State Department of Health was notified and verified the existence of the IJ	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 6 situation. At 1:55 p.m., the ADM, DON, corporate ADM and corporate RN were notified of the IJ situation. At 3:35 p.m., an acceptable plan of removal was presented to the survey team. The facility's plan of removal documented the following: "Physician notification/Assessment and Monitoring 1. 100% in-service of licensed nurses on the requirement for physician notification requirements, care and care services policy, notification of physician (CALL when abnormal findings are noted). Fax is only appropriate in non-emergent circumstances when no abnormal findings are noted. In-service will include the requirements for assessment and monitoring and reporting changes to the MD. In-service will be completed at 4 p.m. on 03/18/14. Any nurse that does not attend this in-service will not be allowed on the floor until the in-service is complete. 2. 100% in-service of CNA's will be completed regarding reporting changes in condition to licensed nurse as soon as noted. This in-service will be completed on 03/18/14 at 4 p.m. any aide that does not complete the in-service at this time will not be allowed to work until the in-service is complete. 3. An audit by staff and resident interview will be complete at least three times weekly to ensure compliance with nurse notification of changes from the CNA.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 7 4. The resident had previously been admitted to the hospital for treatment. 5. Complete a 100% audit of current residents documentation (January through current date) to ensure that any changes of condition have been communicated to the doctor. This audit will be completed by 1 pm on 03/19/14. 6. Audit of the 24 hour report will be completed and documentation reviewed three times weekly to ensure continued compliance. 7. Any identified non-compliance will result in one on one in-servicing and progressive disciplinary action. 8. Results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation, review and changes." On 03/19/14 at 9 00 a.m., a copy of the facility's in-service on the subject of physician notification, change of condition, assessment and monitoring of the patient and CNAs' notifying the nurse of changes in condition was received by the survey team. A copy of the in-service topics included: "03/18/14 4:00-4:45 LPN's/RN Physician Notification of Changes 1. The doctor must be notified with ANY change in the resident condition of abnormal findings.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 8 The notification must be completed at the time the change is noted. Example: Fall, Wound, Abnormal Labs etc. How do we notify the Physician? 1. Fax- this method may only be used when the situation is non-emergent and there are no abnormal findings. (Minor skin tear, lab results received are normal etc.) If you are unsure if you should fax or call, notify your DON for guidance. 2. Call-the doctor must be called when abnormal findings are noted or when the situation is emergent. (New complaint of pain level, abnormal labs, falls with injury etc) ANY CHANGE IN CONDITION MUST BE COMMUNICATED TO THE DOCTOR 1. When completing an assessment vital signs should be completed. The change of condition form is used for documentation and should be complete [sic] filled out. When changes are noted follow up documentation and assessment should be completed to monitor the progress of the condition of the resident. CNA YOU ARE THE FIRST LINE OF DEFENSE! You see the resident more than any other staff. You will be the first to notice small changes and big changes. It is your responsibility to report any and all changes to the nurse! Examples: Walking to the dining room and want a wheelchair, dressing self and now are unable, discolored or stinky urine, not drinking, not eating, skin issue, etc. any change that is not the norm for the resident must be report to the nurse for	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 9 further evaluation. No matter how small you think the change is, always report." The names on the in-service form were compared to the staffing roster. Staff members from various shifts of the nursing department were interviewed in regard to the in-service. The staff members reported they received information including reporting, assessment, monitoring and intervening for change in condition. The staff answered questions appropriately in regard to the in-service. The IJ was removed on 03/19/14 at 1:00 p.m. The deficiency remained at the level of actual harm that was not immediate jeopardy, at a pattern. Based on observation, record review and staff interviews, it was determined the facility failed to notify the physician. a) When a resident experienced black tarry stools for one (#2) of one sampled resident who experienced black tarry stools. b) Of a stage one pressure sore for one (#2) of one sampled resident who had a stage one pressure sore. c) Of a stage two pressure ulcer for three (#7, 8 and #17) of four sampled residents who had a stage two pressure ulcer. d) Of an abnormal blood pressure for one (#2) of one sampled resident who had an abnormal blood pressure.	F 157	1. The doctor was notified of the change in condition (black tarry stools) for resident #2. 2. The doctor was notified of the stage I area for resident #2. 3. The doctors were notified regarding the stage II areas for resident #7,8 and 17. 4. The doctor was notified of the abnormal blood pressure readings for resident #2. 5. An audit was completed to identify other changes in condition that may need reported. 6. Ongoing audits will be completed at least three times weekly to ensure continued compliance by the DON or designee 7. In-servicing will be completed with the nursing staff regarding the requirements for physician notification. 8. Identified non-compliance will result in one on one in-servicing and progressive discipline. 9. Results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation and review.	04-22-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 10 This had the potential to affect all 75 residents who resided in the facility. Findings. A facility policy, dated 02/05/13, documented, "Care and Services-POLICY: It is the center's policy to provide residents with the necessary care and services to maintain his/her highest level of practicable functioning in an environment that enhances each resident's quality of life in the scope of a long term care center. PROCEDURE: Staff and resident are required to follow the procedure listed below. ...8. The Licensed Nurse or designee documents and notifies the resident's physician and responsible party of: Change in condition, including progress and/or decline in physical or mental function, Resident refusal of care or services and Unusual occurrence." 1. Resident #2 was admitted to the facility on 11/05/09 with diagnoses which included embolism and thrombosis arteries lower extremity, hepatic encephelopathy, edema, bipolar disorder, diabetes mellitus type II, Hep. C, HTN, schizophrenia, Alzheimer's disease, renal failure and CHF. A care plan, dated 01/27/13, documented the resident required anticoagulant therapy related to DVT history, as a problem. A goal was for the resident's PT/INR to remain WNL. One intervention listed was for the staff to observe the resident for signs of bleeding such as blood in urine, increased pulse, decreased blood pressure, decreased energy level and abdominal	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 11 pain. The care plan also documented the resident may have incontinence of bowel related to medications (lactulose) use, as a problem. A goal was for the resident to have decreased elimination of diarrhea. Interventions listed were for the staff to notify the physician as needed and to record the resident's bowel movement size and consistency and to report any abnormalities to the licensed nurse. A quarterly assessment, dated 12/20/13, documented the resident was moderately impaired with cognition, required extensive assistance of one person for bathing, limited assistance of one person for dressing and required supervision for transfer, bed mobility, ambulation, eating and hygiene and was always continent of bowel and bladder. The resident received an anticoagulant medication for seven days of the seven day look back period. A computerized physician's order, dated 02/01/14, documented, "...Coumadin (Warfarin Sodium) 2 MG tablet by mouth (Oral) -Evening Shift Everyday: give one tablet daily btwn 6p-9p...Coumadin (Warfarin Sodium) 2.5 MG tablet by mouth (Oral) -Evening Shift Everyday: give one tablet daily btwn 6p-9p..." The coumadin orders had an original start date of 11/05/13. "...PT INR to be drawn every 2 weeks-Evening Shift Every 14 days..." A computerized physician's order, dated 02/06/14, documented, "Hold Coumadin until 021014 Recheck pt/inr on that date." A MAR, dated February 2014, documented the	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 12 Coumadin had been held from 02/06/14 through 02/10/14. A Change Of Condition Communication form, dated 02/09/14 at 1400 (2:00 p.m.), documented, "...Black tarry stool started on 02/07/14..." A nurses note on the back of the form documented, "Received report from resident concerning several black tarry stools. Asked resident about onset of blk stools reports initially started 1-2 days before this date. Res states "I didn't want to worry anyone." ABD flat soft nontender c hyperactive BS x 4 quads." The Change Of Condition Communication form documented, in the area for physician notification, the physician had been notified on 02/09/14 at 1400 (2:00 p.m.). The nurses' notes on the same above date contained no documentation of the black tarry stools or physician notification. A 24 hour report/change of condition report, dated 02/09/14, documented, "[Resident name deleted]...blk stool..." A Change Of Condition Communication form, dated 02/10/14, documented on the front of the form, "...Hgb 5.1 Hct 17.6 black tarry stools, started on 02/09/14...coumadin held since 02/06..." A nurse's note on the back of the form documented, "Received call from PCP reguarding [sic] residents black tarry stools yesterday. Rec'd order for STAT CBC, PT/INR. Spoke c resi about this order. Obtained from RAC [right antecubital] x 1 stick. Resi tol well, pressure applied.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 13 Specimen sent to PCP office. 1040 (10:40 a.m.) Rec'd call from PCP, received order to send resi to ER for Hgb 5.1 & Hct 17.6..." On 02/10/14 at 11:35 a.m., the resident was admitted to [Hospital name deleted] where she was diagnosed with "Abdominal Pain, Left Lower Quadrant, Hematochezia-GI bleed on Coumadin, Anemia-blood loss and macrocytic, Hypovolemia." At 4:22 p.m. the resident was transferred from [Hospital name deleted] to [Hospital name deleted] for further treatment. On 02/18/14 at 9:25 a.m., LPN # 2 was asked if she had notified the physician on 02/09/14 about the resident's complaint of black tarry stools. The LPN stated, "By fax to the physicians office, that's what he prefers." The LPN then stated, "The resident told me her stool had been that way for a couple of days." The LPN was asked if she thought she should have called the physician instead of faxing him. The LPN nodded her head. At 9:45 a.m., the ADON was questioned in regard to physician notification. The ADON reported, the physician had a cellphone and a home phone where he could be contacted. If he didn't answer when called, he would call the facility back fairly quickly. The nurse could text the physician, in the event of a change in condition, and he would call back. At 9:50 a.m., CNA #6 was questioned in regard to the resident having black tarry stools. The CNA reported she had assisted the resident before she went to the hospital the first time and she had	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 14	F 157		

black stools. The CNA reported she had told the charge nurse but could not remember the name of the charge nurse.

At 10:30 a.m., CNA #4 was questioned in regard to the resident having black tarry stools. The CNA reported the resident's stools were dark. The CNA reported she had told the charge nurse.

At 11:20 a.m., the DON was questioned in regard to the resident having black tarry stools and the physician not being notified by phone in a timely manner. The DON reported the physician should have been called right away and not faxed. The DON reported, the nurse responsible for the incident had a coaching report completed on 02/14/14, due to the physician not being notified in a timely manner.

There was no in-service completed at the time of the incident to ensure the staff had been made aware of the facility policy for contacting the physician in a timely manner for changes in a resident's condition.

2. Resident #2 was admitted to the facility on 11/05/09 with diagnoses which included embolism and thrombosis arteries lower extremity, hepatic encephelopathy, edema, bipolar disorder, diabetes mellitus type II, Hep. C, HTN, schizophrenia, Alzheimer's disease, renal failure and CHF.

A care plan, dated 06/12/12, documented the resident had a potential for alterations in skin integrity, as a problem. A goal was for the resident to be free of dry skin and skin irritation or redness. Interventions listed were for the staff to document on a flow sheet if skin was intact,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 15 reddened or had open areas, report to charge nurse any bruising, bleeding, redness, irritation or open areas and perform weekly skin assessment per protocol. A quarterly assessment, dated 12/20/13, documented the resident was moderately impaired with cognition, required extensive assistance of one person for bathing, limited assistance of one person for dressing and required supervision for transfer, bed mobility, ambulation, eating and hygiene and was always continent of bowel and bladder. A re-admission nursing assessment, dated 03/08/14, documented, "...13. Integumentary/feet 1. Skin/Wound condition present: yes Stage I to coccyx area and rash to sacral area..." A nurse's note, dated 03/08/14 at 11:00 a.m., documented, "Readmitted to facility...Sacrum c lg amt. redness present area blanches sluggishly. Dietary notified of readmit, call light in reach." The physician had not been notified of the resident's return to the facility or the new Stage I sore to the coccyx area. On 03/20/14 at 9.15 a.m., the DON and the corporate RN were shown the nurse's note and the re-admission note and asked if the physician had been notified. The DON stated, "It's not in the notes so it doesn't look like it." The DON was then asked if the physician should have been notified. The DON stated, "Yes." 3. Resident #2 was admitted to the facility on 11/05/09 with diagnoses which included embolism and thrombosis arteries lower	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 16	F 157		

extremity, hepatic encephelopathy, edema, bipolar disorder, diabetes mellitus type II, Hep. C, HTN, schizophrenia, Alzheimer's disease, renal failure and CHF.

A care plan, dated 06/12/12, documented the resident had a potential for alteration in cardio status r/t diagnosis of HTN and hx of DVT, as a problem. A goal was for the resident to be free of headaches, dizziness or fatigue. One intervention listed was for the staff to notify the licensed nurse of any bleeding or bruising and of symptoms of headache, dizziness and/or fatigue.

A quarterly assessment, dated 12/20/13, documented the resident was moderately impaired with cognition, required extensive assistance of one person for bathing, limited assistance of one person for dressing and required supervision for transfer, bed mobility, ambulation, eating and hygiene and was always continent of bowel and bladder.

The February 2014 computerized physician's orders documented the resident received Lasix 60 mg daily and Aldactone 50 mg daily for edema. These medications were diuretics and also used to manage hypertension in some residents.

A nurse's note, dated 02/23/14 at 10:30 a.m., documented a blood pressure reading of 105/58. There was no documentation the physician had been notified.

A nurse's note, dated 02/25/14 (no time documented) documented a blood pressure reading of 110/56. There was no documentation the physician had been notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 17 A nurse's note, dated 02/27/14 at 3:00 a.m., documented a blood pressure reading of 100/49. There was no documentation the physician had been notified. A nurse's note, dated 03/02/14 at 1:15 p.m., documented a blood pressure reading of 100/44. There was no documentation the physician had been notified. A nurse's note, dated 03/03/14 at 4:00 p.m., documented a blood pressure reading of 110/54. There was no documentation the physician had been notified. A nurse's note, dated 03/04/14 at 4:00 a.m., documented a blood pressure reading of 105/50. There was no documentation the physician had been notified. A nurse's note, dated 03/05/14 at 3:00 a.m., documented a blood pressure reading of 101/42. There was no documentation the physician had been notified. A nurse's note, dated 03/08/14 at 5:00 p.m., documented a blood pressure reading of 110/58. There was no documentation the physician had been notified. A nurse's note, dated 03/11/14 at 3:00 a.m., documented a blood pressure reading of 111/51. There was no documentation the physician had been notified. A nurse's note, dated 03/12/14 at 2.00 a.m., documented a blood pressure reading of 96/47. There was no documentation the physician had	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 18 been notified. A nurse's note, dated 03/12/14 at 6.00 p.m., documented a blood pressure reading of 100/50. There was no documentation the physician had been notified. A nurse's note, dated 03/14/14 at 1:50 a.m., documented a blood pressure reading of 116/50. There was no documentation the physician had been notified. A nurse's note, dated 03/14/14 at 10:30 a.m., documented a blood pressure reading of 100/56. There was no documentation the physician had been notified. A nurse's note, dated 03/15/14 at 12:05 a.m., documented a blood pressure reading of 94/56. There was no documentation the physician had been notified. A nurse's note, dated 03/16/14 at 10:00 a.m., documented a blood pressure reading of 110/56. There was no documentation the physician had been notified. A nurse's note, dated 03/17/14 at 3:00 a.m., documented a blood pressure reading of 107/45. There was no documentation the physician had been notified. A nurse's note, dated 03/18/14 at 3:00 a.m., documented a blood pressure reading of 101/40. There was no documentation the physician had been notified. On 03/18/14 at 5:15 p.m., the DON was shown the above nurses' notes with the abnormal blood	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 19	F 157		

pressure readings and asked when she expected the physician to be notified. The DON reported she expected the physician to be notified if the diastolic reading was below 60. The DON was then asked if she thought the physician should have been notified. The DON stated, "Yes, I do."

4. Resident #8 had been admitted to the facility on 09/01/11. The resident had current medical diagnoses including abnormal gait, muscular wasting, disuse atrophy and hypothyroidism.

An annual assessment, dated 06/12/13, documented the resident required extensive assistance with transfers, ambulation, dressing and bathing, required moderate assistance with hygiene, required set up help with eating, had no ROM deficits in extremities and was occasionally incontinent of bowel and bladder.

A quarterly assessment, dated 02/26/14, documented the resident required extensive assistance with transfers, dressing and bathing, required total assistance with hygiene, required limited assistance with eating, had ROM deficits in upper and lower extremities and was always incontinent of bowel and bladder.

A care plan revised on 01/02/13, documented the following.

"Focus
...has a potential for skin Alteration r/t [decreased] mobility and occasional incontinence of bladder.

Goals
...will be free of skin irritation and skin redness over the next review. 06/11/14
...will be free of pressure sites over the next

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 20 review. 06/11/14 Interventions Notify L.N. (licensed nurse) of any skin irritations or redness Report new open areas to LN." A review of the resident's medical record was completed. There was no documentation of a pressure ulcer. A Braden Scale- For Predicting Pressure Sore Risk, dated 02/10/14, documented the resident was High Risk for pressure ulcers. On 03/19/14 at 4:30 p.m., the facility was asked for a list of residents with pressure sores. At that time, ADON #2 presented a list of residents with pressure sores. Resident #8's name was on the list. A Pressure Ulcer Documentation Form documented, "03/12/14 size in CM 2x2 Depth less than 0.1." The area had not been staged. At that time, LPN #1, who had signed the form was asked about the pressure sore. She reported a CNA had identified the area and she had filled out the form. She was asked if the physician had been notified, a treatment order had been obtained or if she had documented the area in the nurses' notes or anywhere else. She reported she had not done any of the above. She was asked what she had been doing for the area. She reported she had been using a barrier cream on the area.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 21 She also reported she should have made an incident report, called the doctor, got a treatment and documented the area in the nurses' notes. A nurse's note, dated 03/19/14 documented, "PCP notified that resident had small open area to coccyx measuring approx 2 cm x 2 cm on 03/12/14, He was also notified that this area is now healed. Did receive PRN order for Zguard for redness-Family aware." On 03/20/14 at 10:15 a.m., the resident's buttocks and coccyx area were viewed. No open areas were noted. On 03/20/14 at 10:30 a.m., the DON was asked about the pressure sore identified on 03/12/14. She reported the nurse should have notified the physician and the family. 5. Resident #7 was admitted on 09/20/13 with numerous diagnoses which included paraplegia, chronic pain, s/p MI, anxiety state and HTN. A care plan, dated 02/22/14, documented the resident was at risk for alteration in skin integrity, as a problem. The goal was for the resident's skin to remain intact and free of redness. An intervention listed was for the staff to report any changes in the resident's skin to the physician immediately. An annual assessment, dated 03/05/14, documented the resident was cognitively intact and demonstrated mild depression. The resident did not ambulate and was not transferred during the seven day look back period. The resident required extensive assistance of one person to dress, perform personal hygiene and bathe. The	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 22	F 157		

resident was always incontinent of bowel and had an indwelling urinary catheter.

On 03/20/14 at 9:50 a.m., LPN #2 was observed to perform indwelling urinary catheter care and wound care. The LPN completed the first procedure and assisted the resident to her side. An open area was observed to the resident's coccyx. The LPN stated, "That's new." The LPN covered the resident and left the room to obtain a measuring tape.

The surveyor told the resident she had a new open area to her coccyx. The resident stated, "No, they found that yesterday when they were cleaning me up." CNA #5 was assisting the resident's roommate. The curtain was drawn. The CNA stated, "Yes, that was me, I found the area yesterday evening and reported it to [LPN's name deleted, LPN #1]."

The resident was asked if LPN #1 had observed her wound the day before. The resident stated, "I don't think so."

LPN #2 returned to the residents room and measured the wound at 1.9 cm X 0.3 cm and reported the wound was a stage two and she would contact the physician for treatment orders.

The resident's medical record was reviewed. There was no documentation to reflect the physician had been notified of the wound. The facility wound sheets were reviewed there was no documentation of the wound which had been reported to LPN #1 on the previous day.

At 11:00 a.m., the corporate nurse and DON were interviewed regarding the resident's wound. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 23 corporate nurse reported the wound should have been documented and the physician should have been notified and a treatment obtained, when the wound was found. Both the facility and the surveyor attempted to contact LPN #1 by phone for an interview and were unsuccessful after several attempts. 6. Resident #17 was admitted on 08/10/12 with diagnoses which included persistent mental disorder, frontal lobe executive function deficit and atrophy. A quarterly assessment, dated 01/29/14, documented the resident was severely impaired with cognition and exhibited moderately severe depression. The resident required one person extensive assistance for bed mobility, transfer, ambulation, dressing, personal hygiene and bathing. The assessment indicated the resident was at risk for pressure ulcers. The Pressure Ulcer Documentation form, dated 03/12/14, documented an open area to the coccyx with a treatment of Calazine. The resident's medical record contained no physician order for treatment to the resident's coccygeal ulcer. The resident's medical record contained no documentation the physician was notified of the coccygeal ulcer. On 03/20/14 at 2:00 p.m., LPN #2 was observed to provide pressure ulcer treatment to the resident's left buttock. At that time, the LPN was asked about the coccygeal ulcer which was	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 24 documented on the Pressure Ulcer Documentation form. The LPN reported she had no knowledge of the specific ulcer. No coccygeal ulcer was observed. At the time of the treatment observation, an open (stage two) ulcer to the resident's right buttock was observed. LPN #2 reported she was unaware of the open ulcer to the right buttock. The LPN reported no one had reported the area had opened. The LPN reported two days prior the area was reddened. There was no physician or family notification documented about the reddened area, which the LPN had reported was present two days prior. No treatment order had been obtained when the reddened area was first identified. At 2:40 p.m., an interview with LPN #2 (treatment nurse) was conducted. The LPN reported the physician and family should have been notified. At 4:20 p.m., the DON was interviewed and asked if the physician should have been notified of the resident's skin condition and a treatment order obtained. The DON reported the physician should have been notified. The DON reported any lesion or red areas should be monitored and treatment obtained from the physician. The DON reported skin assessments would be completed on all residents.	F 157		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 25 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure dignity was provided when staff entered residents' rooms for four (#4, 6, 7 and #17) of 15 sampled residents. This had the potential to affect all 75 residents who resided in the facility. Findings: 1. Resident #6 was admitted with diagnoses which included HTN, anxiety state, diabetes mellitus type II and left AKA. A quarterly assessment, dated 01/20/14, documented the resident was severely impaired with cognition with disorganized thinking and exhibited moderately severe depression with behaviors. On 03/18/14 at 11:15 a.m., CNA #4 and CNA #5 transferred the resident to bed and provided incontinent care. During the care observation, CNA #6 knocked on the resident's door and entered without announcement or waiting for permission to enter. CNA #6 had requested assistance when the other aides were finished with care. While in the room, CNA #6 proceeded to relate personal issues to the other CNAs, which were unrelated the resident's care. At 11:40 a.m., CNA #6 knocked again and	F 241	1. Staff will be in-serviced regarding the requirements for dignity and respect of the resident (knocking and waiting for permission to enter resident rooms.) 2. Audits will be completed at least three times weekly to ensure continued compliance by the DON or designee. 3.Identified non-compliance will result in one on one in-servicing and progressive discipline. 4. Resident will be interviewed in resident council monthly for 90 days to ensure compliance. 5. Results of the audits and resident council meetings will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation and review.	04-22-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 26 entered the room without announcement or permission to enter the resident's room. On 03/20/14 at 2:20 p.m., the DON was asked if she expected the staff to knock, announce and wait for permission to enter residents' rooms. The DON stated, "Yes, I will continue to in-service the staff." 2. Resident #17 was admitted to the facility on 08/10/12 with diagnoses which included persistent mental disorder, hyperlipidemia, gout and muscle weakness. A quarterly assessment, dated 01/29/14, documented the resident was severely impaired in cognition with moderately severe depression. On 03/20/14 at 11:02 a.m., LPN #2 was observed to enter the resident's room without knocking, announcing herself or obtaining permission for entrance. At 2:20 p.m., the DON was asked if she expected the staff to knock, announce and wait for permission to enter residents' rooms. The DON stated, "Yes. I will continue to in-service the staff." 3. Resident #7 was admitted on 09/20/13 with numerous diagnoses which included paraplegia, chronic pain, s/p MI, anxiety state and HTN. A care plan, dated 02/22/14, documented the resident was at risk for alteration in skin integrity, as a problem. The goal was for the resident's skin to remain intact and free of redness. An intervention listed was for the staff to report any changes in the resident's skin to the physician	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 27 immediately. An annual assessment, dated 03/05/14, documented the resident was cognitively intact and demonstrated mild depression. The resident did not ambulate and was not transferred during the seven day look back period. The resident required extensive assistance of one person to dress, perform personal hygiene and bathe. The resident was always incontinent of bowel and had an indwelling urinary catheter. On 03/17/14 at 2:15 p.m., CNA #5 and CNA #4 were observed to enter the resident's room. The CNAs knocked, opened the door and walked into the resident's room. The CNAs did not wait for the resident to answer, ask permission to enter or identify themselves prior to entering the resident's room. On 03/18/14 at 3:40 p.m., LPN #2 was observed to perform skin care for the resident. The resident's door was closed. CNA #7 knocked on the door and entered the resident's room. The CNA did not await for an answer or ask permission to enter. The CNA did not identify herself. She walked around the resident's curtain and saw the LPN and the surveyor. The CNA then left the resident's room. On 03/19/14 at 7:30 a.m., the DON was interviewed regarding the above observations. The DON reported she had seen the staff enter without asking permission also and had spoken to the staff members she had seen. The DON reported she would conduct an in-service. 4. Resident #4 had diagnoses which included hypertension, pain and depressive disorder.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 28 A quarterly assessment, dated 02/19/14, documented the resident had severe cognitive impairment, moderate depression and no behavioral symptoms. On 03/18/14 at 9:00 a.m., the resident was observed during transfer and incontinent care, performed by CNA #1 and CNA #2. The resident was alert and responded appropriately to the CNAs. During the incontinent care, a knock was heard at the door. CNA #3 entered the resident's room without identifying herself or waiting on the staff to respond to the knock on the door. The CNA stood in the resident's room and informed the two CNAs of care needs for two other residents. At 10.08 a.m., the resident was observed to receive treatments performed by LPN #1. During the treatment, CNA #1 knocked on the door. The CNA partially entered the room as the LPN stated, "Resident care." The CNA reported he needed to sit the roommate in her recliner and would return when the LPN was finished with the resident. On 03/19/14 at 7.30 a.m., the DON was interviewed regarding the above observations. The DON reported she had seen the staff enter without asking permission also and had spoken to the staff members she had seen. The DON reported she would conduct an in-service.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 29 of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, it was determined the facility failed to ensure activities of interest were provided for two (#1 and #7) of ten sampled residents. This had the potential to affect all 75 residents who resided in the facility. Findings: 1. Resident #1 had been admitted to the facility on 03/09/12, with medical diagnoses including atherosclerosis, anemia, edema, hyperlipidemia, esophageal reflux, low potassium, B-complex deficiency, diabetes II, osteoarthrosis, abnormal gait and hypertension. The activity progress notes documented the following: "Dec 13, 2013...enjoys activities in his room which consist of one to one visits, family visits and pet therapy visits. He also enjoys watching TV and listening to country/big band music... Jan 17 2014...enjoys activities in his room which consist of one to one visits, family visits and pet therapy visits. He also enjoys watching TV and listening to country/big band music...	F 248	1. Records have been reviewed and activity of interest will be provided for resident #1 and 7. 2. An audit will be completed to identify any other resident in need of a change of activity offered. 3. A monthly audit will be completed by the facility Administrator or designee to ensure compliance. 4. The activity director has been in-serviced on the requirements. 5.Identieid non-compliance will result in one on one in-servicing and progressive discipline. 6. Results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation and review.	04-22-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 30 An annual assessment, dated 02/12/14, documented the resident required total assistance with transfers, dressing, eating and personal hygiene, required extensive assistance with bathing, did not ambulate and required an indwelling urinary catheter. An activity care plan, dated 02/19/14, documented the following: "Focus ...has a decreased activity participation characterized by little or no involvement, lack of attendance related to· cognitive impairment, impaired decision making... Goals ...will be seen on a one to one basis at least three xs weekly over the next review... Interventions Assist...in activities of his choice Encourage participation in sensory stimulation activity Engage resident in group activities... Offer activity program directed toward specific interests/needs of resident... Place resident in appropriate psychosocial group..." The activity progress notes documented the following: Feb 26 2014...enjoys activities in his room which consist of one to one visits, family visits and pet therapy visits. He also enjoys watching TV and listening to country/big band music He enjoys conversation and is easily engaged regardless of subject."	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 31 On 03/18/14 at 9.55 a.m., the resident was observed in his room lying in bed. There was no TV in his room. At 11:55 a.m., CNA #1 was observed providing care for the resident. He reported the resident did not like to get out of bed and unless he was restless stayed in the bed. During the five day survey, the resident was observed only in his room, lying in bed. No TV was in his room. On 03/20/14 at 2 30 p.m., the AD was asked about the resident enjoying watching TV. She reported she thought the resident came out of his room to watch TV in the lobby. At 3:30 p.m., CNA #1 was asked about the resident coming out of his room to watch TV. He reported the resident had not been out of his room for several months. 2. Resident #7 was admitted on 09/20/13 with numerous diagnoses which included paraplegia, chronic pain, s/p MI, anxiety state and HTN. A December 2013 activity note documented, "[Resident name deleted] enjoys socialization with staff/peers/family, watching comedies/country & westerns/ and mysteries on TV, therapy pet visits, painting pictures, and religious activities. [Resident name deleted's] husband does come to visit periodically and she seems to enjoy that very much." A January 2014 activity note documented, "[Resident name deleted] enjoys socialization with	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 32 staff/peers/family, watching comedies/country & westerns/ and mysteries on TV, therapy pet visits, painting pictures, and religious activities. [Resident name deleted's] husband does come to visit periodically and she seems to enjoy that very much." A February 2014 activity note documented, "[Resident name deleted] enjoys socialization with staff/peers/family, watching comedies/country & westerns/ and mysteries on TV, therapy pet visits, painting pictures, and religious activities. [Resident name deleted's] husband does come to visit periodically and she seems to enjoy that very much." A care plan, dated 02/25/14, documented the resident initiated self activities, as a problem. The goal was for the resident to continue to participate in self initiated activities five times a week. An intervention listed was for the staff to provide one on one visits two times a week and to encourage the resident to participate in activities. An annual assessment, dated 03/05/14, documented the resident was cognitively intact and demonstrated mild depression. The resident named books, music, pets, keeping up with the news, going outside and participating in religious services as very important to her. On 03/18/14 at 4:30 p.m., the AD was interviewed regarding the resident's activities. The AD reported the resident did not come out of her room and required one on one activities. The AD reported she went to the resident's room and visited her daily. The AD gave the surveyor a check off sheet, dated for March 2014. The check off sheet had an area to document visits	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 33 with the resident which had daily checks. The AD reported she also brought her dog once a month for pet therapy and showed the surveyor a check mark by a pet visit. At that time, the surveyor asked if the AD had completed any activities of interest which were, documented on the assessment as very important to the resident. The AD reported she visited with the resident and the resident enjoyed the visits. The surveyor asked about religious services or music for the resident. The AD reported the resident did not come out of her room but had received a new W/C and was planning on attending some group activities now. At 5:10 p.m., the corporate nurse was shown the activity notes and informed of the interview with the AD. The corporate nurse reported she would in-service the AD to ensure activities of interest were provided to the residents. On 03/19/14 at 8.00 a.m., the resident was interviewed regarding activities. The resident reported she would like to paint by numbers or have staff sit and read a book with her. The resident reported now that she had her new W/C she would be able to attend church services.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 34 Based on observation and staff interview, it was determined the facility failed to: a) Maintain doors, walls, floor mats and furniture in good repair. b) Ensure a clean and dust free environment, faucets were free of build up and shower rooms were free of discolored grout and grime build up. This had the potential to affect all 75 residents who resided in the facility. Findings: On 03/18/14 at 8:25 a.m., an environmental tour of the facility was conducted. Room #1 had marred vanity doors, the entry door had missing wood veneer and the bathroom door leading into room #2 was marred. The bedframe under bed A was dusty. The safety mat beside bed B had areas of a dried brown substance. Room #5 had chipped and gapped areas in the sheetrock behind the head of the resident's bed. The vanity doors did not close properly. The window sill was missing. Room #14 had a gapped area between the wall and the vanity counter, along the entire side, which was missing caulk. The air vent in the hallway above room #7 was dusty. Room #31 had a sink faucet which had build up of soap and mineral deposits.	F 253	1. All identified areas that required repair will be repaired or replaced. 2. All identified areas that required cleaning have been cleaned or replaced. 3.A weekly audit will be completed by the facility Administrator or designee to ensure all housekeeping needs have been met. 4. A weekly audit will be completed by the maintenance supervisor to identify needed repairs. The audit will be supervised by the administrator to ensure repairs are complete. 5. Identified non-compliance with the requirements will result in one on one in-serving and progressive discipline. 6. Results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation and review.	04-22-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 35 Room #21 had a long, waving cobweb hanging from the ceiling over the head of the resident's bed. The sink faucet had soap and mineral deposit buildup. Hall 2's shower room had missing wood from the entry door. The drain cap was off the shower drain leaving the drain hole exposed. Hall 1's shower room had a call cord by the commode which was discolored with a black substance. The entry door to the shower was missing wood veneer. Hall 4's shower room had a round toilet seat on an oval commode, which left a gap in the front of the seat. The junction of the shower stall and the wall was missing caulk along the entire area, which could allow for water to enter behind the area. The baseboard tile grout was discolored and dirty. There was a dirt build up in the corners of the shower room. Hall 5's shower room had discolored grout along the tiled baseboard. There was a dirt build up in the corners of the shower room. The back lobby contained a couch which was discolored and had large slits in the seat. Residents were observed to be sitting on the couch during the survey. One high back chair had torn binding and one chair had stained areas. On 03/19/14 at 10:10 a.m., the ADM was informed of the maintenance and housekeeping issues. The ADM reported the items would be addressed. The ADM reported the housekeeping was a contracted company and he would report the problems to the housekeeping supervisor.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 36 At that time, the ADM was asked who was responsible for cleaning the floor safety mats used for the residents. He reported the cleanliness of the mats were the responsibility of nursing and housekeeping. He reported any staff member who saw a soiled mat should clean the mat.	F 253		
F 274 SS=E	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by. Based on observation, record review and staff interview, it was determined the facility failed to ensure significant change assessments were completed when residents experienced changes in two or more areas for three (#9, #8 and #2) of five sampled residents who required significant change assessments be completed. This had the potential to affect eight residents,	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 37 identified by the DON, who required significant change assessments be completed in the past three months. Findings: 1. Resident #9 was admitted on 04/26/13 with numerous diagnoses which included CVA, HTN, atrial fibrillation, depressive disorder and diabetes mellitus. An admission assessment, dated 05/08/13, documented the resident was cognitively intact and demonstrated severe depression. The resident required extensive assistance of two persons to transfer and bathe. The resident required total assistance of two persons to dress and total assistance of one person to perform personal hygiene. The resident did not ambulate in the room or corridor. The resident required total assistance of two persons to move on and off the unit. A quarterly assessment, dated 08/31/13, documented the resident was cognitively intact and demonstrated moderate depression. The resident required extensive assistance of two persons to transfer and dress. The resident required extensive assistance of one person to perform personal hygiene and to bathe. The resident did not ambulate in the room or corridor. The resident required limited assistance of one person to move on and off the unit. The resident had experienced changes in four areas of the assessment. On 03/17/14 at 5:30 p.m., the resident was observed to be on an electric scooter going down	F 274	1. The significant change assessments for resident #9,8 and 2 will be completed. 2. An audit has been completed to identify other needed significant change assessments. 3. A weekly audit will be completed ongoing to ensure significant change needs are identified by the DON or designee. 4. The MDS Coordinator and the nursing administration staff have been in-serviced on the requirements for significant change assessments. 5. Identified non-compliance with the requirements will result in one on one in-servicing and progressive discipline. 6. Results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation and review.	04-22-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 38 the Center Hall. The resident reported he had been out to smoke and was returning to his room. On 03/18/14 at 11:00 p.m., the resident was observed to be on an electric scooter in his room. The resident was removing a hot dog and hot dog bun from his personal ice box. The resident reported he was making himself something to eat. The surveyor asked when the resident required assistance in his room. The resident reported he required assistance with transfers to and from his scooter and to dress due to his CVA. At 4:00 p.m., the MDS coordinator was asked if the resident should have had a significant change assessment completed. The MDS coordinator stated, "Yes." 2. Resident #8 had been admitted to the facility on 09/01/11. The resident had current medical diagnoses including abnormal gait, muscular wasting, disuse atrophy and hypothyroidism. An annual assessment, dated 06/12/13 documented the resident required extensive assistance with transfers, ambulation, dressing and bathing, required moderate assistance with hygiene, required set up help with eating, had no ROM deficits in extremities and was occasionally incontinent of bowel and bladder. A quarterly assessment, dated 02/26/14 documented the resident required extensive assistance with transfers, dressing and bathing, required total assistance with hygiene, required limited assistance with eating, had ROM deficits in upper and lower extremities and was always incontinent of bowel and bladder.	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 39 The resident had declines in four areas: eating, ROM limits and incontinence of bowel and bladder. On 03/20/14 at 3:30 p.m., the MDS coordinator was shown the declines on the assessments. She reported she should have done a significant change assessment. 3. Resident #2 was admitted to the facility on 11/05/09 with diagnoses which included embolism and thrombosis arteries lower extremity, hepatic encephelopathy, edema, bipolar disorder, diabetes mellitus type II, Hep. C, HTN, schizophrenia, Alzheimer's disease, renal failure and CHF. An annual assessment, dated 06/19/13, documented the resident was moderately impaired with cognition, required extensive assistance of one person for transfers, bed mobility, dressing and bathing. The resident required limited assistance of one person for ambulation and hygiene and was independent with eating. The resident was always continent of bowel and occasionally incontinent of bladder. A quarterly assessment, dated 12/20/13, documented the resident was moderately impaired with cognition, required extensive assistance of one person for bathing, limited assistance of one person for dressing and required supervision for transfers, bed mobility, ambulation, eating and hygiene and was always continent of bowel and bladder. There was no significant change assessment completed for the resident's improvement in ADL function.	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 40 On 03/21/14 at 10:50 a.m., the MDS coordinator was shown the two assessments and asked if a significant change assessment should have been completed. The MDS coordinator stated, "Yes."	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 41 by: Based on record review and staff interview, it was determined the facility failed to ensure a fall was coded for one (#9) of five sampled residents who had experienced a fall. This had the potential to affect 27 residents, identified by the DON, who required a fall be coded on the MDS for the past three months. Findings: 1. Resident #9 was admitted on 04/26/13 with numerous diagnoses which included CVA, HTN, atrial fibrillation, depressive disorder and diabetes mellitus. A nurse's note, dated 09/26/13, documented the resident had been found on the floor. The nurse's note documented the physician and family had been notified and an incident report had been completed. The nurse's note documented neuro checks had been initiated. A quarterly assessment, dated 11/27/13, documented the resident was cognitively intact and demonstrated moderate depression. The resident required extensive assistance of two persons to transfer and dress. The resident required extensive assistance of one person to perform personal hygiene and to bathe. The resident did not ambulate in the room or corridor. The resident required limited assistance of one person to move on and off the unit. The resident had experienced no falls since the prior assessment. On 03/18/13 at 4:00 p.m., the MDS coordinator was asked if the assessment should have	F 278	1. The MDS for resident #9 has been updated. 2. A random audit has been completed to identify any other needs updates related to accuracy. 3. A weekly audit will be completed ongoing to ensure continued compliance by the DON or designee. 4. The MDS coordinator and the nursing administrative staff will be in-serviced on the requirements for accuracy of assessments. 5. the results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation and review.	04-22-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 42 documented the resident's fall. The MDS coordinator stated, "Yes."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview, it was determined the facility failed to ensure the amount of staff assistance needed for ADL care was documented for two (#1 and #7) of ten sampled residents which required ADL assistance be documented on their care plans. This had the potential to affect all 75 residents	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 43 who required comprehensive care plans be completed. Findings: 1. Resident #7 was admitted on 09/20/13 with numerous diagnoses which included paraplegia, chronic pain, s/p MI, anxiety state and HTN. A care plan, dated 03/12/14, documented the following: The resident required assistance for transferring related to paraplegia and contractures, as a problem. The goal was for the resident to transfer with two person assistance and a device if needed. An intervention listed was for the staff to assist with a mechanical device or transfer belt. The resident required assistance with dressing related to paraplegia, immobility and weakness, as problem. The goal was for the resident to choose what clothing to wear daily. An intervention listed was for staff to provide privacy. The resident required assistance with toileting, as a problem. The goal was for the resident to ask and receive assistance with toileting. An intervention listed was for one person to assist with toileting. An annual assessment, dated 03/05/14, documented the resident was cognitively intact and demonstrated mild depression. The resident did not ambulate and was not transferred during the seven day look back period. The resident required extensive assistance of one person to dress, perform personal hygiene and bathe. The resident was always incontinent of bowel and had	F 279	1. The care plans for resident #1 and #7 will be updated as required. 2. An audit will be completed to identify other needed updates to care plans. 3. A three times weekly audit will be completed to ensure continued compliance by the DON or designee. 4. Nursing and MDS staff have been in-serviced on the requirements for care plans. 5. Any identified non-compliance will be addressed with one on one in-servicing and progressive disciplinary action. 6. Results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation and review.	04-22-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 44 an indwelling urinary catheter. On 03/18/14 at 2:15 p.m., CNA #5 and CNA #4 were observed to transfer the resident with a lift. The surveyor asked the CNAs if they used the lift often or a gait belt. The CNAs stated they had always used the lift to transfer the resident. The CNAs were asked about dressing the resident CNA #5 reported one person assisted the resident with dressing. The resident reported she required the lift for transfers and required assistance with dressing and showering. The resident was asked if she was assisted with toileting. The resident reported she was not assisted with toileting. The CNAs were asked how the resident was moved to different areas in the facility. The CNAs reported the resident stayed in her bed because the geri chair had caused the resident discomfort. The CNAs reported the resident had just received a high back W/C and was to be up in the chair two times daily. The resident nodded her head. On 03/18/14 at 4:50 p.m., the MDS coordinator was shown the care plan and informed of the transfer observation. The MDS coordinator reported the care plan should have been more individualized for the resident in all the areas of ADL care. The MDS coordinator reported the resident was not toileted because the resident had a catheter and was incontinent of bowel. 2. Resident #1 had been admitted to the facility on 03/09/12, with medical diagnoses including atherosclerosis, anemia, edema, hyperlipidemia, esophageal reflux, low potassium, B-complex	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 45 deficiency, diabetic II, osteoarthrosis, abnormal gait and hypertension. The physicians' orders, dated 03/13/13 documented, "Good oral Care 2x/day-Day Shift, Evening Shift everyday. Dietary-Diet House consistent carbohydrate Texture: Pureed." A care plan revised on 04/03/13, documented. "Focus ...has a potential for Self Care Deficit... Goals ...will participate in ADL's daily maintaining his functional status... Interventions ...sleeps in his recliner per his choice and prefers his overhead light be kept on all night ...wears dentures: upper and is able to clean himself. Ensure oral care is completed daily and assist as needed... Restorative for ADL's with verbal ques and SBA of one. Assist and/or remind...to toilet before and after meals and HS. Keep...urinal at bedside for night use. Focus Requires assistance for eating... Goals ...To be able to feed self finger foods and liquids Interventions ...Place resident at meals with residents who have similar eating manners... Provide finger foods when available...	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 46 Focus Requires assistance with toileting... Interventions ...Gait belt for transfers to toilet ...Toileting One person continual supervision and phys (physical) assist for safety to assist with adjusting clothing, washing hands... Uses bedpan occasionally Uses commode Uses urinal Focus Decreased mobility... Interventions Encourage resident to position self when in bed. Assist when...unable to perform independently... Focus Requires assistance with dressing... Interventions Position resident so that dressing can occur while resident is in balanced position Provide clothing to resident that has easy-to-handle fasteners such as velcro." A quarterly assessment, dated 11/13/13 and an annual assessment, dated 02/12/14, documented the resident required total assistance with transfers, dressing, eating and personal hygiene, required extensive assistance with bathing, did not ambulate and required an indwelling urinary catheter. On 03/17/14, during the initial nursing tour, the resident was observed in his room. The touring	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 47 staff member reported the resident required two staff for transfers, was fed meals by staff, used a mechanical lift for transfers and required an indwelling urinary catheter. On 03/18/14 at 11:55 a.m., CNA #1 was observed providing care for the resident. He reported the resident did not like to get out of bed and unless he was restless stayed in the bed. The resident was observed with his own teeth. No dentures were observed. The resident was observed receiving incontinent care after a bowel movement. Indwelling urinary catheter care was provided at that time. On 03/18/14 at 1:03 p.m., CNA #1 was observed feeding the resident a pureed meal in his room. He reported the resident always ate in his room and required assistance with all ADLS. On 03/18/14 at 5:45 p.m., the resident was observed being fed a pureed meal in his room by staff. The resident was observed in a hospital gown on all five days of the survey. On 03/20/14 at 9:30 a.m., The MDS coordinator was shown the resident's care plan. She reported whenever the last care plan was pulled up it showed all the old plan. She reported she should have kept the pertinent information and deleted things which were not pertinent.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 48 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, it was determined the facility failed to update the care plan. a) To include the change in restorative care for one (#3) of 10 sampled residents. This had the potential to affect 12 residents, identified by the DON who required restorative services. b) To include weight loss for one (#2) of three sampled residents, who experienced weight loss. This had the potential to affect 18 residents, identified by the DON, who experienced weight	F 280	1. The care plans for resident #3,#2 and #10 have been updated to reflect the current status of the resident. 2. An audit will be completed to ensure that the care plans reflect the current status of the resident. 3. Audits will be completed three times weekly ongoing to ensure continued compliance by the DON or designee. 4. Nursing staff will be in-serviced on the requirements for care plan updates and revisions. 5. Identified non-compliance will result in one on one in-servicing and progressive discipline. 6. Results of the audits will be presented to the facility QA team monthly times 90 days.	04/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 49	F 280		

loss in the past three months.

c) To include a pressure ulcer for one (#2) of three sampled residents who experienced a pressure ulcer in the last three months.

This had the potential to affect 10 residents, identified by the DON during a skin assessment audit during the survey, who experienced pressure ulcers.

d) To include changes in Coumadin therapy for one (#2) of three sampled residents, who required anticoagulant therapy.

This had the potential to affect seven residents, identified by the DON, who utilized anticoagulant medications.

e) To include the use of an electronic cigarette for one (#10) of one sampled resident who utilized an electronic cigarette.

This had the potential to affect three residents, identified by the DON, who utilized electronic cigarettes.

Findings:

1. Resident #3 was admitted with diagnosis which included hypertension, Alzheimer's disease and diabetes.

A care plan, with an initial date of 07/17/12, documented the resident was receiving restorative nursing therapy. The goal documented for the resident to participate in restorative nursing therapy as able over the next review. One intervention documented, "Program:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 50	F 280		

Perform BLE exercises x20 reps...Perform sit to stand as able using sink in room for support...Perform rolling and supine to sit EOB [edge of bed] with mod assist x 3-5xweek as tolerated." The care plan was reviewed on 01/08/14.

The resident's clinical record contained no documentation the resident had received restorative services since April 2013 due to the resident's nonparticipation in the restorative program.

A quarterly assessment, dated 01/08/14, documented the resident had severe cognitive impairment, mild depression and no behaviors. The resident was totally dependent on staff assistance for transfers, dressing, eating, personal hygiene and bathing. The assessment documented the resident received no restorative nursing services.

On 03/18/14 at 10:30 a.m., the resident was observed during care. The resident was transferred with a mechanical lift and did not assist with turning for care.

The March 2014 computerized physician's orders documented, "..Corrective Boot to be worn daily on the left foot...elevate feet and legs as resident will allow while sitting to decrease swelling...TED HOSE ON EVERY MORNING-OFF AT BEDTIME..." The physician's orders contained no orders for restorative nursing services for the resident, as documented on the care plan.

On 03/18/14 at 4:30 p.m., the MDS coordinator was asked if the resident's care plan should contain the entry about the restorative nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 51 services, since the resident was not receiving restorative services. The MDS coordinator reported, "No." 2. Resident #2 was admitted to the facility on 11/05/09 with diagnoses which included embolism and thrombosis arteries lower extremity, hepatic encephelopathy, edema, bipolar disorder, diabetes mellitus type II, Hep. C, HTN, schizophrenia, Alzheimer's disease, renal failure and CHF. The following care issues had not been updated to reflect the resident's current status· a. An initial care plan, dated 06/12/12, documented the resident had a potential for alterations in skin integrity, as a problem. A goal was for the resident's skin to be dry and free of irritation or redness. One intervention listed was for the staff to perform weekly skin assessments. The resident returned from a hospital stay on 03/08/14 with a stage I pressure sore. The care plan had not been updated to reflect the change of the resident's skin condition. b. An updated care plan, dated 12/16/13, documented the resident had a potential alteration in nutrition, as a problem. One goal was for the resident to have no significant weight change. One intervention listed was for the resident to be weighed weekly and to receive a diabetic snack three times a day between meals. The resident weighed 172.8 pounds in December 2013. The resident continued to lose weight until March 2014. The resident weighed 156 pounds on 03/02/14.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 52 The care plan had not been updated to reflect the residents weight loss. A quarterly assessment, dated 12/20/13, documented the resident was moderately impaired with cognition, required extensive assistance of one person for bathing, limited assistance of one person for dressing and required supervision for transfer, bed mobility, ambulation, eating and hygiene and was always continent of bowel and bladder. The resident received an anticoagulant medication for seven days of the seven day look back period. c. An updated care plan, dated 01/17/14, documented the resident required anticoagulant therapy, as a problem. A goal was for the resident's laboratory analysis to remain WNL. Interventions listed were for the resident to receive medication as ordered, the staff to observe for active signs of bleeding and to hold Coumadin for two days then recheck PT/INR every week. The resident's Coumadin had been discontinued on 03/08/14 when she returned from a hospital stay. The care plan had not been updated to reflect the discontinuation of the Coumadin. On 03/19/14 at 2:20 p.m., the corporate RN was shown the care plan and asked if the care plan should have been updated to reflect the changes in weight loss, skin condition and discontinuation of the medication. The corporate nurse stated, "Yes, it should." 3. Resident #10 was admitted on 02/11/13 with diagnoses which included HTN, dyspepsia,	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 53 depressive disorder and hemiplegia affect unspecified side due to cerebrovascular disease. An annual assessment, dated 02/18/14, documented the resident was moderately impaired with cognition and exhibited mild depression. The resident required one person limited assistance for dressing, eating and personal hygiene and one person extensive assistance with bathing. A care plan was reviewed on 02/18/14 and contained no entries in regard to the resident's use of an E-cigarette. On 03/19/14 at 10:00 a.m., the resident reported he utilized an electronic cigarette. The resident was observed to use the electronic cigarette during the survey. The E-cigarette was not addressed on the resident's care plan for safety concerns. The MDS coordinator was interviewed on 03/20/14 at 3:00 p.m. in regards to the resident's care plan. The MDS coordinator reported the area would be addressed.	F 280		
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR 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.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 54 This REQUIREMENT is not met as evidenced by: On 03/18/14, an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to assess, monitor and intervene when a resident who was on Coumadin had black tarry stools. The Oklahoma State Department of Health was notified and verified the existence of the IJ situation. At 1:55 p.m., the ADM, DON, corporate ADM and corporate RN were notified of the IJ situation. At 3:35 p.m., an acceptable plan of removal was presented to the survey team. The facility's plan of removal documented the following: "Physician notification/Assessment and Monitoring 1. 100% in-service of licensed nurses on the requirement for physician notification requirements, care and care services policy, notification of physician (CALL when abnormal findings are noted). Fax is only appropriate in non-emergent circumstances when no abnormal findings are noted. In-service will include the requirements for assessment and monitoring and reporting changes to the MD. In-service will be completed at 4 p.m. on 03/18/14. Any nurse that does not attend this in-service will not be allowed on the floor until the in-service is complete.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 55 2. 100% in-service of CNA's will be completed regarding reporting changes in condition to licensed nurse as soon as noted. This in-service will be completed on 03/18/14 at 4 p.m. any aide that does not complete the in-service at this time will not be allowed to work until the in-service is complete. 3. An audit by staff and resident interview will be complete at least three times weekly to ensure compliance with nurse notification of changes from the CNA. 4. The resident had previously been admitted to the hospital for treatment. 5. Complete a 100% audit of current residents documentation (January through current date) to ensure that any changes of condition have been communicated to the doctor. This audit will be completed by 1 pm on 03/19/14. 6. Audit of the 24 hour report will be completed and documentation reviewed three times weekly to ensure continued compliance. 7. Any identified non-compliance will result in one on one in-servicing and progressive disciplinary action. 8. Results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation, review and changes." On 03/19/14 at 9:00 a.m., a copy of the facility's in-service on the subject of physician notification, change of condition, assessment and monitoring of the patient and CNAs' notifying nurse of	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 56 changes in condition. A copy of the in-service topics included: "03/18/14 4:00-4:45 LPN's/RN Physician Notification of Changes 1. The doctor must be notified with ANY change in the resident condition of abnormal findings. The notification must be completed at the time the change is noted. Example: Fall, Wound, Abnormal Labs etc. How do we notify the Physician? 1. Fax- this method may only be used when the situation is non-emergent and there are no abnormal findings. (Minor skin tear, lab results received are normal etc.) If you are unsure if you should fax or call, notify your DON for guidance. 2. Call-the doctor must be called when abnormal findings are noted or when the situation is emergent. (New complaint of pain level, abnormal labs, falls with injury etc) ANY CHANGE IN CONDITION MUST BE COMMUNICATED TO THE DOCTOR 1. When completing an assessment vital signs should be completed. The change of condition form is used for documentation and should be complete [sic] filled out. When changes are noted follow up documentation and assessment should be completed to monitor the progress of the condition of the resident. CNA	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 57 YOU ARE THE FIRST LINE OF DEFENSE! You see the resident more than any other staff. You will be the first to notice small changes and big changes. It is your responsibility to report any and all changes to the nurse! Examples: Walking to the dining room and want a wheelchair, dressing self and now are unable, discolored or stinky urine, not drinking, not eating, skin issue, etc. any change that is not the norm for the resident must be report to the nurse for further evaluation. No matter how small you think the change is, always report." The names on the in-service form were compared to the staffing roster. Staff members from various shifts of the nursing department were interviewed in regard to the in-service. The staff members reported they received information including reporting, assessment, monitoring and intervening for change in condition. The staff answered questions appropriately in regard to the in-service. The IJ was removed on 03/19/14 at 1:00 p.m. The deficiency remained at the level of actual harm that was not immediate jeopardy, at a pattern. Based on observation, record review and staff interviews, it was determined the facility failed to: a) Assess and monitor a resident with black tarry stools for one (#2) of one sampled resident who experienced black tarry stools. This had the potential to affect two residents,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375418	A. BUILDING _____ B. WING _____	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 58 identified by the DON, who had black tarry stools in the past three months. b) Have FSBS elevated parameters in which to notify the physician for one (#6) of three sampled residents who had FSBS ordered. This had the potential to affect 26 residents, identified by the DON, who had FSBS ordered. c) Follow up on a laboratory analysis with the physician for one (#8) of 10 sampled residents who required laboratory analysis. This had the potential to affect all 75 residents who resided in the facility. d) Have blood pressure parameters in which to notify the physician for three (#3, 7 and #9) of three sampled residents who required blood pressure readings. This had the potential to affect 19 residents, identified by the DON, who required blood pressure readings. e) Assess and monitor a burn for one (#13) of one sampled resident who experienced a burn. This had the potential to affect two residents, identified by the DON, who had a burn in the past three months. Findings A facility policy, dated 02/05/13, documented, "Care and Services- POLICY: It is the center's policy to provide residents with the necessary care and services to	F 309	1. The doctor has been notified for resident #2 regarding the change in condition. 2. The elevated FSBS for resident #6 has been reported to the doctor. 3. The doctor for resident #8 has been notified of the lab results. 4. The doctors for resident #3,7, and 9 have been notified of the blood pressure parameters and abnormal readings. 4. The doctor has been notified of the current condition of resident #13 related to the burn. 5. Nursing staff have been in-serviced on the requirements for assessment and monitoring with changes in the resident status. 6. An audit was completed to identify other need reporting and assessment/monitoring needs. 7. Audits will continue at least three times weekly ongoing to ensure continued compliance by the DON or designee. 8. Identified non-compliance will result in one on one education and progressive discipline. 9. Results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days for further evaluation and review.	04-22-14