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 59	F 309		

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 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 for size

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**

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F 309	Continued From page 60 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 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	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

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F 309	Continued From page 61	F 309		

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 with the same above date contained no other 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..."

The nurses' notes, dated 02/09/14, contained no documentation the resident's vital signs had been obtained.

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. 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..."

The Change Of Condition Communication form contained no documentation the resident's vital signs had been obtained.

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

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F 309	Continued From page 62	F 309		

Continued From page 62

The nurses' notes, dated 02/10/14, contained no documentation the resident's vital signs had been obtained.

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.

An admission note from [hospital name deleted], dated 02/10/14, documented, "CHIEF COMPLAINT: History of GI bleed, tarry stools...The stool guaiac-positive...ASSESSMENT AND PLAN: 1. Gastrointestinal bleed. At this time, we will transfuse 2 units of packed RBCs. We will check a CBC in the morning..."

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 physician's 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 9:50 a.m., CNA #6 was questioned in regard to the resident having black tarry stools. The CNA reported she had assisted the resident with toileting before she went to the hospital the first

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 63	F 309		

time and she had 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.

On 03/21/14 at 8:45 a.m., the DON was questioned in regard to the lack of assessment and vital signs not being completed for the resident. The DON was asked if the assessment should have included vital signs. The DON stated, "Yes they should have been done on both days."

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 and the lack of assessment.

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 and for assessing, monitoring and intervening changes of a resident's condition.

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.

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

"Focus
...has a potential alteration in Nutrition Status R/T

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 64	F 309		

short term memory...has a weight fluctuation R/T edema history and diuretic use

Goals
...will have Safe and comfortable ingestion of fluids and solids over the next review. 06/11/14
...will be free of pressure sites over the next review. 06/11/14

Interventions
Diet as ordered
Labs as ordered..."

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 nurse's note documented, "3/6/14 pt wt on 3/3/14-182.6, pt wt today on 3/6/14 was 190.0 PCP (personal care physician) notified via Fax request possible BMP lab drawn awaiting response."

The medical record was reviewed. No BMP had been completed. There was no follow-up to the nursing note dated 03/06/14.

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**

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F 309	Continued From page 65	F 309		

On 03/20/14 at 4:15 p.m., the DON was notified of the nursing note on 03/06/14, with no follow-up. She reported the nurse should have followed up on the request.

3. 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. The resident was totally dependent on staff assistance for bed mobility, transfers, ambulation in a wheelchair, personal hygiene and bathing. The resident was always incontinent of bowel and bladder.

A care plan, dated on 02/02/14, documented the resident had diabetes type II, as a problem. A goal for the resident was to have no S/S of hyperglycemia or hypoglycemia. An intervention was for the staff to obtain blood sugars as ordered.

A physician's order, dated 03/05/14, documented the resident's FSBS was to be obtained on Monday, Wednesday and Friday daily. Prior to 03/05/14, the physician's order documented the FSBS was to be obtained BID before meals.

The March 2014 computerized physician's orders documented the resident was to receive Glucagon, if the FSBS was below 60 and for the staff to attempt to give food/drink. If unable to feed or the FSBS remained below 60 after feeding or giving Glucagon, notify the physician.

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 66 The physician orders had not indicated, if the FSBS levels were high, when to notify the physician. There were no high level parameters set or obtained from the physician to direct the resident's care. On 03/19/14 at 2:20 p.m., the DON was asked if she expected the resident to have a upper parameter set for the FSBS which indicated when to notify the physician for care directives. The DON stated, "Yes, should have upper parameters." 4. Resident #9 was admitted on 04/26/13 with numerous diagnoses which included CVA, HTN, atrial fibrillation, depressive disorder and diabetes mellitus. 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. A computerized physician's order, dated 03/01/14, documented the resident was to receive Diltiazem 120 mg. daily for HTN. The order documented, "...hold if SBP is less than 90." There were no B/P parameters in which staff was to notify the physician, in the resident's medical record.	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 67 On 03/18/14 at 8:00 a.m., the DON was interviewed regarding blood pressure readings in which the staff was to notify the physician. The DON reported the facility should have B/P parameters and she would contact the physician. 5. Resident #7 was admitted on 09/20/13, with diagnoses which included chronic pain, s/p MI, anxiety state and HTN. A computerized physician's order, with an original order date of 09/20/13, documented, "Metoprolol Tartrate 25 MG Tablet By mouth, (Oral)-Day Shift Everyday: give one tablet [between] 6a-9a and give one tablet [between] 6p-9p: hold if SBP is less than 90 HTN." There were no B/P parameters in which the licensed nurses were to notify the physician, documented in the resident's medical record. 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. A care plan, dated 03/12/14, documented the resident had HTN, as a problem. The goal was for the resident to not complain of headaches, dizziness or fatigue. An intervention listed was for the staff to obtain the resident's B/P as ordered or per facility protocol. At 10:30 a.m., the DON was interviewed	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 68	F 309		

regarding the resident not having B/P parameters in which to notify the physician. The DON reported she would contact the physician for B/P parameters.

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

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 March 2014 computerized physician's orders documented:

"Losartan Potassium 100 MG...give one tab daily...htn...
Lasix...20 MG Tablet...Everyday..HTN/EDEMA...
Norvasc...5 MG tablet..1 PO daily-hold if B/P <90 systolic...UNSPECIFIED ESSENTIAL HYPERTENSION..."

The physician's orders contained no parameters in which to notify the physician of abnormal blood pressure readings.

On 03/19/14 at 10:00 a.m., the DON was asked if the resident should have blood pressure parameters in which to notify the physician. The DON reported the physician informed her he would set parameters on an individual basis for each resident and had not provided parameters for the resident at this time. The DON reported she would address the issue with the physician.

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 69	F 309		

7. Resident #13 was admitted with diagnoses which included cardiovascular disease, bipolar disorder, epilepsy and diabetes.

A Change Of Condition Communication form, dated 01/25/14 at 7:40 a.m., documented, "Writer standing @ N.S. (nurses' station). was informed by other res that res 'spilled her coffee' Writer turned around obs. Res. in geri chair [with] coffee cup in hand angled toward self [with] lg. wet spot on shirt. Writer went to res. and lifted clothing off skin & assisted to rm...Res. has 6 x 3 cm light pink area to mid [upper left] breast. [No] blistering...

0800 (8:00 a.m.) Area remains light pink [no] blistering..
0900 (9:00 a.m.) Assessment unchanged...
1000 (10:00 a.m.) Assessment unchanged [No] pain discomfort. Cool compress applied..."

A nurse's note, dated 01/26/14 at 11:30 a.m., documented the resident had a light fading pink area to her left breast. There was no other documentation of assessment or monitoring of the burn area.

A Non-Pressure Wound And Skin Condition Documentation Form documented the area on 01/25/14. The next entry, dated 02/12/14, documented, "Resolved." There was no weekly skin assessment of the area.

There was no assessment of the burn areas size or appearance for 16 days.

A comprehensive assessment, dated 02/06/14, documented the resident had severe cognitive impairment, moderate depression and no

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 70 behaviors. The resident was totally dependent on staff assistance for bed mobility, locomotion, transfers, dressing and personal hygiene. The resident had range of motion impairment of bilateral upper and lower extremities. On 03/20/14 at 3:00 p.m., the ADON was asked if the burn site should have been monitored. The ADON replied, "Yes."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure ADL assistance with nail care was provided for one (#6) of ten sampled residents who required assistance with personal hygiene. This had the potential to affect 72 residents, identified by the DON, who required assistance with personal hygiene. Findings: 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,	F 312	1. The nail care for resident #6 has been completed. 2. An audit has been completed to identify other residents that required nail or ADL care. 3. A weekly audit will be completed ongoing to ensure compliance by the DON or designee. 4. Staff have been educated on the requirement for ADL care. 5. Identified non-compliance will result in one on one education 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
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(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 312	Continued From page 71 documented the resident was severely impaired with cognition with disorganized thinking and exhibited moderately severe depression with behaviors. The resident was totally dependent on staff assistance for bed mobility, transfers, ambulation in a wheelchair, personal hygiene and bathing. On 03/18/14 at 11.45 a.m., the resident's fingernails were observed to have dark colored/black debris under the nails on both hands. On 03/19/14 at 11:15 a.m., CMA #1 was asked to show the surveyor the resident's fingernails. Both hands had dark colored debris under the fingernails. The CMA was asked who would clean the resident's nails. The CMA reported the aides cleaned the resident's nails with bathing. The CMA showed the surveyor the resident's bath schedule which indicated the resident should have received a shower on the previous evening shift. The CMA reported the resident's fingernails needed to be cleaned. At 2:20 p.m., the DON was informed of the resident's fingernails which needed to be cleaned. The DON reported the resident's fingernails should be kept clean.	F 312		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		

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 314	Continued From page 72 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by. Based on record review, observation and staff interviews, it was determined the facility failed to a) Ensure assessment, monitoring, physician notification or treatment was obtained for pressure ulcers for four (#2, #7, #8 and #17) of six sampled residents who had experienced pressure ulcers. This had the potential to affect 10 residents, identified by the DON, with pressure ulcers. b) Ensure a pressure ulcer was assessed and monitored for one (#15) of six sampled residents who had experienced a pressure ulcer. This had the potential to affect 10 residents identified by the DON, with pressure ulcers. Findings. 1. 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. 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	F 314	1.The assessment, monitoring ,doctor notification, and treatment orders have been obtained for #2,#7,#8 and #17. 2. An audit was completed to ensure that all other residents skin issues have been addressed. 3. A weekly audit will be completed by the DON or designee ongoing to ensure continued compliance. 4. Identified non-compliance will result in one on one in-servicing and progressive discipline. 5. Nursing staff have been educated on the regulatory requirements regarding pressure areas/skin. 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
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F 314	Continued From page 73	F 314		

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 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 ulcers.

At that time, ADON #2 presented a list of residents with pressure ulcers. 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.

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

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F 314	Continued From page 74	F 314		

At 4:50 p.m., 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 and 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 applying barrier cream to the area.

The LPN also reported she should have made an incident report, called the doctor, obtained 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 ulcer identified on 03/12/14. She reported the nurse should have called the physician and obtained a treatment for the area.

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 care plan, dated 02/22/14, documented 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
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F 314	Continued From page 75	F 314		

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 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. A 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."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 76 LPN #2 returned to the resident's room and measured the wound at 1.9 cm X 0.3 cm and reported the wound was a stage II 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 skin assessment sheets were reviewed there was no documentation of the ulcer 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 ulcer. The corporate nurse reported the ulcer 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. 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. 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, reddened or had open areas, report to charge	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	**1200 WRANGLER BLVD SEMINOLE, OK 74868**

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F 314	Continued From page 77 nurse any bruising, bleeding, redness, irritation or open areas and perform weekly skin assessments 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... 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..." The physician had not been notified of the resident's return to the facility or the new Stage I pressure sore to the coccyx area. There was no physician's order for treatment to the Stage I pressure sore. A nurse's note, dated 03/13/14 at 1:30 p.m., documented, "...incontinent care provided. Redness noted to peri area. Notified PCP, rec'd order for Z guard to peri area Q shift til resolved..." A computerized physician's order, dated 03/13/14, documented, "Z guard to peri area Q shift until resolved- Days-Evenings-Nights Everyday."	F 314		

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
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F 314	Continued From page 78 There was no physician's order obtained at that time for treatment to the coccyx area Stage I pressure sore. A weekly pressure ulcer documentation report form, dated 03/14/14, documented the resident had a "10.0x6.0 Stage I to coccyx area easily blanchable..." A weekly pressure ulcer report, dated 03/14/14, documented the resident had a "10.0cmx6.0 to coccyx area treatment Z guard...Healing." A treatment sheet, dated March 2014, documented the resident received no treatments to the coccyx area from 03/08/14 through 03/20/14. On 03/20/14 at 8:50 a.m., LPN #2 was observed to perform wound care to the resident's coccyx area. The LPN cleaned the coccyx area with a wipe and then applied Z guard. At that time, the LPN was asked if the coccyx area had been open. The LPN reported the area was bright red when the resident returned from the hospital and the redness was what they had been measuring. 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." The DON was then asked if she expected the	F 314		

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
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F 314	Continued From page 79 staff to obtain orders for treatment to the coccyx area pressure sore. The DON stated, "Yes." 4. Resident #15 was re-admitted to the facility on 12/30/13 with diagnoses which included dialysis, pressure ulcer lower back stage II, pressure ulcer hip and end stage renal disease. A care plan, dated,12/30/13, documented, the resident, on admit Stage II coccyx, gluteal and R hip ulcers, as a problem. A goal was for the Stage II ulcers to improve or resolve by the next review. Interventions listed were to treat as ordered and to measure weekly. An admission assessment, dated 01/08/14, documented the resident was severely impaired with cognition, totally dependent for transfer, bed mobility, dressing, eating, hygiene and bathing. The resident was always incontinent of bowel and bladder. The resident was admitted with three stage II pressure ulcers. A Non-Pressure Wound and Skin Condition Documentation form documented a site to the right heel. "12/30/13 size 4 x 0.5 x 0, pink wound bed, pink surrounding skin color and pink surrounding tissue/wound edges. 01/05/14 size 7.5 x 5 x 0, pink wound bed, pink surrounding skin color and pink surrounding tissue/wound edges." There was no documentation the wound had been assessed or measured on 01/12/14. A Pressure Ulcer Documentation form	F 314		

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**

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F 314	Continued From page 80 documented a site to the coccyx: "12/30/13 Stage II, size 6 x 4 x 0.2, Serosanguineous exudate, slight odor, moderate amount of exudate. 01/05/14 Stage II, size 10 x 4 x 0.2, Serosanguineous exudate, slight odor, large amount of exudate." There was no documentation the wound had been assessed or measured on 01/12/14. A Pressure Ulcer Documentation form documented a site to the gluteal crease: "12/30/13 Stage II, size 4 x 2 x 0.2, Serosanguineous exudate, no odor, small amount of exudate. 01/05/14 Stage II, size 3.8 x 3 x 0.2, Serosanguineous exudate, no odor, small amount of exudate." There was no documentation the wound had been assessed or measured on 01/12/14. A Pressure Ulcer Documentation form documented a site to the R hip: "12/30/13 Stage II, size 8.5 x 2 x 0, Serosanguineous exudate, no odor, small amount of exudate. 01/05/14 Stage II, size 8.4 x 2 x 0, Serosanguineous exudate, no odor, small amount of exudate." There was no documentation the wound had	F 314		

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

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F 314	Continued From page 81	F 314		

been assessed or measured on 01/12/14.

On 03/20/14 at 3.20 p.m., the DON was shown the pressure ulcer documentation and asked if the assessment and measurements should have been obtained. The DON stated, "Yes."

5. 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 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 documented on the Pressure Ulcer Documentation form. The LPN reported she had no knowledge of the specific ulcer. No coccygeal

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	375418	A. BUILDING ______ B. WING ______	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 82 ulcer was observed. At the time of the treatment observation, an open (stage II) ulcer to the 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 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		

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
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F 315	Continued From page 83 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure an indwelling urinary catheter tubing was secured to the thigh and the catheter bag was not held over the level of the bladder for one (#7) of three sampled residents, who required the use of an indwelling urinary catheter. This had the potential to affect five residents, identified by the Resident Census And Conditions of Residents form, who required the use of an indwelling urinary catheter. Findings. Resident # 7 was admitted on 09/20/13 with numerous diagnoses which included paraplegia, chronic pain, s/p MI, anxiety state and HTN. A computerized physician's order, with an original order date of 10/24/13, documented, "16 /F (French) indwelling Foley catheter-Complex neurogenic bladder." 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	F 315	1. Nursing staff will be in-serviced regarding securing Foley catheter tubing and ensuring the bag remains below the bladder. 2. The tubing for resident #7 has been secured as required. 3. Staff observations will be completed at least twice weekly by the DON or designee for continued compliance. 4. Identified non-compliance will result in one on one in-servicing and progressive discipline. 5.. The results of the audits will be presented to the facility QA committee monthly for at least 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

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F 315	Continued From page 84	F 315		

dress, perform personal hygiene and bathe. The resident was always incontinent of bowel and had an indwelling urinary catheter.

A care plan, dated 03/04/14, documented the resident had an indwelling urinary catheter, as a problem. The goal was for the resident not to have a UTI through the next review date. An intervention listed was for the staff to perform catheter care every shift and PRN.

On 03/18/14 at 2:15 p.m., the resident was observed to be transferred by CNA #5 and #4 with a mechanical lift. The resident's urinary catheter tubing was not secured to the resident's thigh.

The CNAs positioned the lift sling under the resident and secured the sling to the lift. CNA #4 removed the indwelling urinary catheter drainage bag from the bed railing and held the bag. CNA #5 proceeded to lift the resident off the bed and begin to lower the resident to a shower chair.

As CNA #5 lowered the resident, CNA #4 continued to hold the indwelling urinary catheter drainage bag above the level of the resident's bladder. The tubing was observed to be taunt as the resident was lowered to the shower chair. The CNA did not lower the catheter drainage bag until the resident was seated on the shower chair. The CNA then secured the catheter drainage bag to the shower chair.

On 03/19/14 at 7 30 a.m., the DON was interviewed regarding the indwelling urinary catheter tubing not being secured and the catheter drainage bag being above the level of the bladder. The DON reported the catheter

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

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F 315	Continued From page 85 tubing should have been secured to prevent pulling on the urinary meatus. The DON reported the catheter drainage bag should never be above the level of the resident's bladder. The DON reported she would in-service the staff.	F 315		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, it was determined the facility failed to. a) Ensure restorative services were provided for one (#1) of one sampled resident with a decline in range of motion. This had the potential to affect 12 residents, identified by the DON, who received restorative services. b) Ensure restorative services were provided as ordered by the physician for one (#8) of two sampled residents with orders for restorative services. This had the potential to affect 12 residents, identified by the DON, who received restorative services.	F 318	1. Restorative services have been set up and provided for resident #1 2. An audit has been completed to identify other residents that require restorative services. 3.Nurisng staff will be in-serviced on the requirement for restorative services. 4. A weekly audit will be completed by the DON or designee to ensure continued compliance. 5. 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

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F 318	Continued From page 86	F 318		

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, diabetic II, osteoarthrosis, abnormal gait and hypertension.

A care plan revised on 04/03/13, documented:

"Focus
...has a Risk for falls related to decreased balance, confusion...

Interventions
...Restorative Nursing as ordered with queuing (sic) and SBA (stand by assist)
Restorative Program as ordered
Restorative services as ordered..."

The resident had been placed on hospice services on 04/13/13.

A quarterly assessment, dated 11/13/13, documented the resident required total assistance with transfers, dressing, eating and personal hygiene, required extensive assistance with bathing, did not ambulate, required an indwelling urinary catheter and had no deficits in range of motion.

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, required an indwelling urinary catheter and had deficits in

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	375418	A. BUILDING ______ B. WING ______	C 03/21/2014

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F 318	Continued From page 87 range of motion in both upper and lower extremities. The current physician's orders were reviewed. There was no order for restorative services. The ADL flow sheets were reviewed for January, February and March 2014. There was no documentation of basic range of motion exercises being done by the CNAs. 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, unless he was restless, otherwise he stayed in bed. The CNA reported the resident was on hospice and received bed baths. He reported the CNAs turned, fed and kept the resident clean between bed baths. On 03/20/14 at 10:35 a.m., the DON was notified of the resident's decline in range of motion. She reported she would talk to the restorative aide and see why no restorative was being done for him. 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.	F 318		

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

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F 318	Continued From page 88	F 318		

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 decline in Self Care Deficit...decreased balance, assistance with ambulation and walker use...

Goals
...will participate in ADL's daily...06/11/14

Interventions
...Assist...with ambulation with rolling walker as needed
Provide UE (upper extremity) (A) (active) ROM with cueing, toileting and dressing with SBA"

A physician's order, dated 06/05/13, documented, "Restorative: Ambulate using RW (rolling walker) with 150 ft with SBA 3-5x/wk (times per week)."

The Restorative Nursing Program Flow Sheet for November 2013, documented a goal for the resident was to maintain current capabilities with a plan to use a RW (rolling walker) 150 ft with SBA.

The November 2013 flow sheet was blank until the 21st of the month. On the 21st the resident refused to walk. The resident was walked on the 17th and refused on the 25th, 27th and the 29th.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318	Continued From page 89 A note at the bottom of the flow sheet documented, "Will re eval next mth (month). Get charge nurse when refusing so they can chart if they refuse with them." The Restorative Nursing Program Flow Sheet for December 2013, documented the resident had refused to walk twelve times. A note at the bottom of the flow sheet documented, "With continual refusal, restorative aid will have to come and get this nurse ADON, or DON to speak c (with) resident before it can be accepted as a refusal." There were no restorative flow sheets for January, February or March 2014. On 03/19/14 at 9 30 a.m., the RA was asked about restorative services for the resident. She reported the resident had refused and nurses were supposed to have it discontinued. On 03/19/14 at 1:30 p.m., the resident was observed walking with a rolling walker, with assistance of one staff member, to the bathroom and back to her chair. On 03/19/14 at 4:00 p.m., the ADON was notified of the current physician's order for restorative services. She reported the RA was supposed to come and get her or the DON if the resident was refusing. She reported the RA had not been reporting when the resident refused.	F 318		
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

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	375418	A. BUILDING ______ B. WING ______	C 03/21/2014

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F 325	Continued From page 90 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a significant weight loss was addressed for one (#2) of three sampled residents who had experienced a significant weight loss. This had the potential to affect 18 residents, identified by the DON, who had experienced weight loss over the past three months. Findings: 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 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	F 325	1.The weight loss for resident #2 has been addressed. 2. An audit has been completed to ensure any weight loss has been addressed as required. 3. A weekly ongoing audit will be completed by the DON or designee to ensure ongoing compliance. 4. Nursing staff will be educated on the requirements to address significant weight loss. 5. Identified non-compliance will result in one on one education 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

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	375418	A. BUILDING ______ B. WING ______	C 03/21/2014

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SEMINOLE CARE AND REHABILITATION CENTER	**1200 WRANGLER BLVD SEMINOLE, OK 74868**

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F 325	Continued From page 91	F 325		

change. One intervention listed was for the resident to be weighed weekly and to receive a diabetic snack three times a day between meals.

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 dietary consultant report, dated 01/29/14, documented, "Resident had 5.62% weight loss in one month, 7.28% in 3 months and 10.04% in six months. CBW (current body weight) #163. D/T decreased ALB (albumin) 2.4 rec offer High Pro snacks between meals. Rec S.F. (Sugar Free) Health Shakes TID for ADD (additional) Cal/Pro. (calories/protein) Monitor wt status. cont."

A Weight record documented the resident's weights as follows:

September 2013-186.4 pounds
October 2013-175.8 pounds
November 2013-176.8 pounds
December 2013-172.8 pounds
January 2014- 163 pounds
February 2014-169.8 pounds

A computerized physician's order, dated 03/08/14, documented, "...Diet...HOUSE CONSISTENT CARBOHYDRATE (HCC)...Daily weights Q AM after urinating-Daily Everyday..."

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F 325	Continued From page 92 On 03/18/14 at 1:00 p.m., the resident was in the PT room having lunch. The resident's intake for the meal was 10%. PT #1 reported the resident had requested bread and sandwich meat from her personal refrigerator. The resident was observed to eat one sandwich. At 4.25 p.m., the resident was observed in the dining room. The resident consumed 50% of her evening meal. On 03/19/14, the resident weighed 151.8 pounds. At 2:20 p.m., the corporate nurse was interviewed regarding the resident's weight loss. The corporate nurse reported the resident's weight loss should have been addressed.	F 325		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334		

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	375418	A. BUILDING ______ B. WING ______	C 03/21/2014

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F 334	Continued From page 93 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal	F 334		

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F 334	Continued From page 94 immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents received education regarding the benefits and potential side effects before offering the influenza immunization for nine (#1, #2, #3 #4, #5, #6, #7, #8 and #10) of nine sampled residents who received the influenza immunization. This had the potential to affect 47 residents, identified by the DON, had received the influenza vaccination this flu season. Findings: The medical records were reviewed for residents #1, #2, #3 #4, #5, #6, #7, #8 and #10. The residents' medical records documented the residents had received the influenza vaccination on 10/22/13. The residents' medical record contained no documentation the residents had received education regarding the benefits and potential side effects before offering the influenza immunization for the present year. On 03/18/14 at 4:30 p.m., the corporate nurse was shown the facility's Vaccination Consent form.	F 334	1. Nursing staff will be educated on the requirements of education regarding benefits and risk/potential side effects before offering the flu vaccine to resident. 2. All new admission to the facility during flu season will receive the required education and information. 3. A weekly audit will be completed to ensure compliance by the DON or designee. 4. Non-compliance will result in one on one education and progressive disciplinary action. 5. Results of the audits will be presented to the facility QA committee for further evaluation and review monthly for a period of no less than 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

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F 334	Continued From page 95 The form had an area to check if the resident or responsible party had received the CDC vaccine information. None of the above residents' forms contained a check mark in the specified area. The form had an area to check if the residents consented to the annual administration of the influenza vaccination. This area was checked on all the sampled residents' vaccination forms. The corporate nurse reported the facility had not educated the residents and she would address the issue.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure pots, pans, containers, utensils, knives and plates were clean and in good repair. This had the potential to affect all 75 residents, identified by the DM, who took their meals from the dietary department.	F 371	1. Dietary staff have been in-serviced on the requirements for pots, pans,containers, utensils, knives and plates are clean and in good repair. Also for proper drying of dishes. 2. All identified areas have been cleaned. 3. A three times weekly audit of the kitchen area will be completed by the Administrator to ensure continued compliance. 4. Identified non-compliance will result in one on one in-servicing and progressive	04/22/14

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	375418	A. BUILDING ______ B. WING ______	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 96 Findings: On 03/17/14 at 4:20 p.m., an environment tour was conducted of the dietary department with the DM. The follow observations were made: Metal serving containers were stacked wet. Three metal bowls were stored with dried food and debris present. Soiled plastic containers were stacked on shelves for use in the kitchen. A plastic container, stacked on a metal shelves in the kitchen, had standing water and sediment present. Four large pots were stored with food, debris, and moisture present. Three stacked muffin pans were stored with dried food and crumbs present. There were knives with dried debris were in the dry food storage area. A utensil drawer contained food debris. There were chipped plates ready for use in the serving line. When brought to the DM's attention, she removed the chipped plates from service. On 03/18/14 at 2:00 p.m., the DM removed all pots and pans which contained the dried food and standing fluids. The DM reported she would have all items	F 371	discipline. 5. 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.	

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F 371	Continued From page 97 rewashed and dried appropriately. The DM instructed the dietary staff not to stack containers wet. The DM reported all the about areas would be addressed.	F 371		
F 406 SS=E	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to follow physician orders for PT evaluation and treatment for one (#7) of two sampled residents who required PT. This had the potential to affect 14 residents, identified by the DON, who had an order for PT in the past three months. Findings: Resident #7 was admitted on 09/20/13, with diagnoses that included paraplegia, chronic pain, and anxiety state. A computerized physician's order, with an original order date of 02/21/14, documented, "PT/OT TO	F 406	1. The PT evaluation for resident #7 has been completed. 2. An audit has been completed to identify other resident with orders for therapy and evaluations incomplete. 3. weekly audits will be completed by the DON or designee for continued compliance. 4. Identified non-compliance will result in one on one education and progressive discipline. 4, 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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 406	Continued From page 98 EVAL AND TREAT AS INDICATED (BLE contracture)." 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. A care plan, dated 03/12/14, documented the resident had decreased mobility related to paraplegia and bilateral lower extremity contracture, as a problem. The goal was for the resident to maintain mobility and function. An intervention listed was for staff to teach the resident energy-saving techniques. On 03/18/14 at 9:40 a.m., the resident was asked if she had been receiving PT/OT services. The resident reported she had not seen PT or OT. At 9.55 a.m., PT #1 was asked if she had received orders for the resident to receive PT/OT services. The PT reported they had not received any orders. The PT reviewed the physician's order and stated, "I don't know why we didn't get this." At 10:30 a.m., the DON was interviewed regarding the resident receiving PT/OT therapy as ordered by the physician. The DON reported she did not know why PT/OT had not received the order, but she would correct the problem immediately.	F 406		

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

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F 425	Continued From page 99	F 425		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by. Based on observation, staff and family interview and record review, it was determined the facility allowed a family member to administer eye drops without a physician's order to one (#5) of one sampled resident. This had the potential to effect one resident, identified by the DON, who received family administration of medications. Findings	F 425		

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F 425	Continued From page 100 Resident #5 was admitted on 07/29/07 with diagnoses which included CVA, paralysis, depressive disorder, TIA, psychosis and Alzheimer's disease. A quarterly assessment, dated 01/15/14, documented the resident was severely impaired with cognition and exhibited moderately severe depression with behaviors. The resident required total assistance for transfers, dressing, personal hygiene and bathing. The resident required one person extensive assistance with eating. A care plan, dated 01/18/14, documented the resident's wife could administer artificial tears prn, and keep the medication at the bedside. There was no physician's order that documented a family member could administer the eye drops. There was no documentation the family member had been assessed prior to the administration of medications. On 03/18/14 at 9:00 a.m., a bottle of artificial tears was observed in the resident's room. The surveyor asked the spouse if the drops were hers. She stated, "No, they belong to my husband." The spouse reported the doctor told her she could administer the eye drops to her husband. On 03/19/14 at 3:00 p.m., the DON was interviewed in regard to the resident's wife administering the eye drops. The DON reported the physician reported the wife could do it. When asked if the spouse had been assessed on correct administration of the eye drops, the DON stated, "No, we've not checked her off. The	F 425	1. The family member of resident number five has been educated on the requirements for staff to administer medications. 2. Staff have been educated on the requirement for staff to administer medications unless a self administration assessment is in place and they have been found competent to administer, a doctors order is in place, the medication is secure and a care plan is in place. 3. An audit has been completed to identify any other self administration issues and ensure the appropriate elements are in place. 4. A weekly audit will be completed by the DON or designee ongoing to ensure continued compliance. 5. Results of t he audits will be presented to the facility QA committee monthly or a period of no less than 90 days for further evaluation and review.	04/22/14

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F 425	Continued From page 101 doctor said it was ok for her to administer."	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 102 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, it was determined the facility failed to ensure over-the-counter medications were labeled including the resident's name, route of administration, appropriate instructions and precautions for 10 over-the-counter medications observed during the medication pass. This had the potential to affect all 75 residents who resided in the facility. Findings. Medication passes were observed on 03/18/14 and 03/19/14. Twenty-seven medications were observed. The following over-the-counter medications were observed without labels which identified the route of administration, appropriate instructions and precautions. A stool softener, a multivitamin, a vitamin D-400 mg, a calcium 600 mg with vitamin D, a theravitamin, an acid reducer (Zantac), a liquid stool softener, a calcium 600 with vitamin D 400 mg, an aspirin (NSAID) 845 plus 65 fast relief powder and a brimonidene 0.2 % eye drops. On 03/20/14 at 11:30 a.m., the corporate nurse was notified of the over-the-counter medications not having complete labels. She reported the facility should have copies of the physician's orders for each medication with the medications to document how the medications are to be administered.	F 431	1. Staff have been educated on the requirements for labeling and storage of OTC medications. 2. An audit has been completed to ensure all OT C's are labeled and stored properly. 3. A weekly audit will be completed by the DON or designee to ensure continued compliance. 4. Identified non-compliance will result in one on one in-servicing and progressive discipline. 5. Results of the audits will be presented to the facility QA committee for further evaluation and	04/22/14
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 103	F 441		

Continued From page 103

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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

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	375418	A. BUILDING ______ B. WING ______	C 03/21/2014

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F 441	Continued From page 104 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to: a) Provide complete PPE equipment in the laundry department. This had the potential to affect all 75 residents who resided in the facility. b) Ensure contaminated gloves did not touch clean items for two (#6 and #17) of seven sampled residents who required toileting assistance. This had the potential to affect all 75 residents who resided in the facility. c) Ensure an indwelling urinary catheter bag was not on the floor for one (#5) of two sampled residents who required indwelling urinary catheters. This had the potential to affect five residents, identified by the Resident Census And Condition of Residents form, who required indwelling urinary catheters. d) Track and trend infections for two (#2 and #7) of five sampled residents, who had infections in the past three months. This had the potential to affect all 75 residents who resided in the facility. e) Ensure staff members washed their hands prior to providing care for one (#7) of 10 sampled residents.	F 441	1. PPE equipment has been place in the laundry area. 2. Nursing staff have been educated on the requirement for glove use during toileting, peri-care/catheter care, hand washing and not talking meal trays into other resident rooms. 3.Nurisng administration have been educated on the requirement for all infections to be listed on the tracking and trending of infections. 4. The infections for resident number 2 and 7 have been updated to the tracking and trending. 5. Staff observations will be completed by the DON or designee weekly to ensure continued compliance for the following areas; a. hand washing b. catheter care c. glove use during toileting d. handling of meal trays e. PPE use in the laundry 6. A monthly review of the tracking and trending report will be completed to ensure compliance. 7. Any identified non-compliance will result in one on one education and progressive disciplinary action. 8. The results of the audits will be presented to the facility QA committee for further evaluation and review monthly for a period of no less than 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**

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F 441	Continued From page 105 This had the potential to affect all 75 residents who resided in the facility. f) Ensure the used meal trays from other residents were not placed in residents' rooms, while the resident was eating, for one (#1) of five sampled residents, who received their meals in their rooms. This had the potential to affect 26 residents, identified by the DON, who received their meals in their rooms. Findings: 1. On 03/18/14 at 8:45 a.m., an environmental tour of the laundry department was conducted. The laundry staff member was asked about the presence of personal protective equipment. The laundry staff member showed the surveyor a box of disposable gloves and a pair of dusty protective goggles. The staff member was asked about protective gowns or waterproof barriers to be worn when handling soiled items or items from isolation rooms. The staff member reported she was new to the job and did not know about the protective gowns. A housekeeping staff member entered the laundry and reported she was helping the new laundry staff member. The housekeeper was asked about the protective equipment and the handling of items from residents in isolation. The housekeeper stated, "We have never been told we needed items like that before."	F 441		

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F 441	Continued From page 106	F 441		

On 03/20/14 at 10.10 a.m., the ADM was informed of the findings in the laundry department. He reported the items were now in place in the laundry department. He reported the laundry should have protective items for the staff to wear.

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 deficiency, diabetes II, osteoarthrosis, abnormal gait and hypertension.

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 staff member reported the resident was fed meals in his room by staff.

On 03/18/14 at 1:03 p.m., CNA #1 was observed feeding the resident a pureed meal in his room. A partially consumed meal tray was observed on the resident's sink cabinet top.

At that time, the CNA was asked about the partially consumed meal tray. He reported it belonged to another resident and he had brought it in and set it on the cabinet rather than carry it all the way down the hall.

On 03/19/14 at 1:00 p.m., CNA #3 was observed feeding the resident. The resident's tray was

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	375418	A. BUILDING ______ B. WING ______	C 03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 107	F 441		

sitting on the resident's overbed table. Next to the resident's tray was a partially consumed meal tray.

At that time, the CNA was asked about the partially eaten meal tray. She reported another resident had brought it into the room and she had placed it on the overbed table until after she fed the resident.

She was asked if she thought the tray of the other resident was an infection control issue. She stated, "Oh. I know we aren't supposed to do it."

On 03/20/14 at 3:30 p.m., CNA #1 was asked about the infection control issues with bringing another resident's meal tray into the resident's room. The CNA reported he should have taken the tray to the hall cart and not into the resident's room.

3. 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. The resident was totally dependent on staff assistance for bed mobility, transfers, ambulation in a wheelchair, personal hygiene and bathing. The resident was always incontinent of bowel and bladder.

A care plan, dated on 02/02/14, documented the resident was at risk for impairment of skin integrity due to incontinence of bowel and bladder. An intervention listed was for the staff to

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

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SEMINOLE CARE AND REHABILITATION CENTER	1200 WRANGLER BLVD SEMINOLE, OK 74868

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F 441	Continued From page 108	F 441		

assist the resident with incontinent care every two hours and as needed.

On 03/18/14 at 11:15 a.m., CNA #4 and CNA #5 were observed to provide incontinent care for the resident. CNA #4 cleaned the resident's buttocks with wipes and then with the same contaminated gloves placed the resident's clean brief under the resident. Both CNAs had contaminated gloves on when they repositioned the resident with the draw sheet. CNA #5 then touched the resident's pillow with the same contaminated gloves.

On 03/19/14 at 2.20 p.m., the DON was asked if she expected the staff to touch clean items with contaminated gloves during incontinent care. The DON stated, "No."

4. Resident #17 was admitted to the facility on 08/10/12 with diagnoses which included persistent mental disorder, hyperlipidemia, gout and muscle weakness.

A care plan, dated 11/22/13, documented the resident had a potential for progressive self care deficit due to dementia. The care plan documented the resident needed assistance with most of her ADLs. An intervention documented was for the staff to offer assistance to toilet before and after meals and at bedtime.

A quarterly assessment, dated 01/29/14, documented the resident was severely impaired in cognition with moderately severe depression. The assessment documented the resident required one person extensive assistance for transfer, ambulation, dressing, personal hygiene and bathing. The resident was always continent of bowel and bladder.

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	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**

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F 441	Continued From page 109	F 441		

On 03/20/14 at 2:00 p.m., the resident had asked to be taken to the bathroom. CNA #8 and CNA #9 ambulated the resident with a gait belt to the resident's bathroom. CNA #9 wiped the resident's perineal area after the resident had voided. The CNA kept the same contaminated gloves on to pull up the resident's brief and slacks. The CNA then held the gait belt with the same contaminated gloves and ambulated the resident to her recliner. The CNA removed the resident's gait belt with the same contaminated gloves. The CNA then removed her contaminated gloves and applied the gait belt around her waist.

At 2:20 p.m., the DON was asked if she expected the staff to touch clean items with contaminated gloves following perineal care. The DON stated, "No."

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 urine culture and sensitivity report, dated 09/26/13, documented the resident had a UTI with the identified microorganism as E Coli. The physician had wrote on the report to start the resident on an antibiotic therapy for ten days.

The infection control log was reviewed for September 2013. There was no documentation of the resident's UTI being tracked and trended.

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

PRINTED: 04/09/2014
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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

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F 441	Continued From page 110	F 441		

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.

A care plan, dated 03/04/14, documented the resident had an indwelling urinary catheter, as a problem. The goal was for the resident not to have a UTI through the next review date. An intervention listed was for the staff to perform catheter care every shift and PRN.

On 03/18/14 at 2:15 p.m., the resident was observed to be transferred by CNA #5 and #4 with a mechanical lift. The CNAs were observed to come out of another resident's room and enter the resident's room without knocking. The CNAs donned gloves and proceeded to transfer the resident.

Neither CNA washed their hands prior to the procedure.

At 5:45 p.m., ADON #1 was interviewed regarding the lack of the resident's UTI being documented on the September 2013 infection control log. The ADON reported she was new to completing the infection control logs. The ADON reported the infection should have been documented on the infection control log.

On 03/19/14 at 7:30 a.m., the DON was interviewed regarding the lack of handwashing observed prior to rendering care for the resident. The DON reported staff were always supposed to wash their hands and she would in-service the staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINOLE CARE AND REHABILITATION CENTER	**1200 WRANGLER BLVD SEMINOLE, OK 74868**

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F 441	Continued From page 111 6. 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 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 nurse's note, dated 02/21/14 at 5:05 p.m., documented, "Pt readmitted to SNF services...2 new medications Leavaquin 500 mg one daily x 7 days..." A nurse's note, dated 02/21/14 at 8:30 p.m., documented, "...Continue on SNF services for Pneumonia..." An infection control data log, dated February 2014, contained no documentation the resident had been tracked or trended for pneumonia. On 03/18/14 at 5:15 p.m., the DON was shown the nurses' notes and the infection control log and asked if the pneumonia should have been tracked and trended. The DON stated, "Yes." 7. Resident #5 was admitted 07/29/07 with diagnoses which included CVA, paralysis,	F 441		

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
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F 441	Continued From page 112 depressive disorder, TIA, psychosis and Alzheimer's disease. A quarterly assessment, dated 01/15/14, document the resident was severely impaired with cognition, exhibited moderately severe depression and behaviors. The resident required total assistance for transfers, dressing, personal hygiene, and bathing. The resident required one person extensive assistance with eating. The assessment documented the resident was always incontinent of bowel and bladder. On 03/18/14 at 9:30 a.m., the resident was sent to the hospital for evaluation and treatment. On 03/20/14, the resident returned mid afternoon from the hospital. The resident returned with an indwelling urinary catheter. At 3:00 p.m., the urinary drainage bag was observed to be lying on the floor. On 3/21/14 at 10:00 a.m., the urinary drainage bag was again observed lying on the floor. At 10:30 a.m., the DON was interviewed in regard to the urinary drainage bag. The DON reported the urinary drainage bag should not have been on the floor.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456		

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	375418	A. BUILDING ______ B. WING ______	C 03/21/2014

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F 456	Continued From page 113 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure wheelchair arms were in good repair for three (#19, 20 and #21) of 13 sampled residents who utilized wheelchairs. This had the potential to affect 51 residents, identified by the DON, who required the use of a wheelchair. Findings On 03/18/14, during the lunch meal, the following observations were made: Resident #19's right wheelchair arm was cracked and torn. Resident #20's right wheelchair arm was torn. Resident #21's right wheelchair arm was cracked and torn. On 03/21/14 at 10.55 a.m., the ADM was notified of the findings. The ADM reported the wheelchair arms would be repaired.	F 456	1. The wheelchair arms for the identified residents have been repaired or replaced. 2. An audit has been completed to identify any other residents wheelchairs that need repair. 3. A monthly audit will be completed by the maintenance supervisor for continued compliance. 4. Results of the audits will be presented to the facility QA committee for further evaluation and review monthly for a period of no less than 90 days.	04/22/14
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		

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F 465	Continued From page 114 by: Based on observation and staff interview, it was determined the facility failed to: a) Ensure a driveway did not have a large hole full of water. This had the potential to affect seven residents, identified by the DON, who went outside of the facility. b) Ensure eaves were free of peeling paint. This had the potential to affect seven residents, identified by the DON, who went outside of the facility. c) Window screens were in good repair. This had the potential to affect all 75 residents who resided in the facility. Findings On 03/19/14 at 8:30 a.m., an outside environmental tour of the facility was conducted with the maintenance supervisor. A large pothole, approximately five feet by two feet in size in the middle of the main driveway contained standing water. The maintenance supervisor was asked if the pothole was a hazard to residents who could fall into it. The maintenance supervisor reported he was getting bids from companies to repair the pothole. The eaves on the front and east side of the building had peeling paint.	F 465	1. The facility has obtained BIDS for repair of the large hall in the driveway for repair. 2. The identified eves will be repaired. 3. The identified window screens have been repaired or replaced. 4. The maintenance supervisor will complete weekly rounds in order to identify needed repairs with a report to the ADM. 5. Results of the audits will be presented to the facility QA committee for further evaluation and review monthly for a period of no less than days.	04/22/14

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F 465	Continued From page 115 Window screens for rooms # 2, 3, 5, 6, 8 and #9 had holes or tears in them, which could allow pests to enter the building. The maintenance supervisor reported the areas would be addressed. On 03/20/14 at 10:10 a.m., the ADM was notified of the findings. He reported the areas would be repaired.	F 465		
F 502 SS=E	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure laboratory tests were completed as ordered by the physician for one (#7) of ten sampled residents who had laboratory tests ordered by the physician. This had the potential to affect all 75 residents who resided in the facility. Findings: Resident # 7 was admitted on 09/20/13 with numerous diagnoses which included paraplegia, chronic pain, s/p MI, anxiety state and HTN. A physician's order, dated 12/06/13, documented, "CBC, Chem 7 Q 4 MONTHS - April/Aug/Dec."	F 502	1. The lab for resident #7 has been obtained. 2. An audit has been completed to ensure that labs have been drawn as ordered. 3. A weekly audit will be completed by the DON or designee going forward to ensure compliance. 4. An in-service will be completed with the nursing staff on the requirements and the lab process. 5. Identified non-compliance will result in one on one education and progressive discipline. 6. Results of the audits will be presented to the facility QA committee for further evaluation monthly for a period of no less than 90 days.	04/22/14

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F 502	Continued From page 116 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. The resident's medical record contained none of the physician ordered laboratory tests. On 03/18/14 at 4:30 p.m., ADON #2 was interviewed regarding the physician ordered laboratory tests. The ADON reviewed the resident's medical record. The ADON reported the facility must have missed getting the tests and she would contact the physician to obtain new orders.	F 502		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident, a record of the resident's assessments; the plan of care and services provided, the results of any preadmission screening conducted by the State; and progress notes.	F 514		

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F 514	Continued From page 117 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to consistently document intake and output amounts for two (#7 and #1) of three sampled residents, who required intakes and outputs be documented. This had the potential to affect eight residents, identified by the DON, who required intakes and outputs be completed. Findings: Resident # 7 was admitted on 09/20/13 with numerous diagnoses which included paraplegia, chronic pain, s/p MI, anxiety state and HTN. A computerized physician's order, with an original order date of 10/24/13, documented, "16 /F (French) indwelling Foley catheter-Complex neurogenic bladder." A January 2014 Comprehensive Intake and Output Record had 93 opportunities to document the resident's intake, 53 opportunities were blank. Of the 93 opportunities to document the resident's output, 53 opportunities were blank. A February 2014 Comprehensive Intake and Output Record had 84 opportunities to document the resident's intake, 39 opportunities were blank. Of the 84 opportunities to document the resident's output, 39 opportunities were blank. An annual assessment, dated 03/05/14, documented the resident was cognitively intact and demonstrated mild depression. The resident	F 514	1. Staff have been educated on the requirements for completion of I&O's. 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 disciplinary action. 4. Results of the audits will be presented to the facility QA committee monthly for a period of no less than 90 days.	04/22/14

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F 514	Continued From page 118 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. A care plan, dated 03/12/14, documented the resident was at risk for her fluid output to exceed her fluid intake, as a problem. The goal was for the resident to maintain appropriate fluid volume levels. An intervention listed was for the staff to perform and record the resident's intake and output every shift. A March 2014 Comprehensive Intake and Output Record had 54 opportunities to document the resident's intake, 12 opportunities were blank. Of the 54 opportunities to document the resident's output, 12 opportunities were blank. On 03/19/14 at 7:30 a.m., the DON was interviewed regarding the lack of consistent documentation of the resident's intake and output. The DON reported the staff may have written the intakes and outputs in another area. The DON reported the licensed staff should have ensured the comprehensive intake and output records were complete. The DON reported she would in-service the staff. 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 deficiency, diabetic II, osteoarthrosis, abnormal gait, hypertension and neurogenic bladder. An annual assessment, dated 02/12/14,	F 514		

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F 514	Continued From page 119 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. The Comprehensive Intake-Output Records for January 2014 were reviewed. The record did not contain the urinary output amounts on 01/09/14 for the day shift or on 01/30/14 for the evening shift. The Comprehensive Intake-Output Records for February 2014 were reviewed. The record did not contain the urinary output amounts on 02/05/14, 02/07/14, 02/08/14 and 02/28/14 for the day shift. The Comprehensive Intake-Output Records for March 2014 were reviewed. The record did not contain the urinary output amount on 03/16/14 for the evening shift. On 03/20/14 at 10:35 a.m., the DON was notified of the gaps in urinary output amounts for the resident. She stated, "We have been trying to fix that."	F 514		