PRINTED: 04/09/2014 FORM APPROVED OMB NO. 0938-0391

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

CENTER	S FOR MEDICARE 8	MEDICAID SERVICES				NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	100	IPLE CONSTRUCTION		ATE SURVEY
		375418	B. WING			C 03/21/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		03/21/2014
				1200 WRANGLER BLVD		
SEMINOLE	E CARE AND REHABIL	ITATION CENTER		SEMINOLE, OK 74868		
0(0) ID					N OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	EACTION SHOULD BE TO THE APPROPRIATE SIENCY)	(X5) COMPLETIOI DATE
F 309	Continued From page	ae 59	F3	909		
		hest level of practicable				
		vironment that enhances each				
1		life in the scope of a long				1
-	term care center.					
		f and resident are required to				
	follow the procedure	listed below.	0			
	0 The Lineard	l				
		Nurse or designee documents dent's physician and				
		Change in condition,				
		ind/or decline in physical or				
		sident refusal of care or				
	services and Unusu					
		admitted to the facility on				
	20 10 10 10 10 10 10 10 10 10 10 10 10 10	oses which included nbosis arteries lower				
		ncephelopathy, edema,				
		betes mellitus type II, Hep. C,				
1		, Alzheimer's disease, renal				
	failure and CHF.	<ul> <li>or ne electronectomonic 25. Aceste sourcester / Controponents</li> </ul>				
		1/27/13, documented the				
1		ticoagulant therapy related to	9			
		oblem. A goal was for the				
	resident's PT/INR to					
		as for the staff to observe the	1			
		bleeding such as blood in				
1		se, decreased blood d energy level and abdominal				
	pain.	chergy level and abdominal				
	The sere plan also dee	logumented the resident mer				
	have incontinence of	focumented the resident may				
		ose) use, as a problem. A				
		ident to have decreased				
	Concerning analysis second in second	ea. Interventions listed were				
	for the staff to notify	the physician as needed and				
	to record the resider	nt's bowel movement for size				
RM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: KVII	11	Facility ID NH6706	If continuation sh	eet Page 60 of

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Facility ID NH6706

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE COMF	SURVEY
		375418	B. WING				C /21/2014
NAME OF P	ROVIDER OR SUPPLIER		- <b>L</b>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
SEMINOLI	E CARE AND REHABILI	TATION CENTER			WRANGLER BLVD INOLE, OK 74868		
	CLIMMADY CT						1
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	Continued From page	e 60	F	309			i.
	and consistency and to the licensed nurse.	to report any abnormalities					
	A quarterly assessme	ant dated 12/20/13					
1	documented the resid						Ì
		on, required extensive					
0		son for bathing, limited					
1	assistance of one per	for transfer, bed mobility,					
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	d hygiene and was always					
		d bladder. The resident					
		ulant medication for seven					1
	days of the seven day	y look back period.					
	A computerized phys	ician's order. dated					
	02/01/14, documente	d, "Coumadin (Warfarin					
2		by mouth (Oral) -Evening					
1	Shift Everyday: give o	-					
		/arfarin Sodium) 2.5 MG ) -Evening Shift Everyday:					
	give one tablet daily t			8			
	Coumadin orders had	an original start date of					
	11/05/13. "PT INR						
	weeks-Evening Shift	Every 14 days"					
	A computerized physi	cian's order, dated	e				
	02/06/14, documente	d, "Hold Coumadin until					
1	021014 Recheck pt/ir	nr on that date."					
	A MAR, dated Februa	ary 2014, documented the					
		held from 02/06/14 through					
]	02/10/14.						
1	A Change Of Conditio	on Communication form,					
	-	00 (2:00 p.m.), documented,					
		arted on 02/07/14" A					
		ack of the form documented,					
	"Received report from several black tarry str	oresident concerning					
]	7(02-99) Previous Versions Obs				ID NH6706 If contu		ł

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 0		ISTRUCTION		E SURVEY IPLETED
		375418	B. WING			0.	C 3/21/2014
					ET ADDRESS, CITY, STATE, ZIP CODE WRANGLER BLVD		<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
SEMINOLI	E CARE AND REHABILIT			SEMI	NOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	onset of blk stools rep before this date. Res worry anyone." ABD hyperactive BS x 4 qu The Change Of Cond documented, in the a the physician had bed 1400 (2:00 p.m.). The nurses' notes wit contained no other do tarry stools or physici A 24 hour report/char 02/09/14, documente deleted]blk stool" The nurses' notes, da documentation the re been obtained. A Change Of Condition dated 02/10/14, docu form, "Hgb 5.1 Hct started on 02/09/14 02/06" A nurse's n documented, "Receiv [sic] residents black t order for STAT CBC, this order. Obtained x 1 stick. Resi tol we Specimen sent to PC	borts initially started 1-2 days is states "I didn't want to flat soft nontender c uads." htton Communication form rea for physician notification, en notified on 02/09/14 at the same above date boumentation of the black ian notification. hge of condition report, dated d, "[Resident name ated 02/09/14, contained no esident's vital signs had on Communication form, mented on the front of the 17.6 black tarry stools, coumadin held since tote on the back of the form red call from PCP reguarding arry stools yesterday. Rec'd PT/INR. Spoke c resi about from RAC [right antecubital] II, pressure applied. P office. 1040 (10:40 a.m.) received order to send resi	F	309			
		lition Communication form entation the resident's vital ned.					

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		FIPLE CONSTR			ATE SURVEY DMPLETED C
	ROVIDER OR SUPPLIER	375418	B. WING STREET ADDRESS, CITY, STATE, ZIP 1200 WRANGLER BLVD SEMINOLE, OK 74868		NGLER BLVD	03/2 CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 309		e 62 ated 02/10/14, contained no esident's vital signs had	F	309			
	On 02/10/14 at 11:35 admitted to [Hospital was diagnosed with ' Quadrant, Hematoch Anemia-blood loss an	a.m., the resident was name deleted] where she Abdominal Pain, Left Lower ezia-GI bleed on Coumadin, nd macrocytic, Hypovolemia. lent was transferred from					
	dated 02/10/14, docu COMPLAINT: Histor stoolsThe stool guaiac-positiveASS Gastrointestinal blee	eatment. om [hospital name deleted], imented, "CHIEF y of GI bleed, tarry SESSMENT AND PLAN: 1. d. At this time, we will acked RBCs. We will check				,	
	she had notified the p the resident's comple LPN stated, "By fax t that's what he prefers "The resident told me for a couple of days." thought she should h	a.m., LPN # 2 was asked if obysician on 02/09/14 about int of black tarry stools. The o the physician's office, s." The LPN then stated, e her stool had been that way ' The LPN was asked if she ave called the physician . The LPN nodded her					
	the resident having b reported she had ass	was questioned in regard to lack tarry stools. The CNA isted the resident with rent to the hospital the first					

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

STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ING	DNSTRUCTION	(X3) DATE COMP	LETED
	ROVIDER OR SUPPLIER	375418	B. WING	STR 1200	EET ADDRESS, CITY, STATE, ZIP CODE D WRANGLER BLVD MINOLE, OK 74868	03/	21/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XI	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	not remember the name At 10:30 a.m., CNA # to the resident having CNA reported the resident having CNA reported the resident CNA reported the resident On 03/21/14 at 8:45 at questioned in regard and vital signs not be resident. The DON with the the should have included stated, "Yes they should stated, "Yes they should days." The DON reported, the incident had a coachi 02/14/14, due to the p in a timely manner and There was no in-serve the incident to ensure aware of the facility p physician in a timely of monitoring and interver resident's condition. 2. Resident #8 had b on 09/01/11. The resident and a strop	ck stools. The CNA the charge nurse but could me of the charge nurse. 4 was questioned in regard black tarry stools. The ident's stools were dark. e had told the charge nurse. a.m., the DON was to the lack of assessment ing completed for the ras asked if the assessment vital signs. The DON build have been done on both the nurse responsible for the ng report completed on obysician not being notified ad the lack of assessment. ice completed at the time of the staff had been made olicy for contacting the manner and for assessing,	F	309			
	"Focus has a potential alter 67(02-99) Previous Versions Obs	ration in Nutrition Status R/T			y ID NH6706 If cont	inuation sheet	· · · · · · ·

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI !! 7			NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER.		IPLE CONSTRUCTION		TE SURVEY MPLETED
		375418	B. WING			C 3/21/2014
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		5/21/2014
				1200 WRANGLER BLVD		
SEMINOL	E CARE AND REHABILI	TATION CENTER		SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From page short term memory edema history and di	has a weight fluctuation R/T	F	309		
	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"					
	assistance with trans and bathing, required hygiene, required set	dent required extensive fers, ambulation, dressing a moderate assistance with t up help with eating, had no mities and was occasionally				
	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.	dent required extensive fers, dressing and bathing, nce with hygiene, required th eating, had ROM deficits ktremities and was always				
3/ Pro re re Th be	3/3/14-182.6, pt wt to	nented, "3/6/14 pt wt on oday on 3/6/14 was 190.0 ohysician) notified via Fax P lab drawn awaiting				
	converse representation contractions of the	vas reviewed. No BMP had ere was no follow-up to the 3/06/14.				

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						OMB NO. 0938-039 (X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1.1				TE SURVEY MPLETED	
		375418	B. WING				C 3/21/2014	
NAME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		0/2//2014	
					WRANGLER BLVD			
SEMINOLI	E CARE AND REHABILI	TATION CENTER		SEM	INOLE, OK 74868			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 309	Continued From page	65		309				
1 303			F	509				
ĺ		p.m., the DON was notified						
		n 03/06/14, with no follow-up. se should have followed up						
	on the request.	se should have followed up						
	2 Desident #Current							
		admitted with diagnoses anxiety state, diabetes						
	mellitus type II and le							
	A quarterly assessme	ent. dated 01/20/14.						
		lent was severely impaired						
i		sorganized thinking and						
	exhibited moderately	severe depression with						
		lent was totally dependent						
		r bed mobility, transfers,	1					
		Ichair, personal hygiene and		}				
	bowel and bladder.	t was always incontinent of						
	A care plan, dated or	02/02/14, documented the						
	resident had diabetes	s type II, as a problem. A		ļ			l,	
		vas to have no S/S of						
		oglycemia. An intervention		l				
	was for the staff to ob ordered.	otain blood sugars as	ļ					
		ated 02/05/11 decomparted						
		lated 03/05/14, documented vas to be obtained on					1	
		and Friday daily. Prior to					ł	
		an's order documented the					Ĩ	
	and the second s	ined BID before meals.					1	
	The March 2014 com	puterized physician's orders						
	documented the resid							
		S was below 60 and for the					):	
		e food/drink. If unable to	1					
	feed or the FSBS ren							
	reeding or giving Glue	cagon, notify the physician.						

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Facility ID NH6706

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0.0		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		IPLE CONSTRUCTION		OATE SURVEY
		375418	B. WING		_	C 03/21/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		
SEMINOL	E CARE AND REHABILI	TATION CENTER		1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER' (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE INCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 309	<ul> <li>FSBS levels were hig physician. There were set or obtained from the resident's care.</li> <li>On 03/19/14 at 2:20 p she expected the respected the respected the respected the respected the respected the respected the physician DON stated, "Yes, she parameters."</li> <li>Resident #9 was a numerous diagnoses atrial fibrillation, deprecent and demonstrated more resident required exterpersons to transfer an required extensive as perform personal hyg resident did not ambut The resident required person to move on an A computerized phys 03/01/14, documented, ". 90."</li> </ul>	had not indicated, if the gh, when to notify the re no high level parameters the physician to direct the o.m., the DON was asked if ident to have a upper FSBS which indicated when n for care directives. The bould have upper admitted on 04/26/13 with which included CVA, HTN, essive disorder and diabetes ent, dated 11/27/13, dent was cognitively intact oderate depression. The ensive assistance of two nd dress. The resident ssistance of one person to jiene and to bathe. The ulate in the room or corridor. I limited assistance of one nd off the unit. ician's order, dated d the resident was to 0 mg. daily for HTN. The hold if SBP is less than	F	309		
t		arameters in which staff was n, in the resident's medical				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	<u> </u>				NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		riple cons <sup>.</sup>			te survey Mpleted
		375418	B. WING				C 3/21/2014
	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RANGLER BLVD		
GEMINOE				SEMIN	OLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	which the staff was to DON reported the fac parameters and she 5. Resident #7 was a diagnoses which incl anxiety state and HT A computerized phys order date of 09/20/1 Tartrate 25 MG Table Everyday: give one ta give one tablet [betw less than 90 HTN." There were no B/P p licensed nurses were documented in the resident and demonstrated m did not ambulate and the seven day look b required extensive as dress, perform perso resident was always an indwelling urinary A care plan, dated 03 resident had HTN, as for the resident to not	a.m., the DON was g blood pressure readings in o notify the physician. The cility should have B/P would contact the physician. admitted on 09/20/13, with uded chronic pain, s/p MI, N. ician's order, with an original 3, documented, "Metoprolol to By mouth, (Oral)-Day Shift ablet [between] 6a-9a and een] 6p-9p: hold if SBP is arameters in which the e to notify the physician, isident's medical record. nt, dated 03/05/14, dent was cognitively intact ild depression. The resident was not transferred during ack period. The resident sistance of one person to nal hygiene and bathe. The incontinent of bowel and had catheter. B/12/14, documented the is a problem. The goal was t complain of headaches, An intervention listed was the resident's B/P as protocol.	F	309			

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Facility ID NH6706

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	IO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			CONSTRUCTION		TE SURVEY MPLETED
		375418	B. WING			0	C 3/21/2014
NAME OF P	ROVIDER OR SUPPLIER	<b></b>			REET ADDRESS, CITY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI	TATION CENTER		00000	00 WRANGLER BLVD EMINOLE, OK 74868		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	regarding the resider in which to notify the reported she would of parameters. 6. Resident #3 was a which included hyper and diabetes. A quarterly assessme documented the resis impairment, mild dep The resident was tota assistance for transfe personal hygiene and The March 2014 com documented: "Losartan Potassium dailyhtn Lasix20 MG Tablet Norvasc5 MG tablet systolicUNSPECIF HYPERTENSION" The physician's orde in which to notify the pressure readings. On 03/19/14 at 10:00 the resident should h parameters in which DON reported the ph would set parameters each resident and ha for the resident at thi	nt not having B/P parameters physician. The DON contact the physician for B/P admitted with diagnoses rtension, Alzheimer's disease ent, dated 01/08/14, dent had severe cognitive pression and no behaviors. ally dependent on staff ers, dressing, eating, d bathing. nputerized physician's orders 100 MGgive one tab EverydayHTN/EDEMA et1 PO daily-hold if B/P <90 IED ESSENTIAL rs contained no parameters physician of abnormal blood	F	309			

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			(70) 10				D. 0938-039 SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILD				SURVEY
							С
		375418	B. WING		· · · · · · · · · · · · · · · · · · ·	03	/21/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI	ATION CENTER			1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	which included cardid disorder, epilepsy and A Change Of Condition dated 01/25/14 at 7:4 standing @ N.S. (nur by other res that res '' turned around obs. R cup in hand angled to on shirt. Writer went f skin & assisted to rm pink area to mid [upp blistering 0800 (8:00 a.m.) Area blistering 0900 (9:00 a.m.) Ass 1000 (10:00 a.m.) Ass 1000 (10:00 a.m.) Ass pain discomfort. Cool A nurse's note, dated documented the resid area to her left breast documentation of ass the burn area. A Non-Pressure Wou Documentation Form 01/25/14. The next ef documented, "Resolv skin assessment of th There was no assess or appearance for 16 A comprehensive ass	admitted with diagnoses ovascular disease, bipolar d diabetes. on Communication form, 0 a.m., documented, "Writer ses' station). was informed spilled her coffee' Writer es. in geri chair [with] coffee oward self [with] lg. wet spot to res. and lifted clothing off Res. has 6 x 3 cm light er left] breast. [No] a remains light pink [no] essment unchanged sessment unchanged [No] compress applied" 01/26/14 at 11:30 a.m., dent had a light fading pink t. There was no other sessment or monitoring of nd And Skin Condition documented the area on intry, dated 02/12/14, red." There was no weekly he area.	F	309			
	impairment, moderate				acity ID NH6706		

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Facility ID NH6706

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION	(X3) DATE		
	D PLAN OF CORRECTION IDENTIFICATION NOMBER		G	COMP	COMPLETED	
375418			- <u></u>		2	
	375418	B. WING _			- 21/2014	
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
		1	1200 WRANGLER BLVD			
CARE AND REHABILI	ATION CENTER		SEMINOLE, OK 74868			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
behaviors. The resid staff assistance for be transfers, dressing ar resident had range of bilateral upper and lo On 03/20/14 at 3:00 p the burn site should h ADON replied, "Yes."	ent was totally dependent on ed mobility, locomotion, id personal hygiene. The motion impairment of wer extremities. o.m., the ADON was asked if ave been monitored. The					
A resident who is una daily living receives the	ble to carry out activities of ne necessary services to					
by: Based on observatio interview, it was deter ensure ADL assistance provided for one (#6) who required assistant This had the potential identified by the DON with personal hygiene Findings: Resident #6 was admincluded HTN, anxiettype II and left AKA.	n, record review and staff mined the facility failed to be with nail care was of ten sampled residents nee with personal hygiene. I to affect 72 residents, , who required assistance b.		<ul> <li>completed.</li> <li>2. An audit has been completed other residents that required 3. A weekly audit will be control to ensure compliance by the 4. Staff have been educated of for ADL care.</li> <li>5. Identified non-compliance on one education and progres 6. Results of the audits will be facility QA committee month</li> </ul>	ted to identify nail or ADL care. mpleted ongoing DON or designee. on the requirement e will result in one ssive discipline. be presented to the hly for a period of	04/22/14	
	SUMMARY ST (EACH DEFICIENC' REGULATORY OR I Behaviors. The residu staff assistance for be transfers, dressing an resident had range of bilateral upper and low On 03/20/14 at 3:00 p the burn site should h ADON replied, "Yes." 483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives th maintain good nutritic and oral hygiene. This REQUIREMENT by: Based on observatio interview, it was deter ensure ADL assistant provided for one (#6) who required assistant This had the potential identified by the DON with personal hygiene Findings: Resident #6 was adm included HTN, anxiety type II and left AKA.	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 70       F 3         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 extremitites.       F 3         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 3         483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS       F 3         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.       F 3         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.       F	EARE AND REHABILITATION CENTER       SEMINOLE, OK 74868         SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACID REGULATORY OR LSC IDENTIFYING INFORMATION)       ID (EACH CORRECTIVE ACID (EACH CORRECTIVE (EACH COR	Image: Construction of the constend on the construction of the construction of the	

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

Facility ID NH6706

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CON	ISTRUCTION		E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A BUILDI	NG	<u></u>	COM	PLETED
		375418	B. WING			C	
	ROVIDER OR SUPPLIER	070410		STREE	T ADDRESS, CITY, STATE, ZIP CODE	03	/21/2014
					WRANGLER BLVD		
SEMINOLI	E CARE AND REHABILI	ITATION CENTER	2		NOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 312	Continued From pag	le 71	F	312			
	C 18	dent was severely impaired					
		isorganized thinking and		1			
		severe depression with					
		dent was totally dependent on					
		ed mobility, transfers,					
	ambulation in a whe	elchair, personal hygiene and					
	bathing.						
	On 03/18/14 at 11.4	5 a.m., the resident's					
	fingernails were obs						
		under the nails on both					
	hands.						
	On 03/19/14 at 11:1	5 a.m., CMA #1 was asked to					
		ne resident's fingernails. Both					
	hands had dark colo						
		A was asked who would					
	(04100-040	nails. The CMA reported the					
		sident's nails with bathing.					
		e surveyor the resident's bath cated the resident should					
	(G(GG) 8 8 8 8	wer on the previous evening					
		orted the resident's fingernails					
	needed to be cleane						
	At 2:20 p.m., the DO	N was informed of the					
		which needed to be cleaned.					
		ne resident's fingernails					
	should be kept clean	1.					
F 314	483.25(c) TREATME		F:	314			
SS=E	PREVENT/HEAL PR	RESSURE SORES					
	Based on the compr	ehensive assessment of a					
		must ensure that a resident					
		ty without pressure sores					
		essure sores unless the					
		ondition demonstrates that					
	they were unavoidab	ble; and a resident having					1

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES		_		OMB NC	0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY
		375418	B. WING				C 21/2014
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI	TATION CENTER			1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	pressure sores recei	ves necessary treatment and healing, prevent infection and	F	314			
	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			<ol> <li>The assessment, monitoring ,docton notification, and treatment orders has obtained for #2,#7,#8 and #17.</li> <li>An audit was completed to ensure other residents skin issues have been 3. A weekly audit will be completed</li> </ol>	ve been that all addressed	04/22/14	
	notification or treatmost pressure ulcers for for				<ul><li>DON or designee ongoing to ensure compliance.</li><li>4. Identified non-compliance will res on one in-servicing and progressive of</li></ul>	continued ult in one	
		al to affect 10 residents, N, with pressure ulcers.			5. Nursing staff have been educated regulatory requirements regarding pr areas/skin.		
		e ulcer was assessed and 15) of six sampled residents d a pressure ulcer.			6. Results of the audits will be present facility QA committee monthly for a no less than 90 days for further evalu	period of	
		al to affect 10 residents N, with pressure ulcers.			review.		
	Findings.						
	on 09/01/11. The res diagnoses including	been admitted to the facility sident had current medical abnormal gait, muscular ohy and hypothyroidism.					
	assistance with trans required total assista limited assistance wi	ent, dated 02/26/14, dent required extensive fers, dressing and bathing, nce with hygiene, required th eating, had ROM deficits xtremities and was always					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	can caused by		CONSTRUCTION		E SURVEY IPLETED
		375418	B. WING			0:	C 3/21/2014
334 (2009) 10 11 62	ROVIDER OR SUPPLIER	TATION CENTER		12	REET ADDRESS, CITY, STATE, ZIP CODE 00 WRANGLER BLVD EMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	following: "Focus has a potential for s mobility and occasion Goals will be free of skin i over the next review. will be free of press review. 06/11/14 Interventions Notify L.N. (licensed or redness Report new open are A review of the reside completed. There was pressure ulcer. A Braden Scale-For F Risk, dated 02/10/14, was high risk for press On 03/19/14 at 4:30 p for a list of residents At that time, ADON # residents with pressu name was on the list. A Pressure Ulcer Dood documented, "03/12/	and bladder. n 01/02/13, documented the skin Alteration r/t [decreased] hal incontinence of bladder. rritation and skin redness 06/11/14 sure sites over the next nurse) of any skin irritations as to LN." ent's medical record was as no documentation of a Predicting Pressure Sore documented the resident usure ulcers. 0.m., the facility was asked with pressure ulcers. 2 presented a list of re ulcers. Resident #8's	F	314			

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Facility ID NH6706

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 m m			TE SURVEY MPLETED
			A, BUILDING	)		с
		375418	B WING		0	3/21/2014
	ROVIDER OR SUPPLIER	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	SEMINOLE, OK 74868 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 314	At 4:50 p.m., LPN #1 was asked about the reported a CNA had in had filled out the form She was asked if the a treatment order had had documented the anywhere else. She in any of the above. She been doing for the ar- been applying barrier The LPN also reported incident report, called treatment and docum nurses' notes. A nurse's note, dated "PCP notified that rest to coccyx measuring 03/12/14, He was als now healed. Did rect for redness-Family an On 03/20/14 at 10:15 buttocks and coccyx areas were noted. On 03/20/14 at 10:30 about the pressure up She reported the nur- physician and obtained 2. Resident #7 was a numerous diagnoses	<ul> <li>, who had signed the form, pressure sore. She identified the area and she in.</li> <li>physician had been notified, d been obtained and if she area in the nurses' notes or reported she had not done he was asked what she had ea. She reported she had not done he was asked what she had ea. She reported she had receam to the area.</li> <li>ed she should have made an a the doctor, obtained a hented the area in the</li> <li>103/19/14, documented, sident had small open area approx 2 cm x 2 cm on so notified that this area is eive PRN order for Zguard ware."</li> </ul>	F 31	4		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION		TE SURVEY
		375418	B. WING		с	
NAME OF D	ROVIDER OR SUPPLIER	3/ 54 16				3/21/2014
	E CARE AND REHABILI	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 314	resident was at risk f as a problem. The g skin to remain intact intervention listed was changes in the reside immediately. An annual assessme documented the resid and demonstrated m did not ambulate and the seven day look b required extensive as dress, perform perso resident was always an indwelling urinary On 03/20/14 at 9:50 to perform indwelling wound care. The LP procedure and assist A open area was obs coccyx. The LPN sta covered the resident measuring tape. The surveyor told the open area to her cocc "No, they found that cleaning me up." CN resident's roommate. The CNA stated, "Ye area yesterday even name deleted, LPN #	or alteration in skin integrity, oal was for the resident's and free of redness. An as for the staff to report any ent's skin to the physician and the dog of the physician and the dog of the physician and the staff to report any ent's skin to the physician and the staff to report any ent's skin to the physician and t	F3			

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

FICATION NUMBER.	0.02 - 60	PLE CONSTRUCTION		E SURVEY PLETED
375418	B. WING		03	C /21/2014
NTER		STREET ADDRESS, CITY, STATE, ZIP CO 1200 WRANGLER BLVD SEMINOLE, OK 74868	ODE	
RECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
X 0.3 cm and e II and she would ent orders. vas reviewed. o reflect the he wound. The were reviewed the ulcer which on the previous rse and DON were ent's ulcer. The cer should have bician should have bician should have bitained, when the or attempted to interview and I attempts. the facility on included es lower thy, edema, us type II, Hep. C, is disease, renal cumented the rations in skin was for the nd skin irritation or	F 3	14		
		375418     B. WING       NTER     ID       DEFICIENCIES     ID       RECEDED BY FULL     PREFIX       YING INFORMATION)     F 3:       t's room and     F 3:       t's room and     F 3:       t's room and     F 3:       vas reviewed.     F 6:       o reflect the     F 3:       he wound. The     Were reviewed       the ulcer which     F 3:       or the previous     F 3:       rse and DON were     F 3:       ent's ulcer. The     F 3:       cer should have     Sician should have       btained, when the     F 3:       or attempted to     F 3:       o interview and     I attempts.       o the facility on     F 3:       o the facility on <td>375418     B. WING       STREET ADDRESS, CITY, STATE, ZIP C 1200 WRANGLER BLVD SEMINOLE, OK 74868       DEFICIENCIES RECEDED BY FULL VING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) (EACH CORRECTIVE ACT) (EACH CORRECTIVE ACT) (EACH CORRECTIVE ACT) DEFICIENC       X 0.3 cm and e II and she would ent orders.     F 314       X's room and X 0.3 cm and e II and she would ent orders.     F 314       rese and DON were ent's ulcer. The cer should have bician should</td> <td>375418     B. WING    </td>	375418     B. WING       STREET ADDRESS, CITY, STATE, ZIP C 1200 WRANGLER BLVD SEMINOLE, OK 74868       DEFICIENCIES RECEDED BY FULL VING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) (EACH CORRECTIVE ACT) (EACH CORRECTIVE ACT) (EACH CORRECTIVE ACT) DEFICIENC       X 0.3 cm and e II and she would ent orders.     F 314       X's room and X 0.3 cm and e II and she would ent orders.     F 314       rese and DON were ent's ulcer. The cer should have bician should	375418     B. WING

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u>VO. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	STRUCTION		TE SURVEY MPLETED
		375418	B. WING			c	C )3/21/2014
NAME OF P	ROVIDER OR SUPPLIER	<b></b>		2	TADDRESS, CITY, STATE, ZIP CODE	<u>_</u>	
SEMINOLI	E CARE AND REHABILI				IOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 314	nurse any bruising, b open areas and perfr assessments per pro- A quarterly assessm documented the resi impaired with cogniti assistance of one per assistance of one per required supervision ambulation, eating a continent of bowel and A re-admission nursi 03/08/14, documented Skin/Wound conditio coccyx area and rasis A nurse's note, dated documented, "Readr amt. redness presen The physician had nur resident's return to the pressure sore to the There was no physic the Stage I pressure A nurse's note, dated documented, "inco	bleeding, redness, irritation or form weekly skin botocol. ent, dated 12/20/13, dent was moderately on, required extensive inson for bathing, limited inson for dressing and for transfer, bed mobility, and hygiene and was always and bladder. Ing assessment, dated ed, "13. Integumentary 1. In present. yes Stage I to the to sacral area" d 03/08/14 at 11:00 a.m., mitted to facilitySacrum c Ig t area blanches sluggishly" bot been notified of the me facility or the new Stage I coccyx area. d 03/13/14 at 1:30 p.m., ntinent care provided. in area. Notified PCP, rec'd	F	314			
		sician's order, dated ed, "Z guard to peri area Q oays-Evenings-Nights					
RM CMS-256	7(02-99) Previous Versions Ob	solete Event ID KVII1	14	Enality ID	NH6706	continuation she	of Daga 78 of

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Facility ID NH6706

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AND PLAN OF	(EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 78 ian's order obtained at that		NG STR 120 SEI X	ONSTRUCTION EET ADDRESS, CITY, STATE, ZIP CODE O WRANGLER BLVD MINOLE, OK 74868 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION LD BE	C (X5) C (X5) COMPLETION DATE
SEMINOLE (X4) ID PREFIX TAG	E CARE AND REHABILI SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page There was no physic time for treatment to	TATION CENTER TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 78 ian's order obtained at that	ID PREFI TAG	120 SEI X	0 WRANGLER BLVD MINOLE, OK 74868 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	ION LD BE	(X5) COMPLETION
SEMINOLE (X4) ID PREFIX TAG	E CARE AND REHABILI SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page There was no physic time for treatment to	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 78 ian's order obtained at that	PREFI	120 SEI X	0 WRANGLER BLVD MINOLE, OK 74868 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	ION LD BE	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENC REGULATORY OR Continued From page There was no physic time for treatment to	WINDER BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 78 ian's order obtained at that	PREFI	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
F 314	There was no physic time for treatment to	ian's order obtained at that	F	214			
	form, dated 03/14/14 had a "10.0x6.0 Stag blanchable" A weekly pressure ull documented the resid coccyx area treatment A treatment sheet, da documented the resid to the coccyx area fro 03/20/14. On 03/20/14 at 8:50 at to perform wound can area. The LPN clear wipe and then applied At that time, the LPN area had been open. was bright red when the hospital and the r been measuring.	cer documentation report , documented the resident re I to coccyx area easily cer report, dated 03/14/14, dent had a "10.0cmx6.0 to nt Z guardHealing." ated March 2014, dent received no treatments om 03/08/14 through a.m., LPN #2 was observed re to the resident's coccyx ned the coccyx area with a d Z guard. was asked if the coccyx The LPN reported the area the resident returned from redness was what they had		514			
	corporate RN were so the re-admission note had been notified. The the notes, so it doesn	a.m., the DON and the hown the nurse's note and e and asked if the physician he DON stated, "It's not in n't look like it." The DON e physician should have been tated, "Yes."					

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Event ID. KVII11

Facility ID NH6706

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PRINTED: 04/09/2014 FORM APPROVED

		MEDICAID SERVICES			OMB NO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		G		E SURVEY
		375418	B. WING		C 03/21/201	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 1200 WRANGLER BLVD SEMINOLE, OK 74868		5/21/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIC DATE
F 314	staff to obtain order area pressure sore. 4. Resident #15 wa 12/30/13 with diagn pressure ulcer lowe hip and end stage ro A care plan, dated, 1 resident, on admit S hip ulcers, as a prot Stage II ulcers to im review. Interventior ordered and to mea An admission asses documented the res with cognition, totall mobility, dressing, e The resident was all bladder. The residen stage II pressure ulce A Non-Pressure Wo Documentation form right heel. "12/30/13 size 4 x 0 surrounding skin co tissue/wound edges 01/05/14 size 7.5 x surrounding skin co tissue/wound edges There was no docum	s for treatment to the coccyx The DON stated, "Yes." as re-admitted to the facility on oses which included dialysis, r back stage II, pressure ulcer enal disease. 12/30/13, documented, the Stage II coccyx, gluteal and R olem. A goal was for the oprove or resolve by the next as listed were to treat as sure weekly. ssment, dated 01/08/14, sident was severely impaired y dependent for transfer, bed eating, hygiene and bathing. ways incontinent of bowel and int was admitted with three cers. bund and Skin Condition in documented a site to the $1.5 \times 0$ , pink wound bed, pink lor and pink surrounding 5. $5 \times 0$ , pink wound bed, pink lor and pink surrounding 5. mentation the wound had heasured on 01/12/14.	F 3			

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Facility ID NH6706

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TATELACHT		MEDICAID SERVICES				<u>10. 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION		TE SURVEY MPLETED
		375418	B. WING			C 3/21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		5/21/2014
SEMINOL	E CARE AND REHABILI			1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 314	documented a site to "12/30/13 Stage II, si Serosanguineous exi amount of exudate. 01/05/14 Stage II, siz Serosanguineous exi amount of exudate." There was no docum been assessed or me A Pressure Ulcer Doo documented a site to "12/30/13 Stage II, si Serosanguineous exi amount of exudate." 01/05/14 Stage II, siz Serosanguineous exi amount of exudate."	the coccyx: ze $6 \times 4 \times 0.2$ , udate, slight odor, moderate ze $10 \times 4 \times 0.2$ , udate, slight odor, large mentation the wound had easured on $01/12/14$ . cumentation form the gluteal crease: ze $4 \times 2 \times 0.2$ , udate, no odor, small ze $3.8 \times 3 \times 0.2$ , udate, no odor, small mentation the wound had easured on $01/12/14$ . cumentation form the R hip: ze $8.5 \times 2 \times 0$ ,	F	314 DEFIC	IENCY)	
	amount of exudate. 01/05/14 Stage II, siz Serosanguineous exi amount of exudate." There was no docum					

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ISTRUCTION	(X3) DATE COMP	SURVEY LETED
		375418	B. WING				C 21/2014
	ROVIDER OR SUPPLIER	ATION CENTER	<b>_</b>	1200 V	ET ADDRESS, CITY, STATE, ZIP CODE WRANGLER BLVD NOLE, OK 74868		2112014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	been assessed or me On 03/20/14 at 3.20 p the pressure ulcer do the assessment and r been obtained. The D 5. Resident #17 was a diagnoses which inclu disorder, frontal lobe of and atrophy. A quarterly assessme documented the resid with cognition and exid depression. The reside extensive assistance ambulation, dressing, bathing. The Pressure Ulcer D 03/12/14, documented coccyx with a treatme The resident's medica physician order for tre coccygeal ulcer. The resident's medica documentation the ph coccygeal ulcer. On 03/20/14 at 2.00 p to provide pressure ul resident's left buttock. asked about the coccy documentation form.	asured on 01/12/14. b.m., the DON was shown cumentation and asked if neasurements should have DON stated, "Yes." admitted on 08/10/12 with ided persistent mental executive function deficit nt, dated 01/29/14, ent was severely impaired hibited moderately severe dent required one person for bed mobility, transfer, personal hygiene and ocumentation form, dated d an open area to the nt of Calazine. If record contained no reatment to the resident's If record contained no ysician was notified of the A.m., LPN #2 was observed cer treatment to the At that time, the LPN was ygeal ulcer which was	F	314			

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OFNITERO FOR MEDIOADE & MEDIOAD OFDUIOFO

PRINTED: 04/09/2014 FORM APPROVED OMB NO 0938-0391

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING	<u> </u>	C	
	5	375418	B. WING		03/21/201	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ξ.	
SEMINOLI	E CARE AND REHABILI	TATION CENTER		1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPL	
F 314	Continued From page	= 82	F 31	۵		
	ulcer was observed.		, .			
	(stage II) ulcer to the LPN #2 reported she ulcer to the right butto one had reported the	atment observation, an open right buttock was observed. was unaware of the open ock. The LPN reported no area had opened. The LPN or the area was reddened.				
	documented about th	ian or family notification le reddened area, which the as present two days prior.				
	No treatment order h reddened area was fi	ad been obtained when the rst identified.				
	nurse) was conducte	view with LPN #2 (treatment d. The LPN reported the should have been notified.				
	asked if the physiciar of the resident's skin order obtained. The I should have been no	N was interviewed and a should have been notified condition and a treatment DON reported the physician tified. The DON reported any nould be monitored and om the physician.				
	completed on all resid	ETER, PREVENT UTI,	F 31	5		
	resident who enters t indwelling catheter is	ity must ensure that a				

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION		LETED
		375418	B. WING				C 21/2014
20 March 100 M	ROVIDER OR SUPPLIER	TATION CENTER	I	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 200 WRANGLER BLVD EMINOLE, OK 74868	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
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.		F	315	1 Nursing staff will be in-serviced re	garding	04/22/14
	by: Based on observation interview, it was deter ensure an indwelling secured to the thigh a held over the level of three sampled resides an indwelling urinary This had the potential identified by the Resident of Residents form, we indwelling urinary call Findings. Resident # 7 was additional the second the second second second second second second second second second second second the second second second second second second second second second second second second second second second second seco	Il to affect five residents, ident Census And Conditions ho required the use of an			<ol> <li>Nursing staff will be in-serviced resecuring Foley catheter tubing and enthe bag remains below the bladder.</li> <li>The tubing for resident #7 has been as required.</li> <li>Staff observations will be complete twice weekly by the DON or designed continued compliance.</li> <li>Identified non-compliance will resuon one in-servicing and progressive of 5 The results of the audits will be protother facility QA committee monthly for 90 days for further evaluation and reverse.</li> </ol>	suring a secured ed at least e for alt in one discipline esented to or at least	
	chronic pain, s/p MI, A computerized phys order date of 10/24/1 (French) indwelling F neurogenic bladder." An annual assessme documented the resid and demonstrated m did not ambulate and the seven day look b	anxiety state and HTN. ician's order, with an original 3, documented, "16 /F oley catheter-Complex					

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Facility ID NH6706

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330-3	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT		STRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI				PLETED
							с
		375418	B. WING		- 10	03	/21/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI	TATION CENTER		1200 W	RANGLER BLVD		
SEMMOL		IATION CENTER		SEMIN	NOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 315	Continued From page 84		F3	315			
		nal hygiene and bathe. The					
		incontinent of bowel and had					
	an indwelling urinary						
	A care plan, dated 03	3/04/14, documented the					
		elling urinary catheter, as a					
	-	as for the resident not to					
	-	he next review date. An					
	catheter care every s	s for the staff to perform hift and PRN.					
	On 03/18/14 at 2:15	p.m., the resident was					
		ferred by CNA #5 and #4					
		. The resident's urinary					
	catheter tubing was r thigh.	not secured to the resident's					l
	The CNAs positioned	the lift sling under the					
		the sling to the lift. CNA #4					
		ng urinary catheter drainage					
		ing and held the bag. CNA					
		ne resident off the bed and sident to a shower chair.					
	As CNA #5 lowered t	he resident, CNA #4					
		indwelling urinary catheter					
		he level of the resident's					
	_	vas observed to be taunt as					
		ered to the shower chair. The					
		e catheter drainage bag until		ļ			ļ
		ted on the shower chair. ed the catheter drainage bag					
	to the shower chair.	ed the catheter dramage bag		ļ			
	On 03/19/14 at 7 30 a						
		the indwelling urinary					
	catheter tubing not be			Ì			Ĩ
		g being above the level of					
	the bladder. The DO	N reported the catheter					

 $\mathbf{x}$ 

PRINTED: 04/09/2014 FORM APPROVED OMB NO: 0938-0391

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

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED C	
		375418	B. WING			21/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1200 WRANGLER BLVD			
SEMINOLI	E CARE AND REHABILI	TATION CENTER		SEMINOLE, OK 74868			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFID TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE	
F 315 F 318	pulling on the urinary the catheter drainage the level of the reside reported she would i	been secured to prevent / meatus. The DON reported e bag should never be above ent's bladder. The DON		315			
SS=E	resident, the facility r with a limited range	ehensive assessment of a must ensure that a resident of motion receives at and services to increase for to prevent further					
	<ul> <li>by: Based on record revinterviews, it was detained as the second reviews, it was detained as the second a</li></ul>	T is not met as evidenced view, observation and staff termined the facility failed to. e services were provided for pled resident with a decline in al to affect 12 residents, N, who received restorative e services were provided as cian for one (#8) of two ith orders for restorative		<ol> <li>Restorative services has provided for resident #1</li> <li>An audit has been compother residents that require 3.Nurisng staff will be in- requirement for restorative 4. A weekly audit will be DON or designee to ensure compliance.</li> <li>Results of the audits with facility QA committee more no less than 90 days for fur- Review.</li> </ol>	pleted to identify e restorative services. serviced on the e services. completed by the re continued Il be presented to the onthly for a period of	04/22/14	
ide		al to affect 12 residents, N, who received restorative					

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	54 B		CONSTRUCTION		e survey Ipleted
		375418	B. WING			0	C 3/21/2014
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CEMINOL				12	200 WRANGLER BLVD		
SEMINUL	E CARE AND REHABILIT	IATION CENTER		SI	EMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 318	Continued From page	9 86	F	318			
	Findings:						
	on 03/09/12, with me atherosclerosis, anen esophageal, reflux, lo	been admitted to the facility dical diagnoses including nia, edema, hyperlipidemia, wy potassium, B-complex , osteoarthrosis, abnormal n.					
	A care plan revised o	n 04/03/13, documented <sup>.</sup>					
	"Focus has a Rısk for falls balance, confusion	related to decreased					
	Interventions Restorative Nursing (sic) and SBA (stand Restorative Program Restorative services	as ordered					
	The resident had bee services on 04/13/13.						
	personal hygiene, rec with bathing, did not a						
	personal hygiene, rec with bathing, did not a	lent required total fers, dressing, eating and quired extensive assistance					

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Facility ID NH6706

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				M APPROVE <u>)</u> . 09 <u>3</u> 8-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING		(X3) DATE COM	E SURVEY PLETED
		375418	B. WING			C / <b>21/2014</b>
	ROVIDER OR SUPPLIER	TATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD E DRY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE	
F 318	range of motion in bo extremities. The current physiciar There was no order fr The ADL flow sheets February and March documentation of bas being done by the CN On 03/18/14 at 11:55 providing care for the resident did not like to was restless, otherwi CNA reported the res received bed baths. turned, fed and kept to bed baths. On 03/20/14 at 10:35 of the resident's decli reported she would ta and see why no resto him. 2. Resident #8 had to on 09/01/11. The res diagnoses including a wasting, disuse atrop An annual assessme documented the resid assistance with trans and bathing, required	th upper and lower I's orders were reviewed. or restorative services. were reviewed for January, 2014. There was no sic range of motion exercises IAs. a.m., CNA #1 was observed resident. He reported the o get out of bed, unless he se he stayed in bed. The ident was on hospice and He reported the CNAs the resident clean between a.m., the DON was notified ne in range of motion. She alk to the restorative aide was being done for been admitted to the facility ident had current medical abnormal gait, muscular hy and hypothyroidism. nt, dated 06/12/13, dent required extensive fers, ambulation, dressing moderate assistance with up help with eating, had no mities and was occasionally	F 318			

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

Event ID. KVII11

Facility ID NH6706

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING			E SURVEY IPLETED
		375418	B. WING			C 3/21/2014
NAME OF PI	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		0/21/2014
			ACR. 103.07	WRANGLER BLVD		
SEMINOL	E CARE AND REHABIL	ITATION CENTER	SEM	INOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 318	Continued From pa	ge 88	F 318			
		nent, dated 02/26/14,				l
		ident required extensive				
		sfers, dressing and bathing,				
	And the second second second second second second second second	ance with hygiene, required vith eating, had ROM deficits				
		extremities and was always				l.
	incontinent of bowe					
	A care plan revised following <sup>.</sup>	on 01/02/13, documented the				
	"Focus					
		decline in Self Care				
	Deficitdecreased ambulation and wal	balance, assistance with ker use				
	Goals	ADL's daily06/11/14				
	Interventions	lation with rolling walker as				
	needed	and off white forming wanted as				
		extremity) (A) (active) ROM				
	with cueing, toileting	g and dressing with SBA"				
	A physician's order.	dated 06/05/13, documented,				
	"Restorative: Ambu	late using RW (rolling walker)				
	with 150 ft with SBA	A 3-5x/wk (times per week)."				
	The Restorative Nu	rsing Program Flow Sheet for				
	service and the service of the servi	ocumented a goal for the				
	resident was to mai	ntain current capabilities with				
	a plan to use a RW SBA.	(rolling walker) 150 ft with				
	The November 201	3 flow sheet was blank until				
	COLUMN S BUT COMPOSITIONS THAT IS	th. On the 21st the resident				
		e resident was walked on the				
	17th and refused or	n the 25th, 27th and the 29th.				

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Facility ID NH6706

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A BUILDIN	PLE CONSTRUCTION G		E SURVEY	
		375418	B. WING		0	C 3/21/2014	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CC 1200 WRANGLER BLVD			
				SEMINOLE, OK 74868			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
F 318	Continued From page	e 89	F 3	18			
1	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."						
		sing Program Flow Sheet for umented the resident had e times.					
	aid will have to come	ontinual refusal, restorative and get this nurse ADON, or i) resident before it can be					
	There were no restor January, February or						
	about restorative ser	a.m., the RA was asked vices for the resident. She had refused and nurses ve it discontinued.					
	observed walking wit	o.m., the resident was h a rolling walker, with ff member, to the bathroom					
	of the current physici services. She report come and get her or	p.m., the ADON was notified an's order for restorative ed the RA was supposed to the DON if the resident was ed the RA had not been esident refused.					
F 325 SS=E	483.25(i) MAINTAIN	NUTRITION STATUS	F 3:	25			

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Facility ID NH6706

If continuation sheet Page 90 of 120

		MEDICAID SERVICES					. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			LE CONSTRUCTION (2	X3) DATE COMPI	
		375418	B. WING			C 03/21/2014	
NAME OF PI	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
or Million		ATION OFNITED			1200 WRANGLER BLVD		
SEMINOL					SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETIC DATE
F 325	resident - (1) Maintains accepta status, such as body unless the resident's demonstrates that thi (2) Receives a therap nutritional problem. This REQUIREMENT by: Based on observation interview, it was dete ensure a significant w for one (#2) of three s experienced a signific This had the potentian identified by the DON weight loss over the p Findings: Resident #2 was adm 11/05/09 with diagnos embolism and thromt extremity, hepatic end bipolar disorder, diab HTN, schizophrenia,	<ul> <li>comprehensive ity must ensure that a</li> <li>able parameters of nutritional weight and protein levels, clinical condition s is not possible; and beutic diet when there is a</li> <li><sup>-</sup> is not met as evidenced</li> <li>n, record review and staff rmined the facility failed to veight loss was addressed sampled residents who had cant weight loss.</li> <li>I to affect 18 residents, who had experienced bast three months.</li> </ul>	F	32		re any red. oleted ing ght loss. in one line. l to the riod of	04/22/14
f J c a	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						

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Facility ID NH6706

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STATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			NSTRUCTION	(X3) DATE	). 0938-039 SURVEY LETED
	Secure of the second se		A. BUILD	NG		1	0
		375418	B. WING				21/2014
NAME OF PR	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
SEMINOLI	E CARE AND REHABILI	TATION CENTER			WRANGLER BLVD		
				SEM	INOLE, OK 74868	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 325	Continued From page	<del>-</del> 91	F	325			
. 020		ntion listed was for the		525			
		ed weekly and to receive a					
	diabetic snack three						
	A quarterly assessme documented the resid						
	impaired with cognitio						
		rson for bathing, limited					
		rson for dressing and					
		for transfer, bed mobility,					
	The second s	nd hygiene and was always					
		nd bladder. The resident					
	days of the seven da	ulant medication for seven					
		y look back ponda.					
		eport, dated 01/29/14,					
		ent had 5.62% weight loss in					
		3 months and 10.04% in six					
	•	nt body weight) #163. D/T					
		min) 2.4 rec offer High Pro					
		ils. Rec S.F. (Sugar Free) or ADD (additional) Cal/Pro.					
	(calories/protein) Mor						
	A Weight record docu	umented the resident's					
	weights as follows:						
	September 2013-186	•					
	October 2013-175.8						
	November 2013-176.						
	December 2013-172.						
	January 2014- 163 p February 2014-169.8						
	A computerized phys	ician's order. dated					
	03/08/14, documente						
	•	BOHYDRATE (HCC)Daily					
		rinating-Daily Everyday"					
	7(02-99) Previous Versions Ob	solete Event ID, KVII					

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Facility ID NH6706

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TATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COM	D. 0938-039 SURVEY PLETED
NAME OF D	ROVIDER OR SUPPLIER	375418	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE		/21/2014
	E CARE AND REHABILIT		1:	200 WRANGLER BLVD EMINOLE, OK 74868		27.1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 325 F 334 SS=E	PT room having lunch the meal was 10%. If had requested bread her personal refrigera observed to eat one s At 4.25 p.m., the resident dining room. The resident evening meal. On 03/19/14, the resident corporate nurse repo- loss should have bee 483.25(n) INFLUENZ IMMUNIZATIONS The facility must deve that ensure that —	b.m., the resident was in the n. The resident's intake for PT #1 reported the resident and sandwich meat from ator. The resident was sandwich. dent was observed in the adent consumed 50% of her dent weighed 151.8 pounds. porate nurse was interviewed at's weight loss. The rted the resident's weight	F 325 F 334			
	benefits and potential immunization; (ii) Each resident is o immunization Octobe annually, unless the r contraindicated or the immunized during this (iii) The resident or the representative has the immunization; and (iv) The resident's me	es education regarding the I side effects of the ffered an influenza r 1 through March 31 mmunization is medically e resident has already been s time period; he resident's legal e opportunity to refuse				

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Event ID KVII11

Facility ID NH6706

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER	A. BUILDI				PLETED
							С
		375418	B. WING			03	8/21/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI			12	200 WRANGLER BLVD		
SEMINUL		ATION CENTER		SI	EMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR( DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 334	Continued From page	93	F	334			
	(A) That the residen						
		rovided education regarding					
		ntial side effects of influenza					
	immunization; and						
	(B) That the residen	on or did not receive the					
	influenza immunizatio						
	contraindications or n						
,							
	The facility must deve	elop policies and procedures					
	that ensure that						
	(i) Before offering the	pneumococcal					
		esident, or the resident's					
		eceives education regarding					
		ntial side effects of the					
	immunization;	fferred a representation of the		1			
	immunization, unless	ffered a pneumococcal					
		ated or the resident has					
	already been immuni						
	(iii) The resident or th						
		e opportunity to refuse					
	immunization; and						
	(iv) The resident's me	edical record includes					
	documentation that in	dicated, at a minimum, the					
	following:	2 II V 2011 V 10					
	(A) That the residen						
		rovided education regarding					
	the benefits and pote						
	pneumococcal immur (B) That the residen						
		nization or did not receive					
	•	munization due to medical					
	contraindication or re						
	(v) As an alternative,	based on an assessment					
		nmendation, a second					
		nization may be given after 5					
	years following the fir	at pholomogoad					1

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Facility ID NH6706

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<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>. 0938-039</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		375418	B. WING				C 21/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CEMINOL		TATION CENTER		1	200 WRANGLER BLVD		
SEMINUL	E CARE AND REHABILI	IATION CENTER		S	EMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 334		medically contraindicated or sident's legal representative	F	334			
	by: Based on record rev was determined the f residents received ed benefits and potentia the influenza immuni: #4, #5, #6, #7, #8 and residents who receive immunization. This had the potential identified by the DON vaccination this flu set Findings: The medical records #1, #2, #3 #4, #5, #6, residents' medical receive on 10/22/13. The residents' medical documentation the receive	I to affect 47 residents, I, had received the influenza eason. were reviewed for residents #7, #8 and #10. The cords documented the ed the influenza vaccination al record contained no			<ol> <li>Nursing staff will be educated requirements of education regardi and risk/potential side effects befor the flu vaccine to resident.</li> <li>All new admission to the facilit flu season will receive the require and information.</li> <li>A weekly audit will be complet compliance by the DON or design 4. Non-compliance will result in c education and progressive discipli 5. Results of the audits will be pret the facility QA committee for furt evaluation and review monthly for of no less than 90 days.</li> </ol>	ng benefits re offering y during d education ed to ensure ee. ne on one nary action. sented to her	04/22/14
		present year. o.m., the corporate nurse y's Vaccination Consent					

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Event ID KVII11

Facility ID NH6706

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	10 101		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375418	B. WING			C 03/21/2014	
	ROVIDER OR SUPPLIER	TATION CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
			<u> </u>		SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334	Continued From page	95	F	334		(h)(k)	
F 371 SS=F	responsible party had information. None of contained a check ma The form had an area consented to the ann influenza vaccination all the sampled reside The corporate nurse educated the residen the issue. 483.35(i) FOOD PRC STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	ERVE - SANITARY sources approved or ry by Federal, State or local stribute and serve food	F	371			
	by: Based on observatio determined the facilit containers, utensils, I and in good repair. This had the potentia	is not met as evidenced n and staff interview, it was y failed to ensure pots, pans, knives and plates were clean to affect all 75 residents, who took their meals from nt.			<ol> <li>Dietary staff have been in-serviced requirements for pots, pans, containers utensils, knives and plates are clean an good repair. Also for proper drying of 2. All identified areas have been clear 3. A three times weekly audit of the k area will be completed by the Admini to ensure continued compliance.</li> <li>Identified non-compliance will resu one on one in-servicing and progressing</li> </ol>	s, dishes. dishes. ied. itchen strator	04/22/14

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Event ID KVII11

Facility ID NH6706

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			(X3) DATE COMP	
			A. BUILDI	NG	(	
		375418	B. WING		- 03/2	21/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
SEMINOL	E CARE AND REHABILI	TATION CENTER		1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
F 371	Continued From pag	e 96	F	371		
		p.m., an environment tour e dietary department with the rvations were made:		facility QA commi	udits will be presented to the ittee monthly for a period of ys for further evaluation and	
	Metal serving contain	ners were stacked wet.		ALL		
	Three metal bowls w and debris present.	rere stored with dried food				
	Soiled plastic contair for use in the kitcher	ners were stacked on shelves				
		stacked on a metal shelves in iding water and sediment				
	Four large pots were moisture present.	stored with food, debris, and				
	Three stacked muffir food and crumbs pre	n pans were stored with dried sent.				
	There were knives w dry food storage area	ith dried debris were in the a.				
	A utensil drawer con	tained food debris.				
	There were chipped plates serving line. When brough she removed the chipped	rought to the DM's attention,				
		p.m., the DM removed all contained the dried food and				
	The DM reported sh	e would have all items				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY
			A BOILDIN	°		С
		375418	B. WING		03/	21/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1200 WRANGLER BLVD SEMINOLE, OK 74868	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 371	instructed the dietary wet. The DM reported be addressed.	ppropriately. The DM staff not to stack containers al all the about areas would	F 3	71		
F 406 SS=E	483.45(a) PROVIDE/ REHAB SERVICES	OBTAIN SPECIALIZED	F4	06		
	not limited to, physica pathology, occupation health rehabilitative s and mental retardation resident's comprehent must provide the required required services from accordance with §483	tative services such as, but al therapy, speech-language hal therapy, and mental ervices for mental illness n, are required in the sive plan of care, the facility uired services; or obtain the n an outside resource (in 8.75(h) of this part) from a d rehabilitative services.				
	by: Based on observatio interviews, it was dete follow physician order	is not met as evidenced n, record review and staff ermined the facility failed to rs for PT evaluation and of two sampled residents		<ol> <li>The PT evaluation for rescompleted.</li> <li>An audit has been completeresident with orders for there incomplete.</li> <li>weekly audits will be completed.</li> </ol>	eted to identify other apy and evaluations	
		to affect 14 residents, , who had an order for PT in s. Findings:		or designee for continued co 4. Identified non-compliance one education and progressi	ompliance. e will result in one c ve discipline.	
	diagnoses that includ and anxiety state.	itted on 09/20/13, with ed paraplegia, chronic pain,		4, results of the audits will b facility QA committee mont no less than 90 days for furt review.	hly for a period of	
į		cian's order, with an original 4, documented, "PT/OT TO				

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Facility ID NH6706

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILDI			(X3) DATE COMF	SURVEY
		375418	B. WING				C 21/2014
	ROVIDER OR SUPPLIER	TATION CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefi Tag	L X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 406	and demonstrated mi did not ambulate and the seven day look ba required extensive as dress, perform person resident was always i an indwelling urinary A care plan, dated 03 resident had decreas paraplegia and bilater contracture, as a prot resident to maintain m intervention listed was resident energy-savin On 03/18/14 at 9:40 a if she had been receiv resident reported she At 9.55 a.m., PT #1 w received orders for th services. The PT rep any orders. The PT r order and stated, "I de this." At 10:30 a.m., the DC regarding the residen as ordered by the phy	S INDICATED (BLE ht, dated 03/05/14, lent was cognitively intact ld depression. The resident was not transferred during ack period. The resident sistance of one person to hal hygiene and bathe. The ncontinent of bowel and had catheter. /12/14, documented the ed mobility related to ral lower extremity blem. The goal was for the hobility and function. An is for staff to teach the g techniques. h.m., the resident was asked ving PT/OT services. The had not seen PT or OT. ras asked if she had e resident to receive PT/OT orted they had not received eviewed the physician's on't know why we didn't get N was interviewed t receiving PT/OT therapy visician. The DON reported PT/OT had not received the	F	406			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE	SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG		COMP	ETED
							;
		375418	B. WING			03/2	21/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	TY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI			1200 WRANGLER BL	VD		
SEMINOL	E CARE AND REHADILI	IATION CENTER		SEMINOLE, OK 74	868		
(X4) ID		ATEMENT OF DEFICIENCIES	ID ID		DER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ORRECTIVE ACTION SHOULD I FERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 425	Continued From page	e 99	F	125			
F 425	483.60(a),(b) PHARM	ACEUTICAL SVC -	F	125			
	ACCURATE PROCE						
	The facility must prov	vide routine and emergency					
	drugs and biologicals	to its residents, or obtain				1	
	them under an agree						
		rt. The facility may permit					
		I to administer drugs if State					
	law permits, but only supervision of a licen						
	Supervision of a licen	sed hurse.				ļ	
	A facility must provide	e pharmaceutical services					
	(including procedures that assure the accurate		4				
	acquiring, receiving,		8				
		rugs and biologicals) to meet				1	
5	the needs of each res	sident.				1	
	The facility must emp	loy or obtain the services of					
		t who provides consultation					
		provision of pharmacy					
	services in the facility	·.					
			T				
			1			1	
3	This REQUIREMENT	is not met as evidenced				ļ	
	by.						
		n, staff and family interview				1	
		was determined the facility				1	
		nber to administer eye drops order to one (#5) of one					
	sampled resident.						
		I to effect one resident,					
	-	l, who received family					
	administration of med	lications.					
	Findings		l				
	i inuinga					1	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DATE COMP	
		375418	B. WING			03/2	C 21/2014
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SEMINOL	E CARE AND REHABILI	TATION CENTER			1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	L X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	Resident #5 was adm diagnoses which incl depressive disorder, Alzheimer's disease. A quarterly assessme documented the resid with cognition and ex depression with beha total assistance for tr hygiene and bathing. person extensive ass A care plan, dated 01 resident's wife could and keep the medica There was no physic a family member could and keep the medica There was no docum had been assessed p medications. On 03/18/14 at 9:00 tears was observed i surveyor asked the s hers. She stated, "No husband." The spous her she could admini husband. On 03/19/14 at 3:00 interviewed in regard administering the eye the physician reporte asked if the spouse h correct administration	hitted on 07/29/07 with uded CVA, paralysis, TIA, psychosis and ent, dated 01/15/14, dent was severely impaired chibited moderately severe aviors. The resident required ansfers, dressing, personal The resident required one sistance with eating. 1/18/14, documented the administer artificial tears prn, iton at the bedside. ian's order that documented Id administer the eye drops. mentation the family member prior to the administration of a.m., a bottle of artificial in the resident's room. The pouse if the drops were b, they belong to my be reported the doctor told ster the eye drops to her	F	425	<ol> <li>The family member of resident numbers of resident numbers of the requirement staff to administer medications.</li> <li>Staff have been educated on the reactor for staff to administer medications unself administration assessment is in plately have been found competent to adding a doctors order is in place, the medicates secure and a care plan is in place.</li> <li>An audit has been completed to idea any other self administration issues an ensure the appropriate elements are in 4. A weekly audit will be completed to DON or designee ongoing to ensure a compliance.</li> <li>Results of the audits will be present the facility QA committee monthly or of no less than 90 days for further evaluation and review.</li> </ol>	s for juirement less a ace and lminister, ition is ntify nd place. by the ontinued nted to a period	

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Facility ID NH6706

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CENTER	S FOR MEDICARE &	NEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION		TE SURVEY MPLETED
		375418	B. WING		_   (	C 3/21/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		
CEMINOL		ATION CENTER		1200 WRANGLER BLVD		
SEMINOL	E CARE AND REHABILI	IATION CENTER		SEMINOLE, OK 74868	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORR	RS PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 425	Continued From page	e 101	F	125		
	doctor said it was ok					
	483.60(b), (d), (e) DF LABEL/STORE DRU	RUG RECORDS,	F4	131		
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliatio records are in order a controlled drugs is ma reconciled.	loy or obtain the services of t who establishes a system and disposition of all ifficient detail to enable an n; and determines that drug and that an account of all auntained and periodically				
i		e with currently accepted s, and include the y and cautionary				
	In accordance with State and Federal facility must store all drugs and biolog locked compartments under proper ter controls, and permit only authorized p have access to the keys.	drugs and biologicals in s under proper temperature only authorized personnel to				
processor C al processor q	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distribut	ide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ition systems in which the imal and a missing dose can				

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Facility ID NH6706

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	
			A. BUILDING	·	0	;
		375418	B. WING		03/2	21/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
SEMINOLI	E CARE AND REHABILI	TATION CENTER		1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 431	Continued From page	e 102	F 43	1		
	This REQUIREMENT	☐ is not met as evidenced				04/22/1
	by:			1. Staff have been educate	d on the requirements	04/22/1
		iew, observation and staff	1	for labeling and storage of	OTC medications.	
		ermined the facility failed to		2. An audit has been comp		
	ensure over-the-cour			OT C's are labeled and sto	0.00 0.00 0.00	
		resident's name, route of priate instructions and		3. A weekly audit will be		
		er-the-counter medications		DON or designee to ensure	-	
	observed during the i			compliance.	e continueu	
	3	Participation Provide Automatica			as will regult in one	
	This had the potentia	I to affect all 75 residents	ļ	4. Identified non-complian		
	who resided in the fa	cility.		on one in-servicing and pr		
				5. Results of the audits wil	0 <del></del>	
ĺ	Findings.			facility QA committee for	further evaluation	
	Medication passes w	ere observed on 03/18/14		and		
		y-seven medications were				
	observed. The follow					
		served without labels which				
	identified the route of instructions and prec	<sup>administration, appropriate autions<sup>.</sup></sup>				
		ultıvitamin, a vitamin D-400				
	mg, a calcium 600 m					
		reducer (Zantac), a liquid				
i		ium 600 with vitamin D 400 D) 845 plus 65 fast relief				
		idene 0.2 % eye drops.				
		a.m., the corporate nurse				
	secondances a manufacturation second similarity come of	er-the-counter medications				
		labels. She reported the				
		opies of the physician's cation with the medications				
		medications are to be				
F 441	483.65 INFECTION (	CONTROL, PREVENT	F 44	1		
SS=E	SPREAD, LINENS					

Facility ID NH6706

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TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CO	NSTRUCTION	(X3) DATE	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A BUILDI			COM	PLETED
		1				С	
		375418	B. WING	-		03	/21/2014
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
CEMINOL				1200	WRANGLER BLVD		
SEMINULI	E CARE AND REHABILI	IATION CENTER		SEM	INOLE, OK 74868		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	ca mercury surgers of mercury strategy	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	×	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETIC
			_		DEFICIENCY)		
F 441	Continued From page 103		F	441			
		blish and maintain an					
	100 July 141000 100 100 10 10 10 10	gram designed to provide a					
		mfortable environment and					
	of disease and infect	evelopment and transmission					
	or disease and meet	1011.					
	(a) Infection Control	Program					-
	The facility must esta	ablish an Infection Control					
	Program under which			1			1
		trols, and prevents infections					
	in the facility;	and was such as inclution					
		cedures, such as isolation, an individual resident; and					
		d of incidents and corrective					
	actions related to infe						
	(b) Preventing Sprea	d of Infection					
	(1) When the Infectio						
	determines that a res	ident needs isolation to					
	The second secon	f infection, the facility must					
	isolate the resident.	and to the termination of the second s					
		prohibit employees with a se or infected skin lesions					
	0	ith residents or their food, if					
	direct contact will tra						1
		equire staff to wash their					
		ect resident contact for which					
	hand washing is indic	· ·					
1	professional practice						
	(c) Linens						
		lle, store, process and					1
		s to prevent the spread of					
	infection.						ļ

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
							2
		375418	B. WING			03/	21/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI	TATION CENTER			200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	This REQUIREMENT by: Based on observation interview, it was deter a) Provide complete laundry department. This had the potentian who resided in the far b) Ensure contaminan clean items for two (# sampled residents with assistance. This had the potentian who resided in the far c) Ensure an indwellin not on the floor for or residents who required catheters. This had the potentian identified by the Resident of Residents form, with urinary catheters. d) Track and trend in of five sampled reside the past three month This had the potentian who resided in the far	<ul> <li>I is not met as evidenced</li> <li>in, record review and staff</li> <li>imined the facility failed to:</li> <li>PPE equipment in the</li> <li>I to affect all 75 residents</li> <li>cility.</li> <li>ted gloves did not touch</li> <li>f6 and #17) of seven</li> <li>ho required toileting</li> <li>I to affect all 75 residents</li> <li>cility.</li> <li>in affect all 75 residents</li> <li>cility.</li> <li>in affect all 75 residents</li> <li>cility.</li> <li>I to affect all 75 residents</li> <li>cility.</li> <li>I to affect all 75 residents</li> <li>cility.</li> <li>in urinary catheter bag was</li> <li>in (#5) of two sampled</li> <li>in affect five residents,</li> <li>dent Census And Condition</li> <li>ho required indwelling</li> <li>fections for two (#2 and #7)</li> <li>ents, who had infections in s.</li> <li>I to affect all 75 residents</li> </ul>	F	441	<ol> <li>PPE equipment has been place in the laundry area.</li> <li>Nursing staff have been educated requirement for glove use during toil peri-care/catheter care, hand washin not talking meal trays into other resided. Nurising administration have been of the requirement for all infections to be the tracking and trending of infection 4. The infections for resident number have been updated to the tracking and 5. Staff observations will be completed DON or designee weekly to ensure of compliance for the following areas; a. hand washing</li> <li>catheter care</li> <li>glove use during toileting</li> <li>d. handling of meal trays</li> <li>e. PPE use in the laundry</li> <li>A monthly review of the tracking report will be completed to ensure compliance with one-compliance with one on one education and progress disciplinary action.</li> <li>The results of the audits will be prime the facility QA committee for further and review monthly for a period of m 90 days.</li> </ol>	on the eting, g and lent rooms educated on be listed on is. 2 and 7 d trending. ed by the ontinued and trendin ompliance. Il result sive esented to c evaluation	g
		e for one (#7) of 10 sampled					

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Facility ID NH6706

<u>CENTER</u>	S FOR MEDICARE &	VIEDICAID SERVICES				ONB NC	<u>). 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		LETED
l		375418	B. WING				C 21/2014
1012153 E215 = 11	ROVIDER OR SUPPLIER	ATION CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page This had the potential who resided in the fac	to affect all 75 residents	F	441			
	f) Ensure the used more residents were not play while the resident was sampled residents, we their rooms.	eal trays from other aced in residents' rooms, s eating, for one (#1) of five ho received their meals in					
		i to affect 26 residents, , who received their meals					
	1. On 03/18/14 at 8:4 tour of the laundry de The laundry staff mer presence of personal	15 a.m., an environmental partment was conducted. nber was asked about the protective equipment. The showed the surveyor a box and a pair of dusty					
	gowns or waterproof handling soiled items rooms. The staff mer	s asked about protective barriers to be worn when or items from isolation nber reported she was new know about the protective					
	laundry staff member asked about the prote handling of items from	she was helping the new . The housekeeper was ective equipment and the n residents in isolation. The "We have never been told					

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Event ID KVII11

Facility ID NH6706

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER		G		PLETED
						С
		375418	B. WING		03	/21/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
SEMINOL	E CARE AND REHABILI	TATION CENTER		1200 WRANGLER BLVD		
				SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE
F 441	Continued From page	e 106	F4	41		
1	On 03/20/14 at 10.10					
	informed of the findin					
	department. He repo	rted the items were now in				
		lepartment. He reported the				
	laundry should have to wear.	protective items for the staff				
	2. Resident #1 had b	een admitted to the facility				
		dical diagnoses including				
	atherosclerosis, anen	nıa, edema, hyperlipidemia,				
		w potassium, B-complex				
	-	I, osteoarthrosis, abnormal				
	gait and hypertensior	<u>).</u>				
	An annual assessme	nt, dated 02/12/14,				1
	documented the resid	lent required total				
		fers, dressing, eating and		ĺ		
		quired extensive assistance				
		ambulate and required an				
	indwelling urinary cat	neter.				
	On 03/17/14 during t	he initial nursing tour, the				ļ
		d in his room. The touring				
	L	d the resident was fed				
	meals in his room by	staff.				
	On 03/18/14 at 1:03 r	o.m., CNA #1 was observed				
		a pureed meal in his room. A				
		eal tray was observed on				
	the resident's sink ca	binet top.				ļ
j	At that time, the CNA	was asked about the				
		eal tray. He reported it				
1		resident and he had brought				
		cabinet rather than carry it all				
	the way down the hal	Ι.				
1	On 03/19/14 at 1:00 r	o.m., CNA #3 was observed				
	feeding the resident.			1		1

						. 0930-035
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING	CONSTRUCTION	(X3) DATE COMP	LETED
		375418	B. WING	· ····· · ···· ····	03/2	C 21/2014
	ROVIDER OR SUPPLIER	TATION CENTER	12	TREET ADDRESS, CITY, STATE, ZIP 200 WRANGLER BLVD EMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 441	the resident's tray wa tray. At that time, the CNA partially eaten meal to resident had brought placed it on the overto the resident. She was asked if she resident was an infect stated, "Oh. I know w On 03/20/14 at 3:30 p about the infection co another resident's me room. The CNA report the tray to the hall ca room. 3. Resident #6 was which included HTN, mellitus type II and le A quarterly assessme documented the resid with cognition with dis exhibited moderately behaviors. The residen on staff assistance fo ambulation in a whee bathing. The residen bowel and bladder. A care plan, dated on resident was at risk for integrity due to incont	t's overbed table. Next to as a partially consumed meal was asked about the ray. She reported another it into the room and she had bed table until after she fed thought the tray of the other tion control issue. She re aren't supposed to do it." o.m., CNA #1 was asked portrol issues with bringing eal tray into the resident's orted he should have taken rt and not into the resident's admitted with diagnoses anxiety state, diabetes ft AKA. ent, dated 01/20/14, dent was severely impaired sorganized thinking and severe depression with dent was totally dependent r bed mobility, transfers, lichair, personal hygiene and t was always incontinent of	F 441			

Facility ID NH6706

If continuation sheet Page 108 of 120

	STOR MEDICARE &	MEDICAID SERVICES				OWR N	O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		e survey IPleted
		375418	B. WING			0.	C 3/21/2014
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		<u>72172014</u>
SEMINOL	E CARE AND REHABILI			1200	WRANGLER BLVD		
GEMANOL				SEM	INOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	hours and as needed On 03/18/14 at 11:15 were observed to pro- resident. CNA #4 clea with wipes and then y gloves placed the res- resident. Both CNAss on when they reposit draw sheet. CNA #5 pillow with the same On 03/19/14 at 2.20 ( she expected the star contaminated gloves The DON stated, "No 4. Resident #17 was 08/10/12 with diagno persistent mental dis- and muscle weakness A care plan, dated 11 resident had a potent deficit due to dement deficit due to d	th incontinent care every two a.m., CNA #4 and CNA #5 wide incontinent care for the aned the resident's buttocks with the same contaminated bident's clean brief under the had contaminated gloves ioned the resident with the then touched the resident's contaminated gloves. b.m., the DON was asked if ff to touch clean items with during incontinent care. b." admitted to the facility on ses which included order, hyperlipidemia, gout s. /22/13, documented the tial for progressive self care ia. The care plan dent needed assistance with n intervention documented fer assistance to toilet Is and at bedtime.	F	441	DEFICIENCY)		

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Facility ID NH6706

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	S FUR WEDICARE &	VIEDICAID SERVICES				OMB NC	0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION		LETED
		375418	B. WING			1	C 21/2014
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<b></b> ;	
SEMINOLI	E CARE AND REHABILIT				200 WRANGLER BLVD EMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441		9 109 p.m., the resident had asked hroom. CNA #8 and CNA	F	441			
	#9 ambulated the res resident's bathroom. resident's perineal are	ident with a gait belt to the					
	gloves on to pull up the slacks. The CNA the same contaminated g resident to her recline	ne resident's brief and In held the gait belt with the Ioves and ambulated the r. The CNA removed the					
	gloves. The CNA the	h the same contaminated n removed her and applied the gait belt					
	the staff to touch clea	N was asked if she expected n items with contaminated eal care. The DON stated,					
	numerous diagnoses	dmitted on 09/20/13 with which included paraplegia, anxiety state and HTN.					
	with the identified mic physician had wrote o	ensitivity report, dated d the resident had a UTI roorganism as E Coli. The on the report to start the tic therapy for ten days.					
		og was reviewed for ere was no documentation being tracked and trended.					
	and demonstrated mil	nt, dated 03/05/14, ent was cognitively intact d depression. The resident was not transferred during					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
Manufactor and a state of the state of the	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				LETED
							0
		375418	B WING			03/	21/2014
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI	TATION CENTER			SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	required extensive as dress, perform person resident was always if an indwelling urinary A care plan, dated 03 resident had an indwe problem. The goal w have a UTI through the intervention listed was catheter care every s On 03/18/14 at 2:15 p observed to be transf with a mechanical lift to come out of anothe the resident's room w donned gloves and p resident. Neither CNA washed procedure. At 5:45 p.m., ADON a regarding the lack of documented on the S control log. The ADC completing the infection documented on the in On 03/19/14 at 7:30 a interviewed regarding observed prior to reme The DON reported st	ack period. The resident sistance of one person to nal hygiene and bathe. The incontinent of bowel and had catheter. #/04/14, documented the elling urinary catheter, as a as for the resident not to ne next review date. An s for the staff to perform hift and PRN. o.m., the resident was ferred by CNA #5 and #4 . The CNAs were observed er resident's room and enter rithout knocking. The CNAs roceeded to transfer the their hands prior to the #1 was interviewed the resident's UTI being september 2013 infection DN reported she was new to on control logs. The ADON should have been nfection control log.	F	441			

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CENTER	SFOR MEDICARE &	MEDICAID SERVICES					O. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		NSTRUCTION		E SURVEY
		375418	B. WING			0:	C 3/21/2014
NAME OF PF	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI	TATION CENTER		1200	WRANGLER BLVD		
JEMINOLI				SEM	INOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	Continued From pag	e 111	F	441			
	6. Resident #2 was admitted to the facility on						
	11/05/09 with diagno						
	embolism and throm	bosis arteries lower					
I		cephelopathy, edema,					
		etes mellitus type II, Hep. C,					
	failure and CHF.	Alzheimer's disease, renal					
	lanure and CHF.						
	A quarterly assessme	ent, dated 12/20/13,					
		dent was moderately					
		on, required extensive					
		rson for bathing, limited					
		rson for dressing and					
		for transfer, bed mobility, nd hygiene and was always					
		nd bladder. The resident					
		ulant medication for seven					
	days of the seven da						
	A nurse's note, dated	1 02/21/14 at 5:05 p.m.,					
		dmitted to SNF services2					
		avaquin 500 mg one daily x 7					
	days"						
	A nurse's note, dated	1 02/21/14 at 8:30 p.m.,					
		tinue on SNF services for					
	Pneumonia"						
	An infection control of	lata log, dated February					
		locumentation the resident					
	had been tracked or	trended for pneumonia.					
	On 03/18/14 at 5:15	p.m., the DON was shown					
		d the infection control log and					
		nia should have been					
	tracked and trended.	The DON stated, "Yes."					
	7 Resident #5 was	admitted 07/29/07 with					
	diagnoses which incl						

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	F DEFICIENCIES	MEDICAID SERVICES	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER	A. BUILDI				LETED	
				-			с	
		375418	B. WING				21/2014	
NAME OF PF	ROVIDER OR SUPPLIER		- <b>-</b>		STREET ADDRESS, CITY, STATE, ZIP CODE			
				1	1200 WRANGLER BLVD			
SEMINOLE	E CARE AND REHABILI	TATION CENTER			SEMINOLE, OK 74868			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•		PREF		(EACH CORRECTIVE ACTION SHOUL		COMPLETIC DATE	
TAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE		
F 441	Continued From page		F	441	1			
	depressive disorder,	TIA, psychosis and						
	Alzheimer's disease.							
	A quarterly assessme	ent, dated 01/15/14,						
		nt was severely impaired					1	
		ted moderately severe						
1	-	viors. The resident required					1	
		ansfers, dressing, personal						
		. The resident required one						
		stance with eating. The						
		nted the resident was always						
	incontinent of bowel	•						
	On 03/18/14 at 9:30	a.m., the resident was sent						
		aluation and treatment.						
	On 03/20/14, the resi	ident returned mid afternoon					1	
	from the hospital. The	e resident returned with an						
	indwelling urinary cat	heter.						
	At 3:00 p.m., the urin	ary drainage bag was					(	
	observed to be lying							
	On 3/21/14 at 10.00 a	a.m., the urinary drainage						
	bag was again obser	ved lying on the floor.						
	At 10:30 a.m., the D0	ON was interviewed in regard						
		e bag. The DON reported						
		bag should not have been on						
	the floor.							
F 456	483.70(c)(2) ESSEN	TIAL EQUIPMENT, SAFE	F	456	3		1	
SS=D	OPERATING CONDI							
	The facility must main	ntain all essential						
	mechanical, electrica							
	equipment in safe op		1				]	
							1	
			1					

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OLIVIEI	S FOR MEDICARE &	MEDICAID SERVICES			······································	OMB NO	0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		375418	B. WING				C 21/2014
NAME OF PE	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				120	0 WRANGLER BLVD		
SEMINULI	E CARE AND REHABILIT	IATION CENTER		SE	MINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 456	Continued From page	e 113	E4	456			
		is not met as evidenced			1. The wheelchair arms for the identif	ied	04/22/14
	by:				residents have been repaired or replace	ed.	
		n and staff interview, it was			2. An audit has been completed to ide		
		y failed to ensure wheelchair		1	any other residents wheelchairs that n		
	-	pair for three (#19, 20 and			3. A monthly audit will be completed	= 1	
	#21) of 13 sampled re	esidents who utilized		1	maintenance supervisor for continued	-	
	wheelchairs.						
	This had the notentia	I to affect 51 residents,		1	compliance.		
		I, who required the use of a			4. Results of the audits will be presen		
	wheelchair.	.,			facility QA committee for further eva		
					and review monthly for a period of no	less than	
	Findings				90 days.		
	On 03/18/14, during t observations were ma	the lunch meal, the following ade:					
	Resident #19's right v and torn.	wheelchair arm was cracked					
	Resident #20's right v	wheelchair arm was torn.					
	Resident #21's right v and torn.	wheelchair arm was cracked					
	of the findings. The A	a.m., the ADM was notified ADM reported the wheelchair					
	arms would be repair	ed.	-				
	483.70(h)	/SANITARY/COMFORTABL	F4	465			
55=E	E ENVIRON						
	The facility must prov	vide a safe, functional,					
	sanitary, and comfort						
	residents, staff and th						
	This REQUIREMENT	「 is not met as evidenced					

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Facility ID NH6706

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED. 04/09/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		(X3) DATE COMP	SURVEY
		375418	B. WING	<u> </u>		C
NAME OF P	ROVIDER OR SUPPLIER	0/0410		STREET ADDRESS, CITY, STATE, ZIP CO		21/2014
				1200 WRANGLER BLVD		
SEMINOL	E CARE AND REHABILI	TATION CENTER		SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 465	Continued From page	e 114	F 4	65		
	by:					04/22/14
	-	on and staff interview, it was		1. The facility has obtained	BIDS for repair of	04/22/14
	determined the facilit	y failed to:		the large hall in the driveway	y for repair.	
	a) Ensure a driveway	/ did not have a large hole		2. The identified eves will b		
	full of water.	and not have a large hole		3. The identified window scale repaired or replaced.	reens have been	
		I to affect seven residents,		4. The maintenance supervis	or will complete	
	10.1 11.1 10.1 10.1 10.1 10.1 10.1 10.1	I, who went outside of the		weekly rounds in order to id	entify needed	
	facility.			repairs with a report to the A	DM.	e.
	b) Ensure eaves wer	e free of peeling paint.		5. Results of the audits will facility QA committee for fu	<del>.</del>	
		It to affect seven residents, N, who went outside of the		and review monthly for a pedays.	riod of no less than	
	c) Window screens w	vere in good repair.				
	This had the potentia who resided in the fa	I to affect all 75 residents cility.				
	Findings					
	On 03/19/14 at 8 <sup>.</sup> 30					
	environmental tour o with the maintenance	f the facility was conducted e supervisor.				
		oximately five feet by two				
		ddle of the main driveway vater. The maintenance				
		d if the pothole was a hazard				
	to residents who cou	ld fall into it. The				
		isor reported he was getting to repair the pothole.				
	The eaves on the fro building had peeling	nt and east side of the paint.				

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 04/09/2014 FORM APPROVED OMB NO. 0938-0391

		MEDICAID SERVICES					. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		375418	B. WING_		C 03/21/2014		
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
SEMINOL	E CARE AND REHABILI	TATION CENTER			VRANGLER BLVD NOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 465			F4	65			
		ooms # 2, 3, 5, 6, 8 and #9 them, which could allow lding.					
	The maintenance sup would be addressed.	pervisor reported the areas					
	of the findings. He re repaired.	a.m., the ADM was notified ported the areas would be					
F 502 SS=E	u/( )		FS	602			
	services to meet the	ride or obtain laboratory needs of its residents. The for the quality and timeliness					
	555	is not met as evidenced					04/22/14
		iew and staff interview, it acility failed to ensure		2	<ol> <li>The lab for resident #7 has been of</li> <li>An audit has been completed to en</li> </ol>	sure	0 11 22/1
		completed as ordered by			hat labs have been drawn as ordered. 3. A weekly audit will be completed	~	
		poratory tests ordered by the			DON or designee going forward to en compliance.	nsure	
	This had the potentia who resided in the fa	l to affect all 75 residents cility.		I	4. An in-service will be completed was nursing staff on the requirements and process.		
	Findings:				5. Identified non-compliance will res		
	numerous diagnoses	nitted on 09/20/13 with which included paraplegia, anxiety state and HTN.		t	on one education and progressive dis 5. Results of the audits will be presen the facility QA committee for further evaluation monthly for a period of no	ited to	
		lated 12/06/13, documented, IONTHS - April/Aug/Dec."			han 90 days.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	04/09/2014
FORM	APPROVED
OMP NO	0029 0201

PPLIER	275449	1			<u>^</u>
PLIER	375418	B. WING		03	C 5/21/2014
REHABILITAT	ION CENTER	120	REET ADDRESS, CITY, STATE, ZIP CODE 10 WRANGLER BLVD MINOLE, OK 74868		
DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
From page 1	16 dated 03/05/14,	F 502			
strated mild o ulate and wa ay look back ensive assis rm personal	t was cognitively intact depression. The resident as not transferred during a period. The resident tance of one person to hygiene and bathe. The ontinent of bowel and had theter.				
n ordered la 4 at 4:30 p.m regarding th ests. The AI redical record nust have mi	ecord contained none of boratory tests. a., ADON #2 was e physician ordered DON reviewed the d. The ADON reported issed getting the tests and hysician to obtain new				
RES COMPLETE	ACCURATE/ACCESSIB	F 514			
accordance v nd practices	readily accessible; and				
to identify th ssessments; ovided, the re	e resident, a record of the the plan of care and esults of any				
nd loc illy re to sse svie	practices cumented; organized cord must identify the essments; ded, the re screening	practices that are complete; cumented; readily accessible; and organized. cord must contain sufficient identify the resident, a record of the essments; the plan of care and ded, the results of any screening conducted by the State;	practices that are complete; cumented; readily accessible; and organized. cord must contain sufficient identify the resident, a record of the essments; the plan of care and ded, the results of any screening conducted by the State;	practices that are complete; cumented; readily accessible; and organized. cord must contain sufficient identify the resident, a record of the essments; the plan of care and ded, the results of any screening conducted by the State;	practices that are complete; cumented; readily accessible; and organized. cord must contain sufficient identify the resident, a record of the essments; the plan of care and ded, the results of any screening conducted by the State;

PRINTED: 04/09/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	100 C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PLE CONSTRUCTION	(X3) DATE COMPI	ETED
		375418	B. WING		C 03/21/2014	
	ROVIDER OR SUPPLIER	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WRANGLER BLVD SEMINOLE, OK 74868		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 514	Continued From pag	e 117	F 5'	14		
	by: Based on record rew was determined the i document intake and and #1) of three sam intakes and outputs I This had the potentia identified by the DON outputs be completed Findings: Resident # 7 was ad numerous diagnoses chronic pain, s/p MI, A computerized phys order date of 10/24/1 (French) indwelling F neurogenic bladder." A January 2014 Com Output Record had S the resident's intake, Of the 93 opportuniti resident's output, 53 A February 2014 Com Output Record had S the resident's intake, Of the 84 opportuniti	al to affect eight residents, N, who required intakes and d. mitted on 09/20/13 with which included paraplegia, anxiety state and HTN. sician's order, with an original 3, documented, "16 /F Foley catheter-Complex prehensive Intake and 33 opportunities to document 53 opportunities were blank. es to document the opportunities were blank. mprehensive Intake and 84 opportunities to document 39 opportunities were blank. es to document the opportunities were blank. es to document the opportunities were blank.		<ol> <li>Staff have been educated or requirements for completion 4</li> <li>Audits will be completed at times weekly to ensure contine by the DON or designee.</li> <li>Identified non-compliance one on one in-servicing and predisciplinary action.</li> <li>Results of the audits will be facility QA committee months of no less than 90 days.</li> </ol>	of I&O's. It least three nued compliance will result in progressive e presented to the	04/22/14
	documented the resi	dent was cognitively intact ild depression. The resident				

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Event ID: KVII11

Facility ID NH6706

	SFUR WEDICARE &	WEDICAID SERVICES	-		OND IN	ONIB NO. 0930-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			D MANG		С			
		375418	B. WING			03	/21/2014	
NAME OF PROVIDER OR SUPPLIER SEMINOLE CARE AND REHABILITATION CENTER				120	REET ADDRESS, CITY, STATE, ZIP CODE O WRANGLER BLVD MINOLE, OK 74868			
(X4) ID PREFIX TAG	(EACH DEFICIENC	A &	ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)			ULD BE COMPLETION		
F 514	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 the reliuid intake, as a problem. The goal was for the resident to maintain appropriate fluid volume evels. An intervention listed was for the staff to berform 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 butput, 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, asophageal 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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If continuation sheet Page 119 of 120

CENTER	SFOR MEDICARE &	MEDICAID SERVICES				ON R NO	. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 2	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		375418	B. WING			03/2	C 21/2014			
	ROVIDER OR SUPPLIER	TATION CENTER		STREET ADDRESS 1200 WRANGLER SEMINOLE, OK						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACI	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
F 514	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 4 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 amounts on 02/05/14, 02/07/14, 02/08/14 and 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						
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