STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375339	A. BUILDING _____ B. WING _____	C 06/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS REDEEMER HEALTH & REHAB	1530 NORTHEAST GRAND BLVD OKLAHOMA CITY, OK 73117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A re-certification/re-licensure survey was conducted from 06/16/14 through 06/20/14 and 06/23/14. Complaints #OK00044497, OK00044505, and OK00044506, were investigated in conjunction with the survey.	F 000		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

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

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident's physician was notified regarding a change of condition. This affected 1 (#37) of 25 sampled residents whose clinical records were reviewed. Findings: Resident #37 was admitted to the facility on 01/27/14 with diagnoses to include major depressive disorder, esophageal reflux, vascular dementia with delirium, osteoarthrosis, and dementia with behavioral disturbance. The admission assessment, dated 02/05/14, documented the resident had moderate cognitive impairment; required supervision with eating; was 65 inches tall and weighed 135 pounds; had no swallow disorder; and had no oral/dental status issues. The care plan, dated 02/07/14, and most recently reviewed/revised on 05/12/14, did not address a problem with nutrition and/or weight loss. The facility's weight record documented the resident's weights as follows: 01/27/14 - 135.2 pounds 02/23/14 - 137 pounds 03/04/14 - 110 pounds (a severe weight loss of 18.6% in 30 days) 03/06/14 - 114 pounds	F 157		

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F 157	Continued From page 2 04/28/14 - 116 pounds (a severe weight loss of 14.2% in 90 days) 05/11/14 - 112 pounds 05/18/14 - 116 pounds 05/25/14 - 118 pounds 06/04/14 - 118 pounds 06/08/14 - 117 pounds 06/15/14 - 121 pounds A registered dietician recommendation, dated 03/28/14, documented she suggested to add MedPass 2.0 60 milliliters twice daily. The physician signed that he agreed with the recommendation. There was no documentation on the recommendation form which informed the physician of the resident's severe weight loss of 18.6% in 30 days. A physician's progress note, dated 04/23/14, documented: "The patient...has had weight loss which is actually expected because of the progression of his dementia. The staff said he had some chronic diarrhea and was felt to be lactose intolerant. He is now on lactose free diet and diarrhea is essentially resolved. The patient's appetite remains adequate..." There was no documentation in the clinical record to indicate the facility had notified the physician of the resident's severe weight loss prior to 04/23/14. On 06/19/14 at 9:55 a.m., the surveyor showed the director of nursing (DON) the physician's progress note, dated 04/23/14, and asked if the physician had been notified of the resident's severe weight loss prior to that date. She reviewed the progress note and the clinical record and stated that would have been the first time the	F 157		

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F 157	Continued From page 3 physician had been notified about the severe weight loss. The surveyor asked if that was prompt notification of the severe weight loss. The DON stated, "No."	F 157		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available	F 159		

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F 159	Continued From page 4 through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews, it was determined the facility failed to ensure: 1. Residents had access to funds in the resident trust account in the evenings and on weekends for four ((#18, 46, 49 and #65) of four sampled residents who were reviewed for night and evening access to money held in the resident trust account. 2. Resident's accounts were credited with interest for five(#9, 18, 46, 49 and #65) of five sampled residents whose trust ledgers were reviewed for transactions and credited interest. 3. Residents were informed when they were within $200 of the $2,000 resource limit for three (#15, 39 and #42) of three sampled residents whose accounts were reviewed for balances within $200 or over the resource limit. 4. Quarterly statements were provided to residents and/or their representative for five (#9,	F 159		

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F 159	Continued From page 5 18, 46, 49 and #65) of five sampled residents reviewed for trust account statements. 5. The resident's account was closed when the resident transferred to another facility for one (#94) of one sampled resident who had money in the trust account and no longer resided in the facility. These deficient practices had the potential to affect all 40 residents who held money in the resident trust account. Findings: 1. Evening and Weekend accessibility: An interview was conducted on 06/17/14 at 9:17 a.m., with resident #49. She was asked if she could access money in the evening and on the weekends. She stated, "I Get money every Tuesday. There is no way to get money on the weekend." An interview was conducted on 06/17/14 at 3:10 p.m., with resident #18. He was asked asked if he could access money in the evening and on the weekends. He stated he did not know. An interview was conducted on 06/16/14 at 2:53 p.m., with resident #46. She was asked if she could access money in the evening and on the weekends. She stated you could get money from the human resource director when needed. She then stated, "You can not get money on the night and weekends. [Human resource director] is not here on the weekends. There is no one else to ask for it."	F 159		

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An interview was conducted on 06/17/14 at 11:46 a.m., with resident #65. She was asked if she could access money in the evening and on the weekends. She stated she had not asked for money on the weekend and didn't know if she could.

An interview was conducted on 06/23/14 at 9:58 a.m., with the human resource director. He was asked how residents were able to get money from the trust account. He Stated, The residents will come directly to me Monday through Friday."

He then added the residents are able to come down and get money anytime Monday through Friday. I would need to be here, if I was out the business office manager handled the request. We do not have any evening and weekend accessibility for the residents.

2. No interest credited to individual accounts:

A review of the ledgers for residents #9, 18, 46, 49 and #65 contained no documentation the facility was crediting interest to their individual accounts.

A review of the resident trust account bank statements for March, April and May 2014, documented the resident's money was being held in an interest bearing account.

On 06/23/14 at 10:22 a.m., an interview was conducted with the business office manager. She was asked, to show where the interest credited to the individual resident's account was documented. The office manager stated they have not been getting interest credited to their account. She then stated, "There hadn't been a

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F 159	Continued From page 7 way to figure interest." 3. Informed when account is within $200 of resource limit: A review of the ledger for resident #42 documented the resident had a current balance of $1,867.98 on 06/18/14. A review of the ledger for resident #15 documented the resident had a current balance of $2,101.60 on 06/18/14. A review of the ledger for resident #39 documented the resident had a current balance of $3,486.83 on 06/18/14. There was no documentation the facility had provided the residents with a notice when they had reached a balance within $200 of the $2000 resource limit. An interview was conducted on 06/23/14 at 10:22 a.m., with the business office manager. She was asked what the resource limit was for medicaid residents. She stated, "Under $2000". I try to make sure they know what their amount is and keep them under the resource limit. She was asked if she provided resident #15, 42 and #39 with a notice when they were within $200 of the resource limit. She stated, "It has not been done." 4. Quarterly Statements: An interview was conducted on 06/17/14 at 9:17 a.m., with resident #49. She was asked if the facility had provided her with statements of	F 159		

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F 159	Continued From page 8 transactions and balances. She stated, "I get five dollars a week and they do not provide statements or balances." An interview was conducted on 06/17/14 at 3:10 p.m., with resident #18. He was asked if the facility had let him know how much money was in his account. He stated,"They don't tell me." An interview was conducted on 06/16/14 at 2:53 p.m., with resident #46. She was asked if the facility had let her know how much money she had in her account. She stated, "I did not know I had money in the trust account. Social Security just started giving me money." An interview was conducted on 06/17/14 at 11:46 a.m., with resident #65. She was asked if the facility had let her know how much money she had in her account. She stated, "I don't know." A family interview was conducted on 06/17/14 at 2:39 p.m., with a family member of resident #9. They were asked if the facility gave statements of how much money was in the resident's account. They stated they were told verbally but had not received quarterly statements. On 06/23/14 at 10:09 a.m., an interview was conducted with the business office manager. She was asked how often resident's received statements of transactions and balances. She stated we haven't been doing quarterly statements. She then added, "I had no way of doing that." 5. Closing accounts when resident transfers: A review of the clinical record for resident #94	F 159		

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F 159	Continued From page 9 documented she had been discharged from the facility on 08/05/13. A review of the list of residents with money being managed by the facility documented the resident continued to have a balance of $2,036 on 06/18/14. An interview was conducted on 06/23/14 at 10:22 a.m., with the business office manager. She was asked how long the resident had been discharged from the facility. She stated, "She has been gone since the later part of last year. She was asked about the account being closed out and the resident being provided her money. She stated, "She has been gone over ten months, the resident trust account should have been closed out a long time ago."	F 159		
F 160 SS=E	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure residents trust funds were conveyed within thirty days for two (#4 and #44) of two sampled residents who had expired and had money in the facility's resident trust account. This had the potential to	F 160		

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F 160	Continued From page 10 affect all 40 residents identified to have funds in the resident trust account. Findings: On 06/18/14 at 10:00 a.m., a request was made to the human resource director for a list of residents in the past six months who held money in the trust and had expired A list was provided with resident #4 and #44 on it. A review of the clinical record for resident #4 documented the resident had expired on 04/27/14. A review of the clinical record for resident #44 documented the resident had expired on 05/11/14. An interview was conducted on 06/23/14 at 10:27 a.m., with the business office manager. She was asked how long the facility had to convey resident trust funds upon death. She stated,"I want to say it's around thirty days." A request was made for documentation of when the accounts were closed out for resident #4 and #44. The business office manager provided copies of the trust account close out statements. The statements documented each account was closed out on 06/17/14. Resident #4 expired on 04/27/14 and the account was closed 54 days after the resident's death. Resident #44 expired on 05/11/14 and the account was closed 37 days after the resident's	F 160		

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F 160	Continued From page 11 death.	F 160		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure residents were able to have privacy and not have staff enter	F 164		

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their rooms without waiting for permission to enter for two (#93 and #65) of 25 sampled residents. The facility census was 69.

Findings:

1. Resident # 93 was admitted to the facility with diagnoses to included gastro-Intestinal obstruction, diabetes and pain management.

On 06/16/14 at 3:30 p.m., a resident interview screening was being conducted in the resident's room with the door closed.

CNA (certified nurse aide) #2 knocked once on the residents door, opened the door and walked into the room. The CNA did not wait for permission to enter from the resident.

The CNA observed the surveyor and announced, "I'm sorry, I just need this tray." She entered the resident's room, picked up the lunch tray and exited the room.

The resident was asked if staff normally knocked and entered or did they knock and wait. She stated, "Some do, some don't."

2. Resident # 65 was admitted to the facilty with diagnoses to include status post cardiovascular accident.

A significant change assessment, dated 04/05/14, documented the resident exhibited no cognitive deficits and was able to make her needs known.

The assessment further documented the resident required extensive assistance with all aspects of daily living, except eating.

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F 164	Continued From page 13 On 06/17/14 at 11:44 a.m., a resident interview was conducted in the resident's room as she sat in her wheelchair. The door was closed during the interview. At 11:46 a.m., CNA # 2 knocked once on the residents door and immediately pushed it open, stuck her head in, observed the interview in process, excused herself and backed out. She was heard to say, "Oh, I'm sorry." At 11:56 a.m., LPN (licensed practical nurse) # 1 opened the door to the resident's room and walked in. She was not observed to knock on the door prior to entering. As she entered the residents room, NP (nurse practioner) # 1 entered with her. LPN # 1 excused herself as she approached the resident sitting in the wheelchair and stated, "Miss [Resident] the [NP] needs to see the rash you've been complaining about." The NP moved around to the front of the resident sitting in the wheelchair and kneeled down between the surveyor and the resident. She was observed to raise the sleeve on the residents left arm and exam a small dry scaly area on her forearm. After looking at the residents arm the NP moved around to the back of the wheelchair and pulled the residents shirt up to view her back area. Once the examination was completed the LPN and the NP left the room. At 12:01 p.m., CNA # 2, again knocked on the door and pushed it open. The CNA again	F 164		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 14 apologized as she closed the door and backed out. The resident never gave permission to any of the staff which entered her room during the interview. On 06/18/14 at 6:00 p.m., CNA #2 was interviewed and asked if residents were provided with privacy when care was provided. She stated they were. She was asked if she thought staff respected residents' privacy by waiting for the resident to answer when the staff knocked on their door. She stated, "Yes. We do." The CNA was advised of the above observations in which she did not wait for an answer before opening the residents door. The CNA stated, "Yes mame, I know. I was just in a hurry." On 06/20/14 at 2:50 p.m., a follow up interview was conducted with resident # 93 as she sat in a wheelchair at her bedside. The door to the room was closed as the interview began. At 2:52 p.m., housekeeper (HSK) #3 knocked on the residents door and pushed it open. She then began to speak to the resident and announced she needed to clean the room as she began to enter. The resident asked the HSK if she could come back later because she was speaking to the surveyor. The HSK agreed and closed the door. A 2:55 p.m., LPN # 2, opened the residents door, leaned into the room and asked, "Is everything ok?" The resident stated, "Yes. I 'm trying to talk to the state lady." The LPN continued standing	F 164		

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F 164	Continued From page 15 in the doorway looking back and forth between the resident and the surveyor. After approximately 30 seconds of looking, she began to close the door and backed out of the room. At 2:57 p.m., CNA #2 knocked on the residents door once, pushed it open, looked in the room and announced she needed to pick up the meal tray. Not waiting for an answer, she entered the room picked the meal tray up from the bedside table and left the room. On 06/20/14 at 4:30 p.m., an interview was conducted with the director of nursing (DON). She was asked if it was within their policy staff was expected to wait for permission before entering a resident's room. She stated, "Yes it is." She was then advised of the above observations for which she stated, "Well, I guess we have more training to do."	F 164		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure one (#64) of one sampled resident was free of restraints by assessing the resident for a seat belt, monitoring the seat belt use, release times, have medical justification, and reassess	F 221		

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F 221	Continued From page 16 the effectiveness of the restraint. The facility Census and Condition dated 06/16/14, documented one resident resided in the facility who was restrained. Findings: The "General Guidelines for the use of Physical Restraints" documented, "...Purpose: The purpose of these physical restraint guidelines to ensure each resident attains and maintains his/her highest practicable well-being in an environment that prohibits the use of restraints...for convenience and limits physical restraint usage to circumstances in which the resident has medical symptoms that warrant the use of restraints... Guidelines...physical restraint include....seat belts....least restrictive devices include pillows, cushions, bolsters....restraints will only be used after alternate methods have been tried unsuccessfully and upon the written order of a physician that specifies the circumstances for the use of the restraint.... administrative policies governing restraints...clearly delineate the following...orderers indicate the specific medical reason for using the device, the circumstances under which it can be used, the type of device, and the length of time over which it can be used. Restraints must only be a last resort... Steps in the procedure...assessment team, in coordination with the resident and his/her family or representative...will develop and maintain a comprehensive care for the resident...the care	F 221		

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plan will focus on the specific needs of the resident...designated staff must explain the risk and benefits of all options under consideration including using a restraint, not using a restraint and alternatives to restraint use...informed consent for the physical restraint will be obtained from the resident or legal representative, negative outcomes and benefits will be discussed with the resident and or legal representative...facility staff will monitor the resident's medical symptoms, conditions, circumstances and environment in order to evaluate the appropriateness of restraint use...

The use of restraints is identified on the resident's care plan and includes...medical symptoms that warrant the need...the symptoms that are being treated..type of restraint to be used...when the restraint is to be used...the plan for release of the device...plan for monitoring every 30 minutes and how the restraint will assist the resident in reaching his/her highest level of physical and psychosocial well being..."

Resident #64 was admitted to the facility with diagnoses to include altered mental status, difficulty in walking, muscle weakness, schizophrenia, anxiety and psychosis.

A physician's order dated 01/07/14, documented, "Seat belt while up in wheelchair to prevent falls with injuries, may be release q [every] 2 hours for activities, and ADL's [activities of daily living]."

a quarterly assessment dated 02/13/14, documented the resident required limited assistance with bed mobility, transfers, walking, eating. The assessment further documented the resident required extensive assistance with

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F 221	Continued From page 18 dressing, locomotion, toilet use and hygiene. No restraint was coded on the assessment. A significant change assessment dated 05/13/14 documented: the resident required extensive assistance with bed mobility, transfers, walking, dressing, eating, toilet use and hygiene. The resident had no impairments to the upper and lower extremites and need staff to stabilize balance during transitions. The assessment further documented the use of a physical restraint. The current care plan, dated 05/16/14, documented; "Problem: [Name deleted] uses a physical restraint due to confusion and safety concerns... Goal: Will remain free of complications related to restraint use, including contracture, skin breakdown, altered mental status, isolation or withdraw... Interventions...Alternatives to restraining the resident are 1:1 and documented by staff...Anticipate and intervene for potential causes which have precipitated prior falls or accidents...discuss and record with the resident/family/caregivers, the risk and benefits of the restraint, when the restraints should/will be applied, routines while restrained and any concerns or issues regarding restraint use... ensure the resident is positioned correctly with proper body alignment while restrained...ensure valid consent on chart prior to initiating restraint...evaluate [Resident] restraint use: evaluate/record continuing risks/benefits of restraint, alternatives for restraint, need for	F 221		

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F 221	Continued From page 19 ongoing use, reason for restraint use... monitor/document/report PRN any changes regarding effectiveness of restraint, less restrictive device, if appropriate any negative or adverse effects noted...provide meaning full program of activities that accommodates restraint use without drawing unwanted attention. Provide restraint free time during activities... opportunities for restraint free time and physical activity..." The care plan does not address the following: medical symptoms that warrant the need, the symptoms that are being treated, type of restraint to be used, when the restraint is to be used, the plan for release of the device, plan for monitoring every 30 minutes and how the restraint will assist the resident in reaching his/her highest level of physical and psychosocial well being. The resident's care plan does not address the resident standing and walking with her wheel chair while the lap belt is in place. The care plan does not list the specific restraint in use. There was no documentation the facility assessed the resident prior to placing her in the restraint. A review of the clinical record contained no documenation in the nurse's notes under weekly summary regarding the restraint and times the resident is restraint free. There is no documenation of the resident being able to stand up with the wheel chair and walk while the restraint is in place.	F 221		

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F 221	Continued From page 20 There was no documentation of risk versus benefits, (education) prior to placing the resident in a restraint. There was no documentation of less restrictive measures being implemented and tried and the medical condition for the use of the restraint. There was no documentation of the effectiveness or possible negative outcomes of the use of the restraint. On 06/16/14 at 10:30 a.m., the resident was observed in the main common area of the facility in her wheel chair. A soft seat belt was fastened across the resident's lower waist. The resident was observed edging herself to the edge of the wheel chair, while holding both armrests, she lifted straight up to a standing position and started to walk while holding the wheel chair up. Staff was observed to immediately redirect the resident and sit her back down. On 06/17/14 at 8:20 a.m., the resident was observed at the breakfast table with a soft seat restraint in place. The seat belt was fastened and not released during the meal. 06/18/14 at 10:29 a.m., the resident was observed in the common area near the vending machines. The resident was in her wheel chair with a soft seat belt in place. The resident was able to propel herself around the room and was reaching for the vending machines. At 11:55 a.m., the resident remained in the lobby up in her wheel chair with the soft lap belt in place. She continued to propel herself around	F 221		

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F 221	Continued From page 21 the lobby area. On 6/18/14 at 1:10 p.m., the resident was observed being propelled by CNA # 20. The resident had the soft seat belt in place and fastened in the front. The resident was asked if she could unhook the belt. She shook her head no. The CNA stated, "Oh no, she can't un-do it." The aide propelled the resident to her room where she asked if the resident needed to use the bathroom. The CNA assisted the resident to a standing position by holding her hands. The resident stood without much assistance and ambulated into the bathroom. The aide was asked why the resident used the seat belt. She stated because she's a high fall risk. She is very strong and had to be watched because she'll stand up and and fall. The seatbelt is to keep her seated. On 06/18/14 at 3:30 p.m., the resident's roommate was asked about the resident's use of the restraint. She can pick up the wheelchair and walk with it, but staff can get her to sit down. She further stated the resident has had the seatbelt since going to the hospital after a fall. An interview was conducted on 06/18/14 at 4:40 p.m., with CNA (certified nurse aide) #7. She was asked if the resident had a restraint. The aide stated, "There is one on her chair." She was asked if the resident was able to stand while the seatbelt was in place. She stated she had witnessed the resident stand up with the wheelchair. She does it throughout the whole	F 221		

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F 221	Continued From page 22 day. A lot of times she is sitting up here so we can watch her. The charge nurse knows she will stand. Everyone knows to redirect her and have her sit back down. She will always sit back down, sometimes you have to approach her. An interview was conducted on 06/18/14 at 4:44 p.m., with LPN (licensed practical nurse) #7 . She was asked if the resident was able to stand up and walk with the wheel chair while restrained. She stated, "Sometimes she will stand up with the wheel chair." She then added everyone knows about it and redirects her. She was asked if the resident was able to be directed. The nurse stated, "We are always there to redirect her and we walk her down the hall. She was able to be redirected every time. She then stated , "She talks and is alert." An interview was conducted on 06/18/14 at 4:46 p.m., with the social service director. She was asked if the resident had a restraint. She stated, "Yes. She tried to stand and she can lift the wheelchair." She was asked how long the resident had been able to stand with the restraint in place. She stated, since I have known her she has, she is easily redirected. I am not aware of anytime she had a fall. She then added, "We think she wants to walk and try to get her up. All the staff know about it. She is easily redirected and has not fallen." An interview was conducted on 06/18/14 at 5:30 p.m., with the DON (director of nursing). She was asked if the resident had a restraint. She stated the resident had a soft seat belt.	F 221		

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She was asked if the resident is able to stand up with the seat belt in place. She stated. Sometimes she stood up while in the wheelchair with the seatbelt in place. She has never had a fall. Every staff member knew about that.

When asked what the facility had tried before placing her in a restraint. She stated, "Redirection, 1:1, and activities. She is able to be redirected."

06/19/14 at 7:25 a.m., the resident was up in her wheelchair outside the shower room waiting for the shower. Her seat belt was in place.

At 7:42 a.m., the resident was taken back to her room without being bathed or showered.

At 8:22 a.m., the resident was taken from her room to the dining room for her morning breakfast. The resident was placed at the table and served her breakfast. The seat belt was not released during the meal.

An interview was conducted on 06/19/14 at 8:50 a.m., with the DON. She was asked where the restraint documentation was located. She stated the documentation is kept in the nurse's notes under the weekly summary and the assessments should be under the assessment tab on the computer.

She was asked what should be charted on restraints. She stated when the restraint is released during meals and activities. She was asked where complications from the restraints would be documented. She stated, "It should be in the notes about her standing in the wheelchair

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F 221	Continued From page 24 with the restraint in place." When asked about activities she stated the restraint is to be released during activities. On 06/19/14 at 8:53 a.m., the resident was observed being taken from the dining room into the shower room by LPN #7. On 06/19/14 at 8:55 a.m., the resident was observed up in the common area of the facility with her seat belt in place. She scooted to the edge of the wheel chair stood up, lifted the wheel char and walked. Staff immediately redirected the resident and she sat down. The wound nurse asked the resident if she needed to go to the bathroom and the resident stated yes. An interview was conducted on 06/19/14 at 9:13 a.m., with LPN #7. She was asked why the resident went into the shower room. She stated, "To release the seat belt to be walked around the shower room." She then added the resident was going to be toileted but wasn't because once she was standing she wanted to walk around. An interview was conducted on 06/19/14 at 12:27 p.m., with the DON. She was asked where the aassessment was for the resident's restraint. She stated, "I don't see it, I will go and ask therapy." When asked what less restrictive measures were attempted prior to placing the seat belt restraint. She stated, a vest with activities on it to keep her distracted, 1:1 staff, tipped her wheel chair back and gave her small task of things to do such as folding towels.	F 221		

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F 221	Continued From page 25 Do you have any assessments showing these measures did not work. She stated, "We did not document any of it." When asked what the medical condition was for the use of the restraint: The director stated, "There is no medical condition for her it's for safety." Is falls a medical condition. She replied no. When was the resident placed in the seatbelt restraint: The order was written in January. "That is when it was placed on the resident." Where is the documentation of education, risks versus benefits and consent: I have not been able to reach the family. We don't have a consent. We talked to the resident about it. Are there any documentation of risk versus benefits. No. You said the restraint was for safety, safety from what? So she would not harm herself and because she had an unsteady gait and was really confused. What does the care plan say about the restraint and why she has the restraint: She stated, "It's related to confusion and safety." Has the resident had any . She stated she had falls prior to the restraint in place. All of her falls were in 2013. How often do you evaluate the resident for a restraint reduction? At least quarterly we assess for a reduction. Therapy is suppose to do a	F 221		

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F 221	Continued From page 26 reduction assessment. A Request for documentation of restraint use from the nurse's notes and the documentation of the resident standing with restraint in place was made. No documentation was provided. On 06/19/14 at 1:29 P.M., an interview was conducted with the therapy department. They were asked for copies of the restraint assessments for the resident. The speech therapist stated, "There is not anything because she was not on therapy when she was placed in the restraint." They were asked if they had any involvement with the placement of the restraint and further assessments to reduce it. The COTA (certified occupational therapists) stated, "We do not do the reduction assessment. We have not done anything for it." At 1:47 p.m., the DON was asked if the care plan was fully developed to address the resident's use of a restraint. She stated, "I looked at it and it is not good." She then stated there were no assessments done, risks versus benefits, consent and had no medical symptoms for the restraint use. CNA #14 was interviewed on 06/19/14 at 2:13 p.m. She was asked when the restraint was to be released. She stated the restraint is suppose to be removed at meals because the table is a restraint. The only time it's to be removed is in the dining room and going to bed. The activities director was interviewed on	F 221		

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F 221	Continued From page 27 06/19/14 at 2:48 p.m. She was asked about the restraint during activities. She stated, "Most of the activities are sitting down activities. I do not undue the seat belt, unless I am getting her up to walk her." She was asked what the care plan stated about the restraint and activities. She stated, "It's suppose to be removed."	F 221		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure: 1. Residents were not dressed in clothing with a name visibly written on the outside of the clothes. This affected one (#45) of twenty-five sampled residents. The facility Census and Condition Report documented 65 residents required staff assistance from one or two persons with dressing. 2. Residents seated at the same table were served their meals at the same time for two (#1 and #37) of two sampled residents observed at meals and not served at the same time as their	F 241		

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table mates. This had the potential to affect 50 residents who consumed one or more meals in the dining room.

3. A dining room table was free from rocking back and forth while residents were eating for one (#64) of one sampled resident's who received meal assistance in the dining room and their table rocked back and forth. This had the potential to affect 50 residents who consumed one or more meals in the dining room.

4. Resident's who received hall tray meals were not served plastic eating utensils. This deficient practice effected 29 residents who had one ore more meal in their room each day.

Findings:

1. Resident #45 was admitted to the facility with diagnoses to include memory loss and mental illness.

The resident's care plan, dated 10/17/12, and revised last on 06/17/14, documented:

"Focus: [Resident] has an ADL [activities of daily living] Self Care Performance Deficit.

Goals: Will maintain current level of function in... dressing ... through the review date.

Interventions: Dressing - Requires extensive assist from staff."

The resident's 5 day Medicare assessment, dated 02/16/14, documented the resident was moderately impaired in cognition and required extensive staff assistance with dressing.

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EDWARDS REDEEMER HEALTH & REHAB	1530 NORTHEAST GRAND BLVD OKLAHOMA CITY, OK 73117

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The resident's 60 day Medicare assessment, dated 04/12/14, documented the resident's cognitive status had declined and was now severely impaired in cognition and required total assistance with dressing.

On 06/16/14 at 4:18 p.m., the resident was observed at the nurse's station sitting in her wheelchair. The resident was wearing a pair of yellow pants. The pants had a name written on the upper left leg portion in black marker.

The name written on the pants was not the resident's name.

On 06/18/14 at 1:45 p.m., the resident was observed in her wheelchair in the hallway. She was observed wearing a pair of yellow pants with a name written on the upper left portion of the leg in black marker.

The name written on the pants was not the resident's name.

On 06/23/14 at 3:10 p.m., an interview was conducted with the Administrator (ADM) and the Vice President of Clinical Services (VP). They were informed of the above findings. No verbal explanation was provided.

Plastic utensils on hall trays:

On 06/17/14 the morning hall trays were observed with plastic wear on each tray.

On 06/17/14 at 8:15 a.m., a confidential resident interview was conducted. The resident was asked about the plastic wear on his morning tray.

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F 241	Continued From page 30 He stated, "They always provide plastic wear and it's hard to cut the food with plastic." On 06/19/14 at 7:43 a.m. the hall trays were observed being brought out. The trays on the rack were observed with plastic utensils for residents use. An interview was conducted on 06/19/14 at 7:50 a.m., with CNA (certified nurse aide) #18. When asked about the plastic wear on the trays he stated, "Because the residents like to keep them, safety issues and they are waiting on more silverware." On 06/20/14 at 12:17 p.m., the noon meal hall trays were brought out. Each tray was observed with plastic ware for the residents to use. An interview was conducted on 06/20/14 at 12:20 p.m., with CNA #1. When asked why residents were eating their meals in the room with plastic ware she stated, "I don't know why they have them, they are used a lot and are usually rolled up in the napkin. " An interview was conducted on 06/20/19 at 12:23 p.m., with the consulting dietician. When asked why the facility was using plastic ware for the hall trays she stated, "To be honest they don't have enough or didn't have a dishwasher." On 06/23/14 at 9:39 a.m., an interview was conducted with the administrator. He was asked about the plastic ware on the hall trays. he stated, "That's not normal. I don't know if he was out. They normally get silverware." On 06/23/14 at 11:30 a.m., the certified dietary	F 241		

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manager was asked why plastic utensils were used for residents who received hall trays. He stated the facility did not have enough silverware for both the residents who ate in the dining room and the residents who received hall trays. He stated the trays either had to have plastic utensils or no utensils.

He was asked how long plastic utensils had been used on hall trays. He stated the plastic utensils had been used 3 weeks.

When asked why more silverware had not been ordered. The dietary manager stated he had ordered more utensils on 06/22/14. He then stated they had not been put on the order.

Dining room:

On 06/16/14, the noon meal service was observed in the dining room. The table inside the east door was observed to rock back and forth, as residents consumed their meal. Three residents were observed seated at the table.

Resident #1 was observed receiving her meal while her three table mates had to wait. The table mates had to wait fifteen minutes after resident #1 received their meals.

On 06/19/14 from 7:45 a.m. through 8:30 a.m., the morning meal was observed in the dining room.

Resident #37 was observed at his table with one table mate. At 8:05 a.m., the table mate received his meal and started to eat. Resident #37 watched the resident have his meal while he continued to wait. At 8:11 a.m., resident #37

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received his meal tray. The resident waited six minutes before he received his breakfast.

The table inside the east door to the dining room was observed with a telephone book under it to balance it. The table was observed rocking back and forth as staff assisted resident #64 with her meal. Three additional residents were at the table during the observation.

An interview was conducted on 06/23/14 at 2:37 p.m., with CNA #19 She was asked what the facility policy was for serving meals to residents in the dining room. She stated the residents in the dining room who required assistance with meals are first. Then all other residents.

She then stated, "They are suppose to serve everyone at the table first (at the same time)."

She was asked if a resident had to wait five or more minutes for their meal, after the table mates were served, was it a dignity issue. She stated, " Yes if a resident had to wait five to ten minutes for his food after table mate received it is a dignity issue."

An interview was conducted on 06/23/14 at 2:43 p.m., with CNA #20 regarding dignity at meals. She was asked how tables were to be served in the dining room. She stated, "They get served at the same time." She then added, "If they have to wait five to ten minutes it would make a resident feel like they were left out. It is a dignity issue."

An interview was conducted on 06/23/14 at 2:48 p.m., with dietary aide #1 He was asked about the order of meal trays being served. He stated, The trays get served by name and will be served

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F 241	Continued From page 33 at the same time (tables served together). He was asked why residents would have to wait five or more minutes while their table mates had their meal. He stated it is an issue if they have to wait five to ten minutes after the table mate had theirs. When the resident had to wait it would be a major problem. An interview was conducted on 06/23/14 at 2:55 p.m., with the certified dietary manager. He was asked what is the order of tray service was in the dining room. He stated, " We go by the tables." He then added, "We try to get everyone at the same table. If someone shows up late they would not get their food right away." He was asked if their was a problem with having to wait five to ten minutes while the other residents had their meal at the table. He stated, "They would feel left out and not attended to. If they felt that way it would be a dignity issue."	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined the facility failed to maintain the residents' rooms and hallways free from chipped paint, an odor free environment and shower rooms in good repair.	F 253		

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F 253	Continued From page 34 The facility Census and Conditions, dated 06/16/14, documented 69 residents resided in the facility. Findings: Chipped paint On 06/19/14 at 10:30 a.m., the following observations were made on hall 100: The wall located on the south wall had chipped paint. Room 102 had chipped marred paint on the walls beside both beds. There were holes in the north wall above the sink. Room 108 had chipped, marred paint on the west wall by the bathroom. Rm 101 - had chipped, marred paint on the west wall. On 06/16/14 at 3:14 p.m., room 606 was observed with chipped marred paint on the walls and a cabinet had chipped paint on the counter top. On 06/17/14 at 8:27 a.m., room 610 was observed with chipped, flaked paint on the wall by the head of the bed, on the north wall and the bathroom door. Chipped, flaking paint was also observed on the north side of the room beside the bathroom door, vanity cabinet and imitation wood on front of the cabinet.	F 253		

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F 253	Continued From page 35 Paint was observed chipped and flaked in room 606 B on the wall by the head of bed. The wall on the north side of the room, by the bathroom door had chipped and flaked paint. The vanity cabinet was chipped on the front of cabinet. At 10:06 a.m., the walls around the parameter of room in 605 B were marred. Paint was chipped off in several areas around the room. At 3:31 p.m., the ceiling inside room 603 A, a 1 ft x 1 1/2 ft area of paint was missing to the right of the sink. The walls had chipped and peeling paint. At 3:45 p.m., the walls beside the bed in room 603 B were marred. Odors: On 06/16/14 at 5:02 p.m., room # 106 (resident #20's room) had a strong odor of urine. On 06/17/14 at 9:20 a.m., the room of resident #49 and #55 (room 103) was observed. The room had a persistent odor of urine. On 06/18/14 at 10:15 a.m.,11:00 a.m.,11:30 a.m., and 2:00 p.m., a very strong odors of urine and feces were noted on hall 100. At 10:30 a.m., a strong odor of urine was detected at the nurse's station in the central area. The DON (director of nursing) was asked if she detected any odors. She said yes, "I'll have housekeeping check on it." At 10:35 a.m., and 06/19/14 at 10:51 a.m., there	F 253		

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F 253	Continued From page 36 continued to be a strong odor of urine permeating in room 103 and 106. At 11:49 a.m., there was a strong odor of urine in the common area by the television and near the nurse's station. At 11:50 a.m., a strong odor of urine was in room 103 and 106. On 06/19/14 at 3:45 p.m., and 06/20/14 at 2:20 p.m., there was a strong odor of urine permeating from room 103 and 106. An interview was conducted on 06/23/14 at 3:10 p.m., with the housekeeping supervisor. She was asked how long there had been odors in the common area, hallways and resident rooms. She stated I had not noticed a problem unless residents were being changed. If a resident is in the room we have a deodorizer spray. We use a spray to eliminate odors. She then stated, "It is hard because we can not get the right chemicals and not enough staff to keep the odors down." She was asked about room 103 and 106. She stated, I had been in room 103 and 106 myself and cleaned them. We try to do what we can to eliminate the odors. Whirlpool and shower rooms: On 06/20/14 at 2:00 p.m., the whirlpool, in the hall 500 shower room, had caution tape wrapped around the handles and faucets. There were blue incontinent pads, a shower curtain and various unidentified items laying in the bottom of the	F 253		

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F 253	Continued From page 37 whirlpool. At 2:31 p.m., CNA(certified nurse aide)#8 was asked if the whirlpool in the hall 500 shower room worked. She stated the shower room was not used for bathing residents. At 2:44 p.m., several observations were made in the hall 300 shower room. A black substance was observed on the floor tiles under the shower bed and around the walls by the whirlpool. The whirlpool was being used as a storage area for pillows, a shower curtain, towels, clothing, blue incontinent pads, and adult incontinent briefs. A shower chair with a piece of plastic protruding through a crack near the front of the seat was observed. The plastic protrusion was located on the seat area where resident contact would be made when seated in the chair. The protruded area was sharp to the touch which was a potential harm to a resident. The counter in the whirlpool room was cluttered with boxes of open gloves and disposable gloves which have been pulled out of the box were laying on the counter. A used razor was laying on the counter with the blade side down. One shower stall was missing a shower curtain. Tile was observed missing from a portion of the wall next to the shower stalls. The missing tiles exposed the interior part of the wall, including the end of a 2 X 4 board. The exposed interior area was dark in color, the end of the 2 X 4 board showed signs of deterioration. The board was rotting and pieces of the board were splitting a part.	F 253		

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F 253	Continued From page 38 On 06/23/14 at 9:45 a.m., maintenance #1 was asked if he was aware of the missing tile in the hall 300 shower room. He stated the tile had been ordered. He was asked when the tile was ordered, he stated, "About a month ago." At 1:55 p.m., the administrator was shown the shower room on hall 300 and room 603. He was asked who was responsible for cleaning the shower rooms. He stated housekeeping and the CNAs. He was asked if work orders were in place for repairs to the shower room and to complete the ceiling repair in room 603. He stated he was aware there were many areas that needed to be taken care of across the facility. He was asked if he would like to see the other rooms that had been identified as needing repairs and/or paint. He stated, "We have hired a painter and will prioritize projects when funding is available." A review of the maintenance log book did not contain documentation the facility was addressing any of the concerned areas as noted.	F 253		
F 256 SS=E	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to ensure there was adequate lighting in the common area of the facility, where activities were held. This had the potential to affect all 69 residents who resided in	F 256		

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F 256	Continued From page 39 the facility. Findings: An interview was conducted on 06/16/14 at 2:30 p.m., with resident #46. She was asked if she had any problems with lighting in the facility. She stated, "Not enough light out in the common areas" . On 06/18/14 at 2:30 p.m., eight lights were out in the common area near the vending machines, where residents participated in activities. On 06/19/14 at 10:40 a.m., the lights continued to be out in the common area near the vending machines. On 06/20/14 at 11:53 a.m., resident # 16 was observed in the common area working on a word puzzle. She was asked if there was enough light for her to read and do activities. She stated, "It's not enough,it is dark." She then added there is something wrong with the lights. It has been that way for over a month. Eight lights continued to be out above the resident where she was working on her puzzle. An attempt was made to turn on the lights with all the switches in the area and the lights were not able to be turned on. An interview was conducted on 06/20/14 at 12:11 p.m., with maintenance #1. He was asked how often lights were checked for being out. He stated, "I just go through or the nurses will tell you, its a daily thing." He was asked about the eight lights in the	F 256		

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F 256	Continued From page 40 common area. He stated they are not always out. He went over to the common areas and attempted to turn on the lights that were out. He came back and stated, "They did not come on." When asked how long they had not been working he stated he did not know. An interview was conducted on 06/23/14 at 8:10 a.m., with the administrator. He was asked about the lights being out in the common area. He stated, "I know we have been having problems. I do not know how long it's been out." He then added, "It's something electrical that an electrician will need to come out and take care of." A request was made for facilty maintenance policy regarding lighting in the facility and replacing bulbs. He stated he did not have a policy.	F 256		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272		

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F 272	Continued From page 41 Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, it was determined the facility failed to ensure a resident was assessed prior to the use of seat belt restraint and reassessed for the effectiveness of the restraint for one (#64) of one sampled resident's revived for restraint use. The facility Census and Condition dated 06/16/14 documented one resident resided in the facility who was restrained. Findings: The "General Guidelines for the use of Physical	F 272		

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F 272	Continued From page 42 Restraints" documented, "...Purpose: The purpose of these physical restraint guidelines to ensure each resident attains and maintains his/her highest practicable well-being in an environment that prohibits the use of restraints...for convenience and limits physical restraint usage to circumstances in which the resident has medical symptoms that warrant the use of restraints... administrative policies governing restraints...clearly delineate the following...restraints must only be a last resort... Steps in the procedure...assessment team, in coordination with the resident and his/her family or representative...will develop and maintain a comprehensive care for the resident...the care plan will focus on the specific needs of the resident...designated staff must explain the risk and benefits of all options under consideration including using a restraint, not using a restraint and alternatives to restraint use...informed consent for the physical restraint will be obtained from the resident or legal representative, negative outcomes and benefits will be discussed with the resident and or legal representative...facility staff will monitor the resident's medical symptoms, conditions, circumstances and environment in order to evaluate the appropriateness of restraint use..." Resident #64 was admitted to the facility with diagnoses to include altered mental status, difficulty in walking, muscle weakness, schizophrenia, anxiety and psychosis. A physician's order dated 01/07/14, documented, "Seat belt while up in wheelchair to prevent falls	F 272		

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	375339	A. BUILDING _____ B. WING _____	C 06/23/2014

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F 272	Continued From page 43 with injuries, may be release q [every] 2 hours for activities, and ADL's [activities of daily living]." A quarterly assessment dated 02/13/14, documented the resident required limited assistance with bed mobility, transfers, walking and eating. The assessment further documented the resident required extensive assistance with dressing, locomotion, toilet use and hygiene. No restraint was coded on the assessment. A significant change assessment dated 05/13/14 documented the resident required extensive assistance with bed mobility, transfers, walking, dressing, eating, toilet use and hygiene. The resident had no impairments to the upper and lower extremites and need staff to stabilize balance during transitions. The assessment further documented the use of a physical restraint. The current care plan, dated 05/16/14, documented: "Problem: [Name deleted] uses a physical restraint due to confusion and safety concerns... Goal: Will remain free of complications related to restraint use, including contracture, skin breakdown, altered mental status, isolation or withdraw... Interventions...discuss and record with the resident/family/caregivers, the risk and benefits of the restraint, when the restraints should/will be applied, routines while restrained and any concerns or issues regarding restraint use... ...evaluate [Resident] restraint use: evaluate/record continuing risks/benefits of	F 272		

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F 272	Continued From page 44 restraint, alternatives tor restraint, need for ongoing use, reason for restraint use... monitor/document/report PRN [as needed] any changes regarding effectiveness of restraint, less restrictive device, if appropriate any negative or adverse effects noted..." There was no documentation the facility assessed the resident prior to placing her in the restraint. A review of the clinical record contained no documenation in the nurse's notes under weekly summary regarding the restraint and times the resident is restraint free and the appropriateness of the restraint. There was no documenation of the resident being assessed once she was able to stand up with the wheel chair and walk while the restraint was in place. There was no documentation of less restrictive measures having being implemented and assessed for effectiveness prior to the resident being placed in a restraint. There was no documentation of the effectiveness or possible negative outcomes to the resident due to the restraint use. On 06/16/14 at 10:30 a.m., the resident was observed in the main common area of the facility in her wheel chair. A soft seat belt was fastened across the resident's lower waist. The resident was observed edging herself to the edge of the wheel chair, while holding both armrests, lifted straight up and started to walk while holding up	F 272		

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F 272	Continued From page 45 the wheel chair. On 06/18/14 at 10:29 a.m., the resident was observed in the common area near the vending machines. The resident was in her wheel chair with a soft seat belt in place. The resident was able to propel herself around the room and was reaching for the vending machines. On 06/18/14 at 3:30 p.m., the resident's roommate was asked about the resident's use of the restraint. She stated the resident can pick up the wheelchair and walk with it, but staff can get her to sit down. An interview was conducted on 06/18/14 at 4:40 p.m., with CNA (certified nurse aide) #7. She was asked if the resident had a restraint. The aide stated, "There is one on her chair." She was asked if the resident was able to stand while the seatbelt was in place. She stated she had witnessed the resident stand up with the wheelchair and did throughout the whole day. On 6/18/14 at 1:10 p.m., the resident was observed being propelled by CNA # 20. The resident had the soft seat belt in place and fastened in the front. The resident was asked if she could unhook the belt. She shook her head no. The CNA stated, "Oh no, she can't un-do it." The aide propelled the resident to her room where she asked if the resident needed to use the bathroom. The CNA assisted the resident to a standing position by holding her hands. The resident stood without much assistance and	F 272		

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F 272	Continued From page 46 ambulated into the bathroom. The aide was asked why the resident used the seat belt. The seatbelt is to keep her seated. An interview was conducted on 06/18/14 at 4:46 p.m., with the social service director. She was asked if the resident had a restraint. She stated, "Yes. She tried to stand and she can lift the wheelchair." She was asked how long the resident had been able to stand with the restraint in place. She stated, since I have known her she has, she is easily redirected. She then stated, "We think she wants to walk and we try to get her up." An interview was conducted on 06/18/14 at 5:30 p.m., with the DON (director of nursing). She was asked if the resident had a restraint. She stated the resident had a soft seat belt. She was asked if the resident is able to stand up with the seat belt in place. She stated. Sometimes she stood up while in the wheelchair with the seatbelt in place. When asked what the facility had tried before placing her in a restraint. She stated, "Redirection, 1:1, and activities. She is able to be redirected." An interview was conducted on 06/19/14 at 8:50 a.m., with the DON. She was asked where the restraint documentation was located. She stated the documentation is kept in the nurse's notes under the weekly summary and the assessments should be under the assessment tab on the computer.	F 272		

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F 272	Continued From page 47 An interview was conducted on 06/19/14 at 12:27 p.m., with the DON. She was asked where the assessments were for the resident's restraint. She stated, "I don't see it, I will go and ask therapy." When asked what less restrictive measures were attempted prior to placing the seat belt restraint. She stated, a vest with activities on it to keep her distracted, 1:1 staff, tipped her wheel chair back and gave her small task of things to do such as folding towels. She was asked if there were assessments showing these measures did not work. She stated, "We did not document any of it." She was asked when the resident was placed in the seatbelt restraint. She stated the order was written in January. "That is when it was placed on the resident." She was asked how often the resident was evaluated for a restraint reduction, effectiveness of the restraint and hazards associated with the restraint. She stated, "At least quarterly we assess for a reduction. Therapy is suppose to do the reduction assessments." On 06/19/14 at 1:29 P.M., an interview was conducted with the therapy department. They were asked for copies of the restraint assessments for the resident. The speech therapist stated, "There is not anything because she was not on therapy when she was placed in the restraint." They were asked if they had any involvement with assessing the resident for the restraint. The	F 272		

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F 272	Continued From page 48 COTA (certified occupational therapists) stated, "They do not do the reduction assessment. They have not done anything for it." At 1:47 p.m., the DON was asked if there were any assessments done prior to placing the resident in a restraint , to see if the restraint was effective and had any potential negative outcomes. She stated, "There are no assessments done."	F 272		
F 274 SS=E	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure a significant change assessment was conducted when a resident's cognition, behavior and physical status declined for one (#45) of 25 sampled residents.	F 274		

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F 274	Continued From page 49 The facility Census and Condition Report, dated 06/16/14, documented 69 residents resided in the facility. Findings; Resident #45 was re-admitted to the facility on 02/07/14, with diagnoses to include acute kidney failure, muscle weakness, and dementia. A 30 day Medicare resident assessment with an ARD date of 03/08/14, documented the resident's was moderately impaired in cognition, wandered aimlessly about the facility and rejected care 1-3 days out of seven. The assessment further documented the resident required extensive assistance from one staff member for transfers, ambulation on and off the unit, ambulation in her room and corridor and required extensive assistance with dressing, personal hygiene, and bathing. The 60 day Medicare assessment with an ARD date of 04/12/14, documented the resident was severely impaired in cognition and had behaviors to include rejection of care and wandering 4-6 days out of seven. The assessment further documented the resident required extensive assistance from one staff for bed mobility, transfers, eating, and was totally dependent on staff for dressing and personal hygiene. The assessment also documented the resident was no longer able to ambulate in the room or corridor. No significant change assessment was completed between the 30 and 60 day Medicare	F 274		

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F 274	Continued From page 50 assessments, when the resident experienced a decline in cognition, bed mobility, walking in the room and corridor, dressing, eating, and personal hygiene. The resident also exhibited an increase in rejecting care and wandering. The 90 day assessment with an ARD date of 05/10/14, documented the resident was severely impaired in cognition and ADL (activities of daily living) abilities remained the same. The assessment also documented the resident now received an anti-psychotic medication, an anti-anxiety medication and a hypnotic 7 out of seven days. No significant change assessment was completed between the 60 day and 90 day Medicare assessments when the resident was now receiving an anti-psychotic, anti-depressant and hypnotic medication 7 days a week. On 06/19/14 at 7:30 a.m., the resident was observed receiving a wound treatment. The resident did not respond to verbal stimulation and required two staff while the treatment was being provided due to the resident's combative behaviors. On 06/19/14 at 8:20 a.m., the resident was observed in the dining room for breakfast. The resident was observed to be totally dependent on staff for her meal. On 06/23/14 at 10:25 a.m., LPN (licensed practical nurse) #4, the assessment coordinator, was interviewed regarding the resident's significant changes. She was shown the differences in the resident's	F 274		

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F 274	Continued From page 51 status between the 30 and 60 day assessments and the 60 and 90 day assessments. She stated, "I see what you mean. She did have some significant changes."	F 274		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure care plans reflected the current status for five (#20, #37,#55, #59 and #64) of 25 sampled residents whose care plans were reviewed.	F 279		

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F 279	Continued From page 52 The facility Resident Census and Conditions, dated 06/16/14, documented 69 residents resided in the facility. Findings: The "General Guidelines for the use of Physical Restraints" documented, "...Purpose: The purpose of these physical restraint guidelines to ensure each resident attains and maintains his/her highest practicable well-being in an environment that prohibits the use of restraints...for convenience and limits physical restraint usage to circumstances in which the resident has medical symptoms that warrant the use of restraints... Steps in the procedure...assessment team, in coordination with the resident and his/her family or representative...will develop and maintain a comprehensive care for the resident...the care plan will focus on the specific needs of the resident...designated staff must explain the risk and benefits of all options under consideration including using a restraint, not using a restraint and alternatives to restraint use...informed consent for the physical restraint will be obtained from the resident or legal representative, negative outcomes and benefits will be discussed with the resident and or legal representative...facility staff will monitor the resident's medical symptoms, conditions, circumstances and environment in order to evaluate the appropriateness of restraint use... The use of restraints is identified on the resident's care plan and includes...medical symptoms that warrant the need...the symptoms that are being treated..type of restraint to be used...when the	F 279		

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F 279	Continued From page 53 restraint is to be used...the plan for release of the device...plan for monitoring every 30 minutes and how the restraint will assist the resident in reaching his/her highest level of physical and psychosocial well being..." A facility policy for Wandering and Elopement documented, "The resident's care plan will be modified to indicate the resident is at risk. Interventions will be entered onto the resident's care plan and medical record. " weight loss 1. Resident #37 was admitted to the facility on 01/27/14, with diagnoses to include major depressive disorder, esophageal reflux, vascular dementia with delirium, osteoarthrosis, and dementia with behavioral disturbance. The admission assessment, dated 02/05/14, documented the resident had moderate cognitive impairment, required supervision with eating, was 65 inches tall and weighed 135 pounds, had no swallowing disorder, and had no oral/dental issues. The care plan, dated 02/07/14, and most recently reviewed/revised 05/12/14, did not address a problem with nutrition and/or weight loss. The facility's weight record documented the resident's weights as follows: 01/27/14 - 135.2 pounds 02/23/14 - 137 pounds 03/04/14 - 110 pounds (a severe weight loss of 18.6% in 30 days) 03/06/14 - 114 pounds	F 279		

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F 279	Continued From page 54 04/28/14 - 116 pounds (a severe weight loss of 14.2% in 90 days) 05/11/14 - 112 pounds 05/18/14 - 116 pounds 05/25/14 - 118 pounds 06/04/14 - 118 pounds 06/08/14 - 117 pounds 06/15/14 - 121 pounds A physician's telephone order, dated 03/05/14, documented the resident was to be administered a Lactaid tablet with meals for lactose intolerance. A physician's order, dated 03/06/14, documented the resident was to be served lactose free milk and no dairy products. A dietary note, dated 03/28/14, written by the consultant dietician, documented the resident weighed 114 pounds, a decrease of 21 pounds in 30 days. The note documented the resident was on a regular diet with large portions and the dietician suggested to add MedPass 2.0 60 milliliters twice daily. She also documented, "No issues noted." On 06/19/14 at 9:55 a.m., the surveyor reviewed the above findings with the director of nursing (DON) and asked if the resident's severe weight loss and/or his lactose intolerance had been addressed in the care plan. She reviewed the care plan and stated neither the resident's severe weight loss and/or lactose intolerance had been care planned. The surveyor asked the DON if the severe weight loss and lactose intolerance should have been addressed in the care plan. She stated, "Yes."	F 279		

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F 279	Continued From page 55 side effect monitoring with targeted behaviors. 2. Resident #55 had diagnoses which included anxiety and Multiple Sclerosis. A quarterly assessment, dated 05/12/14, documented the resident was moderately impaired in cognition, made herself understood and understood others. The resident's care plan, dated 02/10/14 and revised on 05/12/14, documented: " Focus ...uses anti-anxiety medications r/t [related to] Anxiety disorder... will be free from discomfort or adverse reactions related to anti-anxiety therapy... Monitor/document/report PRN [when required] any adverse reactions to Anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Sslurred [sic], confusion and disorientation, depression, dizziness, lightheadness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinati [sic] Monitor/record occurrence of for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others,etc.) and document per facility protocol."	F 279		

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F 279	Continued From page 56 On 06/18/14 at 3:00 p.m., the resident was interviewed about her medication regime. She stated she did suffer from anxiety. She said that when the anxiety episodes occurred she would start shaking, her heart would race and she would start crying, without being able to stop. On 06/20/14 at 3:30 p.m., the DON was asked to review the resident's care plan. She was asked if the targeted behaviors documented on the care plan were specific to the resident. She stated they were not an accurate description of the resident's targeted behaviors. 3. Resident # 59 was admitted to the facilty with diagnoses to include hypertension, alcohol induced dementia, and seizures. A quarterly assessment, dated 05/01/14, documented the resident had severe cognitive impairments, exhibited daily behaviors which interfered with her care, and put others at risk. The assessment also documented the resident required extensive assistance for bed mobility, dressing, bathing, and toilet use, required limited assistance for hygiene, transfers, eating, ambulation on the unit, and in the halls. The assessment further documented the resident used a walker and/or wheelchair for mobility, required stand by assistance from the staff to steady and had no range of motion limitations of the upper or lower extremities. A facilty elopement risk assessments dated, 02/01/14, 02/05/14, and 02/20/14, documented the resident was at risk for elopement.	F 279		

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	375339	A. BUILDING _____ B. WING _____	C 06/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 57 A care plan, dated 02/14/14 and 2/20/14, did not address the resident's high risk for elopement/wandering. A facility incident report dated 4/12/14 at 4:50 p.m., documented, "Narrative of Event (factual description of event): Found @ [at] back door of kitchen, wheelchair found @ back of hall 4 by exit door. No signs of distress. Denies pain. Placed in w/c [wheelchair] & propelled self to dining rm [room], 0 [no] further attempts to leave noted on report. spent rest of shift watching TV till [until] she went to bed. Resident's statement of Event: Unable to remember events. Stated, "I walked," when asked how she got out. Condition of Resident: Confused, disoriented, Denies pain, 0 signs of distress noted. Immediate intervention implemented: Placed in dayroom after meal so she could be observed by all staff." The form was signed by LPN # 3. A facility form titled, "Incident/Event Committee intervention form documented, "Elopement assessment, Activities to continue c [with] 1:1 [one on one] PT [physical therapy] /OT [occupational therapy]/ST [speech therapy] / will continue to visit c resident often & re-direct." The form contained signatures of seven committee staff members, the ADM and the facility Medical director and was dated 04/23/14.	F 279		

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F 279	Continued From page 58 The form required a 5 - 7 day post-event follow up, which was blank. No documentation was located to indicate a follow up was completed. The form did not contain any additional interventions to prevent the reoccurrence of an elopement. On 06/18/14 at 5:15 p.m., the DON was interviewed and asked which residents were at risk for elopement. The DON went to the nurses' station and retrieved a small, white, three ring binder. The binder contained the names of seven residents known to be at risk for elopement. She was asked how the staff monitored the residents at risk. She stated, "By knowing which ones are at risk and by making sure they stay away from the door areas." She was asked if the resident's care plan included 'Elopement as a focus care area. She stated, "It should." Elopement was not found to be addressed on the residents initial care plan or on any revisions made to the care plan during the previous six months. 4. Resident #64 was admitted to the facility with diagnoses to include altered mental status, difficulty in walking, muscle weakness, schizophrenia, anxiety and psychosis. A physician's order dated 01/07/14, documented, "Seat belt while up in wheelchair to prevent falls with injuries, may be release q [every] 2 hours for	F 279		

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F 279	Continued From page 59 activities, and activity of daily living [ADLs]." A quarterly assessment dated 02/13/14, documented the resident required limited assistance with bed mobility, transfers, walking, and eating. The assessment further documented the resident required extensive assistance with dressing, locomotion, toilet use and hygiene. No restraint was coded on the assessment. A significant change assessment dated 05/13/14, documented the resident required extensive assistance with bed mobility, transfers, walking, dressing, eating, toilet use and hygiene. The resident had no impairments to the upper and lower extremites and needed staff to stabilize and balance during transition. The assessment further documented the use of a physical restraint. The current care plan, dated 05/16/14, documented; "Problem: [Name deleted] uses a physical restraint due to confusion and safety concerns... Goal: Will remain free of complications related to restraint use, including contracture, skin breakdown, altered mental status, isolation or withdraw... Interventions...Alternatives to restraining the resident are 1:1 and documented by staff...Anticipate and intervene for potential causes which have precipitated prior falls or accidents...discuss and record with the resident/family/caregivers, the risk and benefits of	F 279		

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F 279	Continued From page 60 the restraint, when the restraints should/will be applied, routines while restrained and any concerns or issues regarding restraint use... ensure the resident is positioned correctly with proper body alignment while restrained...ensure valid consent on chart prior to initiating restraint...evaluate [Resident] restraint use: evaluate/record continuing risks/benefits of restraint, alternatives for restraint, need for ongoing use, reason for restraint use... monitor/document/report PRN any changes regarding effectiveness of restraint, less restrictive device, if appropriate any negative or adverse effects noted...provide meaning full program of activities that accommodates restraint use without drawing unwanted attention. Provide restraint free time during activities... opportunities for restraint free time and physical activity..." The care plan does not address the following: medical symptoms that warrant the need, the symptoms that are being treated, type of restraint to be used, when the restraint is to be used, the plan for release of the device, plan for monitoring every 30 minutes and how the restraint will assist the resident in reaching his/her highest level of physical and psychosocial well being. The resident's care plan does not address the resident standing and walking while holding her wheel chair up with the lap belt in place. There was no documentation the facility assessed the resident prior to placing her in the restraint. On 06/16/14 at 10:30 a.m., the resident was	F 279		

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F 279	Continued From page 61 observed in the main common area of the facility in her wheel chair. A soft seat belt was fastened across the resident's lower waist. The resident was observed edging herself to the edge of the wheel chair, while holding both armrests, she lifted straight up to a standing position and started to walk while holding the wheel chair up. Staff was observed to immediately redirect the resident and sit her back down. On 06/17/14 at 8:20 a.m., the resident was observed at the breakfast table with a soft seat belt restraint in place. The seat belt was fastened and not released during the meal. On 6/18/14 at 1:10 p.m., the resident was observed being propelled by CNA # 20. The resident had the soft seat belt in place and fastened in the front. The resident was asked if she could unhook the belt. She shook her head no. The CNA stated, "Oh no, she can't un-do it." The aide propelled the resident to her room where she asked if the resident needed to use the bathroom. The CNA assisted the resident to a standing position by holding her hands. The resident stood without much assistance and ambulated into the bathroom. The aide was asked why the resident used the seat belt. She stated because she's a high fall risk. She is very strong and had to be watched because she'll stand up and and fall. The seatbelt is to keep her seated. On 06/18/14 at 3:30 p.m., the resident's roommate was asked about the resident's use of the restraint. She stated, "She can pick up the	F 279		

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wheelchair and walk with it, but staff can get her to sit down." She further stated the resident has had the seatbelt since going to the hospital after a fall.

An interview was conducted on 06/18/14 at 4:40 p.m., with CNA (certified nurse aide) #7. She was asked if the resident had a restraint. The aide stated, "There is one on her chair."

She was asked if the resident was able to stand while the seatbelt was in place. She stated she had witnessed the resident stand up with the wheelchair. She does it throughout the whole day. A lot of times she is sitting up here so we can watch her. The charge nurse knows she will stand. Everyone knows to redirect her and have her sit back down. She will always sit back down, sometimes you have to approach her.

An interview was conducted on 06/18/14 at 4:44 p.m., with LPN (licensed practical nurse) #7 . She was asked if the resident was able to stand up and walk with the wheel chair while restrained. She stated, "Sometimes she will stand up with the wheel chair." She then added everyone knows about it and redirects her.

She was asked if the resident was able to be re-directed. The nurse stated, "We are always there to re-direct her and we walk her down the hall."

An interview was conducted on 06/18/14 at 4:46 p.m., with the social service director. She was asked if the resident had a restraint and was able to stand from her wheelchair with the restraint in place. She stated, "Yes. She tries to stand and she can lift the wheelchair."

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F 279	Continued From page 63 She was asked how long the resident had been able to stand with the restraint in place. She stated, since I have known her she has, she is easily redirected. I am not aware of anytime she had a fall. She then added, "We think she wants to walk and we try to get her up, all the staff know about it and she is easily redirected and has not fallen." An interview was conducted on 06/18/14 at 5:30 p.m., with the DON (director of nursing). She was asked if the resident had a restraint. She stated the resident had a soft seat belt restraint. She was asked if the resident is able to stand up with the seat belt in place. She stated. Sometimes she stands up while in the wheelchair with the seatbelt in place. She has never had a fall. Every staff member knows about that. When asked what the facility had tried before placing her in a restraint. She stated, "Redirection, 1:1, and activities. She is able to be redirected." On 06/19/14 at 8:53 a.m., the resident was observed being taken from the dining room into the shower room by LPN #7. Two minutes later at 8:55 a.m., the resident was observed in the common area of the facility with her seat belt in place. She scooted to the edge of the wheel chair stood up, lifted the wheel chair up and walked approximately five feet. Staff immediately redirected the resident and she sat down. The wound nurse asked the resident if she needed to go to the bathroom and resident stated, "Yes."	F 279		

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An interview was conducted on 06/19/14 at 9:13 a.m., with LPN #7. She was asked why the resident went into the shower room. She stated, "To release the seat belt to be walked around the shower room." She then added the resident was going to be toileted but wasn't because once she was standing she wanted to walk around.

An interview was conducted on 06/19/14 at 12:27 p.m., with the DON. She was asked what less restrictive measures were attempted prior to placing the seat belt restraint. She stated, a vest with activities on it to keep her distracted, 1:1 staff, tipped her wheel chair back and gave her small task of things to do such as folding towels.

When asked what the medical condition was for the use of the restraint: The director stated, "There is no medical condition for her, it's for safety."

She was asked when the resident was placed in the seat belt restraint. She stated the order was written in January. "That is when it was placed on the resident."

She was asked to clarify how the restraint was for safety. The DON stated, "So she would not harm herself and because she had an unsteady gait and was really confused."

What does the care plan say about the restraint and why she has the restraint. She stated, "It's related to confusion and safety."

At 1:47 p.m., the DON was asked if the care plan was fully developed to address the resident's, medical symptoms which warranted the need for

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the restraint, type of restraint to be used, when the restraint is to be used, the plan for release of the restraint, plan for monitoring every 30 minutes, the resident standing and walking with the wheelchair and how the restraint will assist the resident in reaching his/her highest level of physical and psychosocial well being.

She stated, "I looked at it and it is not good." She then added it does not address everything like it should."

Elopement:

A quarterly assessment dated 02/13/14 and a significant change assessment dated 05/13/14, documented the resident did not wander the facility which would place the resident at risk for a potentially dangerous situation.

An elopement assessment dated 08/08/13, did not have a documented summary completed to indicate if the resident was at risk for elopement.

A review of the elopement book on 06/18/14, documented seven resident's, including resident #64 was at risk for elopement.

The elopement book was identified as the means for developing care plans for resident's at risk for elopement by the MDS/Care plan coordinator (LPN #4).

The current care plan dated 05/16/14, was not developed to addresses the resident's elopement risk.

An interview was conducted on 06/20/14 at 4:37 p.m., with the activity director. She was asked if

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F 279	Continued From page 66 resident's #64 was an elopement risk. She stated the resident tries to get up and walk without assistance and her cognition is poor. She then added she was an elopement risk. She was asked if the resident had every displayed exit seeking behavior. She stated, "She had never tried to get out of the building." An interview was conducted on 06/19/14 at 4:54 p.m., with CNA #4 . She was asked if the resident was an elopement risk. She stated, "Yes. She can get up and walk." She was asked if the resident had exit seeking behavior. She stated none of them had tried to get out the building. An interview was conducted on 06/23/14 at 8:30 a.m., with LPN #2. She was asked if the resident's was at risk for elopement. She stated, "Yes." She was asked what placed her at risk for elopement. She stated the resident wonders throughout the facility and she will stand at the end of hall 600. She then added the resident's room is at the end of the hall and will get up unaware at times, that places her at risk. When asked how long the resident had been at risk for elopement she stated, "A little over a year." On 06/23/14 at 9:52 a.m., the DON was asked if the resident's elopement risk dated 08/08/13, placed the resident at risk for elopement. She	F 279		

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F 279	Continued From page 67 stated, "Yes, because she wanders aimlessly and confused." She then added we consider a resident approaching or near a door to be exit seeking and exhibiting exit seeking behavior. She was asked if elopement was developed and addressed on the resident's care plan. She stated, "This should have been on the care plan." On 06/20/14 at 10:13 a.m., an interview was conducted with the MDS/Care plan coordinator (LPN #4). She was asked if the resident was an elopement risk. She stated, "I am not sure I have not look at the list." She was asked how she determined an elopement care plan would need to be developed. She stated, "I look at the elopement book to determine if the resident is at risk and needs a care plan." She was asked how she knew the elopement book was accurate. She stated, "I would have to trust what the nurses say according to the assessment. She was asked if the care plan was developed for the resident's elopement risk. She stated, "It addresses that she wanders. It only address that she wanders." She then added elopement is it's own problem and should be on the care plan. 5. Resident #20 was admitted to the facility on 05/29/14, with diagnoses to include muscle weakness, chronic kidney disease, hypertension, anemia, symbolic dysfunction, schizophrenia and manic depression.	F 279		

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F 279	Continued From page 68 An initial elopement assessment dated 05/29/14, documented the resident was observed with a wander guard on at the time of admission. If further documented, "The resident is at risk for elopement as evidenced by mental status, presence of wander guard." An admission assessment dated 06/05/14 documented the resident exhibited no wandering behaviors during the assessment look back period. It further documented the resident understands and is understood, had impaired vision and was severely impaired in cognition. The current care plan dated 06/11/14, did not address the resident's risk for elopement. A 14 day assessment dated 06/14/14 documented no wandering had been exhibited. An elopement assessment dated 06/18/14 documented the resident was at risk for elopement due to confusion. A review of the elopement book on 06/18/14, documented seven resident's, including resident #20 was at risk for elopement. An interview was conducted on 06/20/14 at 4:37 p.m., with the activity director. She was asked if resident #20 was an elopement risk. She stated, " She just got here I have never seen her try to wonder off." She was asked if the resident had every had exit seeking behavior. She stated, "She had never tried to get out of the building."	F 279		

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F 279	Continued From page 69 An interview was conducted on 06/19/14 at 4:54 p.m., with CNA #4 . She was asked if the resident was an elopement risk. She stated, "Yes. She can get up and walk." She was asked if the resident had exit seeking behavior. She stated, "None of them had tried to get out of the building." An interview was conducted on 06/23/14 at 8:25 a.m., with LPN #2. She was asked if resident #20 was at risk for elopement. She stated, "Yes." She was asked what placed the resident at risk for elopement. She stated because of her elopement assessment at admission, wanders from hall to hall and she will stand at the nurses station. An interview was conducted on 06/20/14 at 9:10 a.m., with the MDS/Care Plan (LPN #4). She was asked if the resident's admission care plan dated 06/11/14 was developed to address the resident's risk for elopement. She stated, "No"	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 70 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to implement interventions to reduce the occurrence of falls for one (#59) of five sampled residents who had experienced one or more falls since January 2014. Findings: Resident # 59 was admitted to the facilty with diagnoses to include hypertension, ETOH (alcohol) induced dementia, and seizures. A care plan dated 02/14/14 documented, "Focus [Resident] is at risk for falls r/t [related to] poor balance. Goals; Will resume usual activities without further incident through the review date. Interventions; Continue interventions on the at-risk plan, for no apparent acute injury, determine and address causative factors of fall..."	F 280		

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	375339	A. BUILDING _____ B. WING _____	C 06/23/2014

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F 280	Continued From page 71 A quarterly assessment dated 05/01/14, documented the resident had severe cognitive impairments, exhibited daily behaviors which interfered with her care, and put others at risk. The assessment also documented the resident required extensive assistance for bed mobility, dressing, bathing, and toilet use, required limited assistance for hygiene, transfers, eating, ambulation on the unit and in the halls. The assessment further documented the resident used a walker and/or wheelchair for mobility, required stand by assistance from the staff to steady and had no range of motion limitations of the upper or lower extremities. The resident had two non-injury falls since the last assessment on 04/19/14. The facility incident reports were reviewed from January 1, 2014 through June 16, 2014. The resident had falls on the following days. 02/04/14, 03/02/14, 030/6/14, 04/28/14, 05/09/14, 05/14/14, 05/26/14, and 06/08/14. Two falls resulted in injuries for the resident on 4/28/14 and on 5/09/14. The resident's care plan had not been reviewed and revised after the resident had seven falls two with injuries, between 03/02/14 and 06/08/14. The resident's interventions remained the same as the care plan written on 02/14/14. On 6/18/14 at 5:00 p.m., an interview was conducted with OT (occupational therapist] #1. She was asked if she had worked with the	F 280		

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F 280	Continued From page 72 resident to help reduce her incidence of falls. She stated she had. She was asked if the therapy was considered helpful. She stated, "For a little while it was. I remember she had a fall one weekend and we transitioned her to a wheelchair from a walker." She was asked what the resident's mobility status was today. She stated, "She has had a really big decline since her fall, which is significant, but we keep working with her, she likes to come in here." On 06/20/14 at 2:55 p.m., the DON was interviewed and asked what interventions were implemented to reduce the resident's falls. She stated, "We tried a lot of different things." She was asked if she thought the things which were tried were helpful in protecting the resident from falling. The DON stated, "I guess they weren't." She was asked if she thought the things tried should have been included on the care plan. She stated, "Of course it should have."	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record	F 282		

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F 282	Continued From page 73 review, it was determined the facility failed to enure a resident's care plan was followed for restraint free time for one (#64) of one sampled resident's care plan reviewed for restraint use. The facility Census and Condition dated 06/16/14 documented one resident resided in the facility who was restrained. The facility also failed to follow care plan interventions for side effect monitoring for one (#55) of five sampled residents whose care plans were reviewed for side effects monitoring. The facility Census and Conditions, dated 06/16/14, documented 49 residents resided in the facility who received psychoactive medications which required side effect monitoring. Findings: 1. Resident #64 was admitted to the facility with diagnoses to include altered mental status, difficulty in walking, muscle weakness, schizophrenia, anxiety and psychosis. A physician's order dated 01/07/14, documented, "Seat belt while up in wheelchair to prevent falls with injuries, may be release q [every] 2 hours for activities, and ADL's [activities of daily living]." A quarterly assessment dated 02/13/14, documented the resident required limited assistance with bed mobility, transfers, walking, eating. The assessment further documented the resident required extensive assistance with dressing, locomotion, toilet use and hygiene. No restraint was coded on the assessment.	F 282		

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F 282	Continued From page 74 A significant change assessment dated 05/13/14 documented the resident required extensive assistance with bed mobility, transfers, walking, dressing, eating, toilet use and hygiene. The resident had no impairments to the upper and lower extremites and needed staff to stabilize balance during transitions. The assessment further documented the use of a physical restraint. The current care plan, dated 05/16/14, documented; "Problem: [Name deleted] uses a physical restraint due to confusion and safety concerns... Goal: Will remain free of complications related to restraint use, including contracture, skin breakdown, altered mental status, isolation or withdraw... Interventions...Alternatives to restraining the resident are 1:1 and documented by staff...Anticipate and intervene for potential causes which have precipitated prior falls or accidents...discuss and record with the resident/family/caregivers, the risk and benefits of the restraint, when the restraints should/will be applied, routines while restrained and any concerns or issues regarding restraint use... ensure the resident is positioned correctly with proper body alignment while restrained...ensure valid consent on chart prior to initiating restraint...evaluate [Resident] restraint use: evaluate/record continuing risks/benefits of restraint, alternatives tor restraint, need for ongoing use, reason for restraint use... monitor/document/report PRN any changes	F 282		

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F 282	Continued From page 75 regarding effectiveness of restraint, less restrictive device, if appropriate any negative or adverse effects noted...provide meaning full program of activities that accommodates restraint use without drawing unwanted attention. Provide restraint free time during activities... opportunities for restraint free time and physical activity..." There is no documentation of the effectiveness or possible negative outcomes of the restraint use. There is no documentation the care plan was being followed for restraint free time. There was no documentation the facility had addressed the risks versus the benefits of the restraint, received consent for the restraint and on going benefits of the restraint as care planned. On 06/16/14 at 10:30 a.m., the resident was observed in the main common area of the facility in her wheel chair. A soft seat belt was fastened to the resident. The resident was observed edging herself to the edge of the wheel chair, she squatted down and lifted straight up with the wheel chair and started to walk. An activity was going at the time of the observation. The restraint had not been released during the activity. On 06/17/14 at 8:20 a.m., the resident was observed at the breakfast table with a soft seat restraint in place. The seat belt was fastened and not released during the meal. 06/18/14 at 10:29 a.m. The resident was observed in the common area near the vending machines. The resident was in her wheel chair with a soft seat belt in place. The resident was able to propel self around the room and was	F 282		

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F 282	Continued From page 76	F 282		

reaching for the vending machines. An activity was going on at the time of the observation.

On 06/19/14 at 8:22 a.m., the resident was observed being taken from her room to the dining room for her morning breakfast. The resident was placed at the table and served her breakfast. The restraint was in place and not released during the meal.

An interview was conducted on 06/19/14 at 8:50 a.m., with the DON. She was asked where the restraint documentation was located. She stated the documentation is kept in the nurse's notes under the weekly summary. The assessments should be under the assessment tab on the computer.

She was asked what should be charted on restraints. She stated when the restraint is released, during meals and activities. She was asked where the complications from the restraints would be documented. She stated, "It should be in the notes about her standing in [up with] the wheel chair with the restraint in place."

When asked about activities she stated the restraint is to be released during activities.

An interview was conducted on 06/19/14 at 12:27 p.m., with the DON. She was asked if the care plan was being followed for release time. She stated, "No."

When asked if the care plan was being followed for documentation of the restraints effectiveness, potential negative outcomes, education of the restraint, risks versus befits and consent. She stated, "No, none of that is being done."

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F 282	Continued From page 77 CNA #14 was interviewed on 06/19/14 at 2:13 p.m. She was asked when the restraint was to be released. She stated the restraint is suppose to be removed at meals because the table is a restraint. The only time it's to be removed is in the dining room and going to bed. The activities director was interviewed on 06/19/14 at 2:48 p.m. She was asked about the restraint during activities. She stated, "Most of the activities are sitting down activities. I do not undue the seat belt, unless I am getting her up to walk her." She was asked what the care plan stated about the restraint and activities. She stated, "It's suppose to be removed." 2. Resident #55's quarterly assessment, dated 05/12/14, documented the resident was moderately impaired in cognition, she made herself understood and understood others. The resident had diagnoses which included anxiety and Multiple Sclerosis. The resident's care plan, dated 02/10/14 and revised on 05/12/14, documented: " Focus ...uses anti-anxiety medications r/t [related to] Anxiety disorder... will be free from discomfort or adverse reactions related to anti-anxiety therapy... Monitor/document/report PRN [when required]	F 282		

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F 282	Continued From page 78 any adverse reactions to Anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Sslurred [sic], confusion and disorientation, depression, dizziness, lightheadness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinati [sic]" The clinical record contained no documentation the facility had initiated or conducted side effect monitoring for the resident. A quarterly assessment, dated 05/12/14, documented the resident was moderately impaired in cognition, she made herself understood and understood others. On 06/18/14 at 2:32 p.m., the DON (director of nursing) was asked if there was documentation of the resident's behavior/side effect monitoring. She reviewed the clinical record. She was unable to locate the side effect monitoring. She stated I guess it didn't get moved over when we changed to the computer.	F 282		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 79 This REQUIREMENT is not met as evidenced by: On 06/18/14 at 6:00 p.m., an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to have a system in place to prevent identified residents who were at risk for elopement from eloping. At 6:30 p.m., the Oklahoma State Department of Health (OSDH) confirmed the existence of the IJ situation. At 6:35 p.m., the Administrator (ADM), Director of Nursing (DON) and Vice President of Clinical Services, were informed an IJ situation existed due to the facility's failure to protect and identify residents who were at risk of elopement, and staff failed to ensure entry/exit doors were monitored and/or were functioning properly. On 6/19/14 at 11:20 a.m., a Plan of Removal was received from the ADM. The Plan of Removal documented: "Abatement for IJ cited for Edwards Redeemer on 6-18-14 (Amended) 1. At approx [approximately]. 5:30 the Administrator demonstrated the proper functioning of Hall 4 door alarm and mag lock and verified that hall 4 exit door had passed annual inspection by a certified alarm company, [name withheld] on 2-20-14 and that all exit doors and alarms are tested on a weekly basis documented in the facility's inspection logs to the survey team. 2. On 6-18-14 at 7 pm, resident #1 was placed on one on one to observe resident's behavior for	F 323		

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F 323	Continued From page 80 24 hrs. 3. The residents's attending physician was notified. No new orders. 4. On 6-18-14 an elopement risk assessment was completed for resident #1 and care plan initiated by the Director of Nursing at 7:30. 5. On 6-18-14 an elopement risk assessment was completed for all Residents in facility by Director of Nursing, Social Services Director and MDS [minimum data set] coordinator. Care plan initiated for any Resident deemed at risk for elopement. 6. On 6-18-14 at 7:05 pm, the Director of Nursing began in servicing all staff on residents at risk for elopement, facility elopement policy, checking on door that alarm has sounded and visually confirm a resident has not gone out door and the resident at risk elopement book and location of at risk book. Will be completed by 6-19-14. Any staff on leave will be inserviced upon return to work. 7. On 6-19-14 a report to State on ODH [Oklahoma Department of Health] form 283 was made by Administrator regarding resident #1 elopement. 8. An elopement risk assessment will be conducted for all residents on admission, quarterly, annually and or significant change. 9. The facility performs a weekly check of all exit doors and alarms to ensure that the 15 second push bar activates the alarm functions properly and the mag lock works properly. On 6-18-14 the weekly check was performed. All door mag locks,	F 323		

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F 323	Continued From page 81 push bar and alarms were in proper working condition. this process is documented in the TELS system online, provided by Direct Supply. 10. An audit will be conducted by the Director of Nursing on any resident whose MDS completed, to review accuracy of elopement risk assessment and insure care plan was initiated as deemed appropriate; weekly x 4, then monthly x 2 months and/or until substantial compliance is achieved. The results of these audits will be reported by the Quality Assurance/Performance Improvement Committee for review. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, and Dietary manager, Housekeeping Director, Activities Director, Unit Managers and Medical Director." An amended plan of removal was given to the surveyors on 06/20/14 at 3:00 p.m., from the Administrator and included the following change to #6: "...Will be completed by 6-20-14 at 11:00 am." Interviews were conducted with facility nursing staff for all three shifts on 06/19/14 and 06/20/14. It was determined the facility had removed the immediacy by placing the resident on one on one watch by staff, educating the nursing staff on how to identify residents at risk for elopement and the proper monitoring of facility doors and alarms. After the last staff member was interviewed and was able to verbalize knowledge of the facility's policy for identifying residents at risk for elopement and how to properly monitor doors and	F 323		

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F 323	Continued From page 82 alarms, the IJ was removed back to 06/20/14, at 11:00 a.m. when the inservices had been completed. Based on observation, interview and record review, it was determined the facility: a. failed to ensure residents who were at risk for elopement were provided adequate supervision and interventions were put into place to prevent elopement of residents. This affected one (# 59) of three sampled residents whose records were reviewed for elopement risks. This resulted in an immediate jeopardy. The DON identified an additional seven residents who were at risk for elopement. b. failed to ensure interventions were put into place and adequate supervison was provided to prevent falls for one (# 59) of five sampled residents who had experienced one or more falls since January 2014. This deficient practice resulted in actual harm to the resident due to sustaining a compression fracture of the spine. There were no other residents who had experienced falls during this timeframe. c. failed to ensure residents on hall 600 had safe hot water. The temperature reading ranged from 124.2 degrees Fahrenheit to 125.6 degrees at the hand sink in the residents rooms. The facility identified two residents who were cognitively impaired and wandered in and out of rooms. d. ensure cleaning and maintenance chemicals were locked and secured. This had the potential to affect two wandering residents who were cognitively impaired and wandered in and out of	F 323		

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F 323	Continued From page 83 rooms. e. failed to ensure an electrical plate in the whirlpool room on hall 300 was not broken and exposed the metal portion of the electric switch. This had the potential to affect all residents in the facility. Findings: A facility policy documented,"Wandering Residents/Elopements. Every effort will be made to prevent wandering episodes while maintaining the least restrictive environment for residents who are at risk for wandering/elopement. Purpose: To identify resident's at risk for wandering and/or elopement and to provide a mechanism to ensure the safety of all residents. Appropriate assessments will be completed on residents who have been deemed wandering /elopement risks as noted above. The At Risk Committee will meet weekly to review each resident on the program for changes. The At risk log notes that new at risk residents will be monitored weekly times 4 weeks. The resident's care plan will be modified to indicate the resident is at risk. Interventions will be entered onto the resident's care plan and medical record. " a.) Resident # 59 was admitted to the facilty with diagnoses to include hypertension, ETOH (alcohol) induced dementia, and seizures. A quarterly assessment dated 05/01/14, documented the resident had severe cognitive impairment and exhibited behaviors which interfered with her care and put others at risk on a daily basis.	F 323		

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F 323	Continued From page 84 The assessment also documented the resident required extensive assistance for bed mobility, dressing, bathing, toilet use, and limited assistance for hygiene, transfers, eating, ambulation on the unit, and in the halls. The assessment further documented the resident used a walker and/or wheelchair for mobility, required stand by assistance from the staff to steady, but had no range of motion limitations of the upper or lower extremities. Facilty elopement assessments dated 02/01/14, 02/05/14, and 02/20/14, documented the resident was at risk for elopement. A care plan dated 02/14/14, did not contain any entries which identified the resident as an elopement/wandering risk, nor any interventions addressed for elopement based on the three prior risk assessments completed. Facility incident reports were reviewed from January 1, 2014 through June 16, 2014. A "Resident Incident Report" dated 4/12/14 at 4:50 p.m., documented the following; "Narrative of Event (factual description of event): Found @ [at] back door of kitchen, wheelchair found @ back of hall 4 by exit door. No signs of distress. Denies pain. Placed in w/c [wheelchair] & propelled self to dining rm [room], 0 [no] further attempts to leave noted on report. spent rest of shift watching TV till [until] she went to bed. Resident's statement of Event: Unable to remember events. Stated, "I walked," when asked how she got out.	F 323		

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F 323	Continued From page 85 Condition of Resident: Confused, disoriented, Denies pain, 0 signs of distress noted. Immediate intervention implemented: Placed in dayroom after meal so she could be observed by all staff." The form was signed by LPN # 3. A facility form titled, " Incident/Event Committee intervention form documented, "Elopement assessment, Activities to continue c [with] 1:1 [one on one] PT [physical therapy] /OT [occupational therapy]/ST [speech therapy]/ will continue to visit c resident often & re-direct." The form contained signatures of seven committee staff members, the ADM and the facility Medical director and was dated 04/23/14. The form did not contain any information in the area for which a 5 to 7 day post-event follow-up was to have occurred. In addition, the form contained no interventions put into place to prevent additional elopement attempts. The incident form did not include any information to address when the resident was last seen prior to being found outside, how long she was outside, nor how she actually got outside. On 06/16/14 at 5:50 p.m., the resident was observed to propel her wheelchair independently in and out of the facility dining room. As she propelled independently around the area, she was observed to propel herself down the length of hall 6, turn around and come back down	F 323		

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F 323	Continued From page 86 to the center of the foyer. She was then observed to propel herself down hall 5 and attempt to open the shower room door. At 6:00 p.m., she was observed to open and close an inner door in the therapy room. At 6:28 p.m., the resident was observed to propel herself down hall 3, look out the door, turn around and come back to the main TV area. The resident was observed to move about the facility without difficulty or staff supervision until 6:45 p.m. On 6/16/14 at 6:30 p.m., an interview was conducted with occupational therapist (OT) #1. She was asked if she was aware of the resident attempting to get out of the building at any time. She stated , "No. I'm not. She was asked if she thought the resident could ambulate without any assistance. She stated, "If she tried she could maybe go 10 feet at the most and would then fall down." She was asked if she thought the resident was capable of ambulating the distance described in the incident report. She stated, "She could have then." 6/16/14 at 7:30 p.m., the resident was observed sitting in her wheel chair near the front door of the facility. 06/16/14 at 7:45 p.m., certified medication aide (CMA) #1 was interviewed and asked what she knew about the resident. She stated, "She can get angry and combative at times." She was asked if the resident could ambulate.	F 323		

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She stated, "Yes, but she has had falls because she is wobbly when she walks, but she's able to walk. She walked from her room to the another resident's room."

The distance described by the CMA was observed to be approximately 75 to 100 feet in distance.

On 6/18/14 at 4:44 p.m., CNA # 5 was interviewed and asked if the resident could ambulate. She stated, "She is strong and walks pretty good." She was asked if the resident ambulated often. She stated, "Yes, normally when she walks away from her wheelchair, we find it, then her and walk her back to it."

She was asked if she knew weather or not the resident was at risk for elopement. She stated, "No one has informed me she was an elopement risk."

The CNA was asked if she had ever seen the resident try to leave the facility. She stated, "She does sit by the front door, but I've never seen her try to leave when people are coming in and out of the door."

At 5:08 p.m., certified nurse aide (CNA) #2 was interviewed and asked if she had ever observed the resident stand up without assistance or attempt to leave facility. She stated she had not and the resident was always very quiet.

She further stated "I don't think she can stand up, and I've never seen her walk."

She was then asked if the resident required close monitoring to make sure she didn't elope

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from the facility. She stated, "No. Not that I'm aware of. She doesn't stand on her own." The CNA was asked how long she had worked at the facility. She stated about two months.

On 6/18/14 at 5:10 p.m., an interview was conducted with OT #1. She was asked if she was aware of elopement attempts made by the resident. She stated, "I was told she had an incident some time ago, but none since then. She was asked if she thought the resident was at risk for elopement. She stated, "I have caught her pushing on the doors at the front at least once, but she is very weak and has declined a lot since last April."

On 06/18/14 at 5:15 p.m., the DON was interviewed and asked which residents were at risk for elopement from the facilty. The DON went to the nurses' station and retrieved a small, white, three ring binder. The binder contained the names of seven residents known to be at risk for elopement. She was asked how the staff monitored residents at risk. She stated, "By knowing which ones are at risk and by making sure they stay away from the door areas."

She was asked if doors to the facility were set to alarm when they were opened without a key code. She stated, "Yes, but the doors have not always functioned like they're supposed to." She further stated, "The alarm will turn off without the key code being entered."

She was asked if the door alarms had been serviced recently. She stated, "They were out here a little while ago." She was asked what was expected of the staff when they heard a door alarm sounding. She stated, "They should get

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F 323	Continued From page 89 up and go check the doors." She was asked what her knowledge was of the resident's elopement. She stated, "She got out and the cook found her." The DON was asked if anyone knew how the resident had gotten out of the facility. She stated, "Not that I know of." She was asked if anyone knew how long the resident was outside. She stated, "No, not as far as I know." She was asked what else she knew about the incident. She stated, "That's all, other than her wheelchair was found at the door on hall 4 and she was found outside by the kitchen door." She was asked if an investigation of the incident had been initiated to address the elopement and if the incident was reported to the OSDH. She stated, "No, [Administrator] told me it didn't need to be reported, so it wasn't investigated or reported to state." The DON was asked if the door alarm on hall 4 worked properly. She stated, "It hasn't been. It will quit sounding after someone goes out." She was asked if this was what the door alarm was supposed to do. She stated, "No, it should alarm until it's reset." She was asked if the door problem had been reported. She stated she had advised the Administrator (ADM) of the problem and he knew the door didn't work. That's why they came to look at it. On 06/18/14 at 5:30 p.m., the secure door at the	F 323		

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end of hall 4 was pushed open by the surveyor. The door alarm sounded. Once the door closed the alarm stopped. This was repeated three times with the same results. Facility staff were not observed to monitor the door at any time during the testing.

At 5:55 p.m., the ADM was interviewed and asked if the door alarm on hall 4 functioned properly. He stated, "Yes. It does." He was asked to demonstrate for the surveyor.

The ADM and admission coordinator (AC) #1, approached the door, entered the key code on the key pad and pushed the door open, and closed it again. The door alarm did not sound.

He was asked what happened when the key code wasn't used. He stated, "The alarm will sound until someone resets it." He was asked who had the ability to reset the alarm. He stated anyone with the key code or the staff at the nurses' desk.

The ADM was asked if the staff was expected to come down the hall to check the door alarm. He stated, "No, they can reset it from the desk." The nurses' desk was in direct view of the door at the end of the hall.

The ADM was asked to open the door again, without using the key code. He pushed the door open and the alarm sounded. He then pulled the door closed and the alarm ceased to sound.

The ADM was asked if he thought this was the proper way for the door to function. He stated, "No, its not supposed to stop alarming until it's reset."

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F 323	Continued From page 91 He was asked when the doors were last serviced to ensure they were functioning properly. He stated,"They are monitored regularly." Maintenance records from a local service company were reviewed. The date on the submitted records documented the last service date for the doors was 02/20/14. The ADM was asked if there were any other records. He stated, "No, but I just started doing my own checks for the doors weekly. " He was asked for the documentation for the weekly checks. The single form provided included a start date of 06/09/14, and one time weekly for the next three weeks. The ADM was asked if the door alarm company had been out since the February service date. He stated, "No." On 6/19/14 at 9:15 a.m., surveyors observed two males working within the facilty. They were observed to check the call lights at the desk, lights outside the rooms and door alarms. A worker from the local door security company (#1), was asked what they were doing and he stated, "Checking the doors and call lights again." He was asked when they last serviced the door on hall 4. He stated, "I don't remember exactly, but within the last month." Surveyors observed the door over a two day period. Staff was observed to use the door frequently during the entire day. They were not observed to use the key pad to exit the facility. In addition, the alarm on the door did not sound after the door was closed, whether the code was keyed in or not.	F 323		

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F 323	Continued From page 92 Falls/Actual Harm. Facility Incident reports reviewed from January 2014, to June 16, 2014, documented the following incidents of falls for resident #59: 1. "02/04/14 @ [at] 9:30 am in room. Person reported to : _____(blank) Resident in room 603-b. Resident stated she was ambulating in her room when she fell backwards onto the floor. family and physician notified, Res attempting to get in bed. Intervention: may (sic) sure shoes her (sic) properly fitted, ask for assistance if weakness or unsteady. The report was signed by LPN #5. Interventions cont. [continue] PT [physical therapy] /OT [occupational therapy] to encourage resident to call for assistance per PT (sic), no dietary; Pharmacy medications, activity eval [evaluation] and encourage participation." 5-7 day follow-up = Effective The form was signed by the DON and the ADM on 02/07/14, and by the physician on 2/27/14. A care plan dated 02/14/14 documented, "Focus [Resident] is at risk for falls r/t [related to] poor balance. Goals Will resume usual activities without further	F 323		

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F 323	Continued From page 93 incident through the review date. Interventions Continue interventions on the at-risk plan, for no apparent acute injury, determine and address causative factors of fall..." 2. "3/2/14 @ 745 am, hallway, Person reported to (wknd RN supervisor) Physician and Family notified. mobility: Ambulates in room, uses w/c [wheelchair] for distance, Mental: poor memory, intermittent confusion. Heard scream from hall 6, observed resident face down on floor in front of bedroom door, Wheelchair w wheels unlocked near by. Resident report she stood to close the door to her room and lost her balance and fell to the floor. Condition: no injuries noted, able to MAE [move all extremities], requested to return to bed. assisted up, able to bear weight without discomfort. Intervention; Educated about locking w/c, call for assist. Fall Scene investigation Report: what appears to be the root causes of the fall ? = poor memory, Residents mental status. No bumps/abrasions noted, moves all extremities." The form was signed by LPN #3. The care plan was not updated to include interventions implemented to prevent reccurrence of falls. 3. "3/6/14 @ 907 p.m. witnessed Fall, [CNA #3]	F 323		

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F 323	Continued From page 94 at nurses station from w/c, no injury, family and physician notified. narrative: Res [resident] standing up at nurses station attempting to sit in w/c and fell to floor. no injury. Intervention: fall assessment, assist res back in w/c. signed by LPN # 6. FSI [Fall Scene Investigation]. encourage Res not to get up s [without]/assist. Encourage resident to lock wheels prior to sitting down or getting up". The care plan was not updated to include interventions to prevent reoccurrence's of falls. 4. "4/28/14 at 10:00 a.m., Found sitting on floor w [with] back to the door on buttocks. Resident unable to verbalize what happened. Condition of resident: Assessment c/o [complain of] headache, back of head, shoulder b/e [between] neck pain. no open areas or bruising. Intervention: Assist x 2 staff stood up, unable to ambulate, carry to bed, Transport EMSA [local ambulance company] at 10:15 a.m. to local ED [emergency department]. Mental status: alert and oriented." The report was signed by the DON and the ADM. The form did not contain any additional interventions implemented to prevent further falls. The care plan was not updated to include interventions to prevent additional falls.	F 323		

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F 323	Continued From page 95 A local hospital emergency department discharge form documented the following; "April 28, 2014, diagnosis Fall: Chronic Dementia: Thoracic Spine Compression Fracture." A nurse's note dated 4/28/14 at 12:10 p.m., documented, "10:00 am resident in her room sitting on buttocks on the floor back against the door, roommate witness fall. This nurse did head to toe assessment resident has complaints of headache, back of head, shoulder neck and bilateral lower extremity pain. Notified Dr. [Name withheld] with report new order received to transport to [local hospital] family notified at 10:15 am, 911 called, arrived to transport resident with back board on stretcher and neck brace ..." The note was electronically signed by LPN #5. A nurse's note dated 04/28/14 at 6:59 p.m., documented, "Resident returned to faciltiy via stretcher with diagnosis of compression fracture to back. Resident awake and alert x 1, Denies pain, Back brace in place. resident tolerating well. No new orders received, will continue to monitor." The note was electronically signed by LPN # 6. A nurse's note dated 04/29/14 at 2:31 p.m., documented, "Resident receives new order Norco (narcotic pain tablet) 5-325 [5 milligram/325 milligram]. 1 tab [tablet] by mouth every 4 hours as needed for pain in relation to back injury..." A physician's order dated 04/29/14, documented "Norco Tablet 5-325 mg one tablet by mouth every 4 hours as needed for pain." Nursing notes reviewed included documentation the resident requested and received pain	F 323		

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F 323	Continued From page 96 medication during the month of April 2014, six times. The month of May 2014, twenty times, and six times from 06/01/14 through 06/09/14. The care plan was not updated to include interventions to prevent further falls. A quarterly assessment dated 05/01/14, documented the resident had experienced two or more falls since admission and none with injuries since the last assessment (4/19/14), none with major injuries. 5. "5/09/12 at 2:00 p.m., Resident sitting on floor w buttocks against door, of room, unable to recall event. Assessment: head to toe, nickle size bruise to right forehead intact and no drainage swelling, no discoloration, noted, moves all extremities R [right] and Left [left] upper and lower extremities. Interventions: Res tx [transferred] to [local hospital]." The form was signed by the ADM. A local hospital report dated 05/09/14, documented the resident received the following diagnostic tests while in the facility. A CT (computerized tomography) scan of head, cervical and chest x-ray, with two views and a CT of the pelvis, and a urinalysis test, were all completed. Diagnosis results of the fall: Chest Contusions. The care plan did not include new interventions to be implemented due to the fall. 6. "5/14/14 6:45 p.m., Res ambulating in hallway, fell and lost balance, landed on L side,	F 323		

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F 323	Continued From page 97 no injury noted. She stated, she was looking for her son. No injury noted, no change in LOC [level of consciousness], MAEW [moves all extremities well]. No immediate interventions documented. Fall Scene Investigation Report documented: Ensure w/c @ [at] w/resident: Res was assisted to bed, w/c left in DR [dining room], root cause = Residents mental status. more interventions: Cont w PT/OT Label her W/C, Cont w re-direct. 5-7 day F~U signed by ADM. and documented intervention as "Not Effective" The care plan did not include any additional interventions to be implemented to reduce the re-occurrence of falls. 7. "5/26/14 @ 4:30 p.m., Resident sitting on floor in room, witness reports, resident walking in room, fell, didn't hit head. Narrative report: Resident sitting on floor in room, assessed, no injury noted, transferred to bed, witness reports resident walking in room and fell, didn't hit head. L [left] hip tender to touch. Family notified, staff instructed to leave resident in bed until x-ray results are in. No pain noted when LEFT hip is not moved. Immediate intervention: Instructed res to remain in bed and call for assistance when needed, until x-ray completed. X-ray results negative. FSI: Describe resident's mental status prior to fall: forgetful..., Initial interventions to prevent further falls: Assistance with transfers. Committee intervention: Cont [continue] w	F 323		

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F 323	Continued From page 98 therapy, Redirect (education) Eval for Hospice. The care plan did not include any additional interventions to be implemented to reduce the reccurrence of falls or the evaluation for Hospice. 8. "06/08/14 at 6:30 p.m., (main TV room in w/c) Resident bending over in w/c reaching for something on floor and slid from w/c landing on R buttock. no injuries, reports pain at level 3, unable to verbalize what happened. Intervention: able to MAE, assisted up in w/c and assisted to bed, Norco 5 mg given with good results. FSI : Resident slipped, Cont w previous fall interventions" The care plan did not include any additional interventions to be implemented to reduce the reccurrence of falls. The resident had experienced a total of eight falls between 02/20/14 and 06/08/14. The care plan did not include any additional interventions. On 6/18/14 at 5:00 p.m., an interview was conducted with OT #1. She was asked if she had worked with the resident to help reduce her incidence of falls. She stated she had. She was asked if the therapy was considered helpful. She stated, "For a little while it was. I remember she had a fall one weekend and we transitioned her to a wheelchair from a walker." She was asked what the resident's mobility status was today. She stated, "She has had a really big decline since her fall which is significant, but we	F 323		

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F 323	Continued From page 99 keep working with her, she likes to come in here." On 06/20/14 at 2:55 p.m., the DON was interviewed and was asked what interventions were implemented to reduce the resident's falls. She stated, "We tried a lot of different things." She was asked if she thought the things which were tried were helpful in protecting the resident from falling. The DON stated, "I guess they wasn't." She was asked if she thought the things tried should have been included on the care plan. She stated, "Of course it should have." Hot Water temperatures On 06/16/14, between 12:05 p.m. and 12:30 p.m., the following hot water temperatures were taken from the sink faucets in Hall 6 rooms: Room 601 - 125.6 degrees Fahrenheit (F) Room 603 - 125.1 degrees F Room 604 - 124.2 degrees F Room 605 - 125.0 degrees F Room 606 - 124.8 degrees F On 06/16/14 at 12:37 p.m., the surveyor asked certified nurse aide (CNA) #1 if there were any residents on Hall 6 who were confused and wandered independently. She stated resident #11 ambulated and resident #59 was in a wheelchair and both wandered into other rooms. The residents were interviewed and the survey team determined they would both know to remove their hands from the water if it was too hot.	F 323		

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At 1:12 p.m., the surveyor asked the administrator and the maintenance supervisor to go to Room 601 and to bring a thermometer. The surveyor took the hot water temperature at the same time as the maintenance man, who used an infrared thermometer. The surveyor obtained a 125.1 degree F temperature and the maintenance man obtained a 123.8 degree F temperature.

The surveyor asked the administrator what the facility's hot water temperature policy was. He stated, "One hundred fifteen degrees or below." He stated the water had never been 125 degrees F before and that no incidents had occurred due to hot water and no residents had complained the water was too hot. The administrator stated he took the water temperatures in random rooms on each hall weekly, however, the facility never produced a hot water temperature log for the surveyor to review.

The surveyor showed the administrator the temperatures which had been obtained in the Hall 6 rooms and asked if the water temperatures were too high. The administrator acknowledged the water temperatures were too high.
Chemicals

During the initial tour of facility on 06/16/14 at 9:35 a.m., a storage room next to the shower room on hall 300 was observed to be unlocked. The following items were observed in the room: 4 gallons of Wiwax, one bottle of Spitfire, one gallon of Oops (paint remover). All items had a warning to keep out of reach of children.

The room was continuously observed from 9:35 a.m. through 10:10 a.m. The room remained

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unlocked with access to the chemicals listed above.

06/16/14 at 12:37 p.m., CNA #1 was asked if there were any wandering residents in the facility with cognitive impairment. She identified residents #11 and #59 as residents who wandered in and out of rooms.

An interview was conducted on 06/23/14 at 1:38 p.m., with the administrator. He was asked what was stored in the room. He stated, floor care and paint products. He was asked if the chemicals were a hazard to residents. He stated, "If they were left unlocked, they are supposed to be locked."

An interview was conducted on 06/23/14 at 1:42 p.m., with the housekeeping supervisor. She was asked what was in the room. She stated wax, maintenance cleaners, air filters and paint.

She was asked if the chemicals were hazardous to residents. She stated, "It is supposed to stay locked at all times. So the residents cannot get in and get into the chemicals." We are supposed to check the door and make sure it is closed and locked."

The surveyor requested copies of the Material Safety Data Sheets (MSDS) for all the chemicals in the storage room on hall three hundred next to the shower room. She stated, "Everything in there is a hazard to the residents, especially when it is left unlocked". No MSDS sheets were provided.
Electrical Faceplate

On 06/20/14 at 3:24 p.m., a broken electrical

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F 323	Continued From page 102 faceplate was observed in the Hall 300 whirlpool room. The broken plate exposed the metal portion of the electrical switch. On 06/23/14 at 9:45 a.m., maintenance #1 was asked if he was aware of any electric faceplates that needed to be repaired. He stated he was aware of some faceplates that needed to be replaced and he kept a stock in his office. He was shown the face plate in the whirlpool room on Hall 3. He stated he was not aware it was broken, and that he would fix the faceplate.	F 323		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facilty failed to ensure licensed nursing staff were trained in the care/management of an implanted intravenous port site for one (#89) of two sampled residents who had intravenous access. The director of nursing identified one additional	F 328		

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F 328	Continued From page 103 residents with intravenous access. Findings: Resident #89 was admitted to the faciltiy with diagnoses to include hypertension, diabetes, osteomylitis of the left foot, and depression. A physician admission order dated 05/30/14, documented: "Piperacillin [antibiotic] Sod-Tazobactam So Solution Reconstituted 3-0.375 gm [gram] Use 100 ml [milliliter] intravenously every 6 hours for osteomylitis until 06/24/2014, (infuse 100 ml over 30 min [minutes]). Vancomycin HCl [hydrochloride] Solution Reconstituted 750 mg Use 250 ml intravenously every 12 hours for osteomylitis until 06/25/2014. (infuse 250 ml over 1.5 hrs [hours]). Change infusion port IV access dressing and Lumen [needle] every 7 days, one time a day every Sat [Saturday] for f/u [follow up]." A physician's order, dated 05/31/14, documented, "Monitor infusion port IV access site to right chest for swelling, redness, warmth and s/s [signs and symptoms] of infection every shift. Flush infusion port to right chest before and after medication administration." A medication administration record (MAR), dated June 2014, documented the above antibiotic medications were administered as ordered, ports were flushed as ordered and the IV site was monitored every shift.	F 328		

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F 328	Continued From page 104 A treatment administration record, (TAR) dated June 2014, contained no documenation the physician's order for the IV access dressing, Lumen, and IV tubing had been completed. The dressing and Lumen should have been changed on 06/07/14 and 06/14/14. An admission assessment, dated 6/11/14, documented the resident was severely impaired in cognition, but was able to make her needs known. The assessment further documented the resident received intravenous medications of antibiotics, dressings to the left foot. On 06/16/16 at 2:55 p.m., the resident was observed to have an occlusive (clear) dressing covering a infusion port on her right shoulder area. The date on the dressing documented the dressing was placed on 05/29/14. She was asked if any of the staff had looked at her site and/or changed the dressing since she was admitted. She stated, "No, they come in and plug my medications up to here." (The resident was holding a port on the IV tubing in her hand) At 3:15 p.m., LPN (licensed practical nurse) #14 was interviewed and asked if she was the nurse taking care of the resident. She stated she was and had just come on duty. She was asked who administered the resident's IV medications. She stated she did. She was asked if she assessed the IV site before giving the medication. She stated she did.	F 328		

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F 328	Continued From page 105 She was asked where she documented the assessments. She stated in the computer. The LPN was asked if she had noticed the date on the dressing. She stated she didn't do dressing changes, only administer the medication. She was asked if the facilty had provided her with IV infusion training. She stated, "No, I just started here a couple of weeks ago." She was asked if she knew how to change the Lumen/needle in the IV port, she stated she did not. At 3:30 p.m., RN (registered nurse) #1 was asked if she was certified to change a IV Lumen/needle. She stated she had done it before but not at this facility. At 4:20 p.m., LPN #7 was asked if she was aware of the resident's IV port and if she had administered medications to the resident. She stated she was and she had given the antibiotics to the resident. She was asked how and when the IV site was assessed. She stated, "Before the meds are given." She was asked when the dressing and Lumen were last changed. The LPN pulled the resident's name up on a nearby computer and located the TARs for June 2014. Once the record was located LPN #7 and RN #1, observed the form was blank. LPN #7 stated, "It was supposed to be changed every Saturday." The staff was asked who had changed the needle and dressing. LPN #7 stated, "It hasn't been	F 328		

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F 328	Continued From page 106 done" They were asked who was supposed to change the dressing and Lumen. LPN #7 stated, "LPN #3 should have changed it on Saturday." On 06/16/14 at 5:40 p.m., the DON was interviewed and asked if she was aware the resident had an implanted IV port. She stated she was. She was asked which of her staff was certified to manage the implanted port and to infuse IV medications. She stated all her nurses had completed an IV medication infusion course which was administered by the facility pharmacist. She was asked to provide a list of those who had completed the course. She was then asked which of her staff was certified and/or had the knowledge of how to change the Lumen [needle] in an implanted port. She stated the ones giving the medication. The DON stated she would have to look through their records. She was asked to review the TARs for June 2014, and advise who had changed the dressing and/or the Lumen for the resident. After reviewing the blank TAR the DON stated, "I guess it wasn't done yet." She was advised the resident was admitted on 5/30/14, with orders to change the dressing and Lumen every seven days and neither had been completed since admission. Inservice pharmacy records were reviewed for	F 328		

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F 328	Continued From page 107 staff nurses who had completed the facility administered IV certification course. The June 2014, MAR documented nine different nurses had administered the IV medications. Of the nine staff identified, three were found to have successfully completed the IV certification course administered by the facility pharmacist. On 06/17/14 at 11:15 a.m., nurse practitioner (NP) #1 was interviewed and asked if she was aware resident #89 had an implanted infusion port. She stated, "I have not seen the resident today and would have to review her chart to be sure." She was advised of the resident's implanted port, the physician's orders, the dressing and needle which had not been changed because staff did not know how to change it. She stated, "If the order says to change the dressing every seven days that's what should have been done. That's my answer!" The NP was then asked if she thought this had potential to put the resident at greater risk for infection. No further answer was given.	F 328		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

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F 329	Continued From page 108 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure: a. three (#20, #55 and #92) of four sampled residents who received antianxiety medications were monitored for behaviors and/or side effects. The facility Census and Conditions,dated 06/16/14, documented 19 residents received antianxiety medications. b. two (#20 and #92) of three sampled residents who received antipsychotic medications were monitored for side effects.	F 329		

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F 329	Continued From page 109 The facility Census and Conditions, dated 06/16/14, documented 26 residents received antipsychotic medications. c. one (#92) of three sampled residents who received antidepressant medications were monitored for side effects. The facility Census and Conditions, dated 06/16/14, documented 44 residents received antidepressant medications. d. two (#20 and #92) of four sampled residents who received hypnotic medications were monitored for side effects. The facility Census and Conditions, dated 06/16/14, documented 14 residents received hypnotic medications. Findings: The facility's medication management and monitoring policy documented: "In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform on going monitoring for appropriate, effective, and safe medication use..." 1. Resident #55 had diagnoses which included anxiety and Multiple Sclerosis. The resident's care plan, dated 02/10/14, and revised on 05/12/14, documented:	F 329		

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F 329	Continued From page 110 " Focus ...uses anti-anxiety medications r/t [related to] Anxiety disorder... will be free from discomfort or adverse reactions related to anti-anxiety therapy... Monitor/document/report PRN [as necessary] any adverse reactions to Anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Sslurred [sic], confusion and disorientation, depression, dizziness, lightheadness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinati [sic] Monitor/record occurrence for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others,etc.) and document per facility protocol." The clinical record contained no documentation of side effect monitoring having been initiated or conducted for the resident. The clinical record also contained no documentation of the resident's specific targeted behaviors. The June 2014, physician orders, documented the resident was to be administered Xanax (an antianxiety medication) 1 mg (milligram) two times a day for anxiety. On 06/18/14 at 2:32 p.m., the DON (director of nursing) was asked if there was documentation of the resident's behavior/side effect monitoring.	F 329		

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F 329	Continued From page 111 She reviewed the clinical record. She was unable to locate the side effect monitoring. She stated I guess it didn't get moved over when we changed to the computer. At 3:00 p.m., the resident was interviewed about her medication regimen. She stated she did suffer from anxiety. She stated that when the anxiety episodes occurred she would start shaking, her heart would race and she would start crying, without being able to stop. 2. Resident #20 was admitted to the facility on 05/29/14, with diagnoses to include muscle weakness, chronic kidney disease, hypertension, anemia, symbolic dysfunction, schizophrenia, and manic depression. The current orders documented the resident was on the following psychoactive medications which required monitoring for side effects. Clonazepam, a hypnotic, 2 mg give one tablet by mouth at bedtime for sleep. Hold if sedated. Lorazepam, an antianxiety, 1 mg give one tablet by mouth every eight hours as needed for agitation. Zyprexa, an antipsychotic, 5 mg give one tablet by mouth two times a day for bipolar. Olansapine [Zyprexa] 10 mg give one tablet by mouth two times a day for bipolar Haloperidol, an antipsychotic, 10 mg give one tablet by mouth two times a day for schizophrenia Lamactal 150 mg give one tablet by mouth two	F 329		

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F 329	Continued From page 112 times a day for bipolar An admission assessment, dated 06/05/14, documented the resident received antipsychotics, antianxiety medications and antidepressants. An undated intern [admission] care plan documented, "Psychotropic drug use: resident will show benefits without side effect...monitor for side effects and report abnormal findings; evaluate as needed for potential dose reduction..." There was no documentation the facility had monitored the side effects of these medications. An interview was conducted on 06/18/14 at 2:50 p.m., with the DON. She was asked where the documentation was located for the monitoring of side effects for psychotropic medications. She stated, "We are not documenting the side effects of the medications. We have not put that into the computer. She was asked how long the facility had been doing electronic charting. She stated, "Since the end of October first of November." 3. Resident #92 was admitted to the facility with diagnoses to include depressive disorder, anxiety state, and chronic pain. The facility's TARs (treatment administration records) through 04/01/14 through 06/18/14, were reviewed. They contained no documentation of the resident's targeted behaviors to be monitored. The TARs also documented the resident was receiving Prozac 20 mg (an antidepressant	F 329		

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F 329	Continued From page 113 medication); Ativan 1 mg (an antianxiety medication), Seroquel 25 mg and 50 mg (an anti-psychotic medication), Buspar 10 mg (an antianxiety medication), and Restoril (a hypnotic medication), per physician's order. The Resident's admission 5 day Medicare assessment, dated 06/10/14, documented the resident was moderately impaired in cognition, she made herself understood and understood others. The assessment documented the resident had continuous signs/symptoms of delirium of inattention, disorganized thinking, altered level of consciousness and required limited to extensive staff assistance with all activities of daily living. The resident's care plan, dated 06/18/14, documented: " Focus ...uses antidepressant medication r/t [related to] Depression. Goals [Resident] will be free from discomfort or adverse reactions related to antidepressant therapy through the review date... Interventions ...Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q [every] SHIFT. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given.	F 329		

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F 329	Continued From page 114 Monitor/document/report PRN [as needed] adverse reactions to ANTIDEPRESSANT therapy:change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance probs [problems], tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia, appetite loss, wt [weight] loss, n/v [nausea/vomiting], dry mouth, dry eyes. Focus [Resident] is on sedative therapy r/t [related to] insomnia. Goals [Resident] will be free of any discomfort or adverse side effects of hypnotic use through the review date. Interventions ...Monitor/document/report PRN for following adverse effects of SEDATIVE/HYPNOTIC therapy: day time drowsiness, confusion, loss of appetite in the morning, increase risk of falls and fractures, dizziness. Administer SEDATIVE/HYPNOTIC medications as ordered by physician. Monitor/Document side effects and effectiveness Q-SHIFT. Focus [Resident] uses psychotropic medications r/t	F 329		

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F 329	Continued From page 115 Behavior management. Goals [Resident] will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. [Resident] will reduce the use of psychotropic medication through the review date. Interventions Medications: Seroquel tab [tablet] 25 mg and 50 mg. Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc. [etcetera] and document per facility protocol." Focus [Resident] uses anti-anxiety medications r/t Anxiety disorder. Goals [Resident] will be free from discomfort or adverse reactions related to anti-anxiety therapy through	F 329		

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F 329	Continued From page 116 the review date... Interventions Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of (SPECIFY: anti-anxiety medication drugs being given. Monitor the resident for safety. The resident is taking ANTI-ANXIETY meds [medications] which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. Monitor/record occurrence for target behavior symptoms of pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc. and document per facility protocol." The current physicians order documented the resident received Ativan1 mg, and Buspirone HCL [hydrochloride]10 mg. The clinical record contained no documentation of side effect monitoring having been initiated or conducted for the resident. On 06/18/14 at 2:32 p.m., the DON (director of nursing) was asked if there was documentation of the resident's behavior/side effect monitoring. She reviewed the clinical record. She was unable to located the side effect monitoring. She stated I	F 329		

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F 329	Continued From page 117 guess it didn't get moved over when we changed to the computer.	F 329		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		

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F 441	Continued From page 118 infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to: a. Protect clean linens and adult incontinent briefs for 1 of 6 linen carts from potential cross contamination from a container of tea and an individual's tote bag which was stored on a linen cart. This had the potential to affect all 6 linen carts in the facility; b. Maintain a shower bed to prevent the spread of infection for 1 (hall 300)of one shower beds. This had the potential to affect all residents who used a shower bed and; c. Prevent cross contamination when handling drinking glasses being served to all residents eating breakfast in the dining room. The facility identified 67 residents who consumed their meals in the dining room. Two residents were identified as receiving all nutrition/hydration through a gastrostomy tube. Findings: On 06/20/14 at 2:48 p.m., an open bottle of partially consumed tea was observed stored on the clean linen cart next to folded gowns and an open bag of adult briefs in the shower room on hall 300. An individual's tote bag was also observed on the cart. The cart's curtain was pulled up and left open exposing all items on the	F 441		

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cart. The items included: disposable gloves, folded gowns and open packages of adult incontinent briefs.

At 3:05 p.m., a cart with bath supplies was observed in the shower room on hall 300. The cart had three sticks of deodorant, one of which was opened with no lid. Additional personal care items were stored under a brown blanket with the deodorant. None of the personal care items, including the deodorant sticks, were labeled to identify individual resident use.

At 3:21 p.m., a shower bed was observed in the shower room on hall 300. The coated foam pad on the shower bed had cracks and puncture holes on both sides exposing the foam interior. The exposed cracked foam would make it difficult to sanitize between and after use.

On 06/23/14 at 9:40 a.m., LPN(licensed practical nurse)#15 was asked who used the stick deodorant on the cart by the whirlpool. She stated she didn't know. She was asked how the staff would know which deodorant belonged to which resident. She stated most resident's had their own deodorant. She was asked how personal items were noted for each resident. She stated they had a bag to keep their items in.

On 06/23/14 at 1:55 p.m., the administrator was shown the shower bed. He was asked if the cracks and punctured areas would make it difficult to clean and sanitize the padding. He agreed the pad would be difficult to keep clean.
********** Dining Room **********

On 06/16/14 at 11:45 a.m., CNA (certified nurse aide) #17 was observed pushing a cart, that

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F 441	Continued From page 120 contained glasses filled with fluids, around the dining room. She would place her gloved hands on the side handles of the cart as she pushed the cart from table to table. Without changing gloves she would pick up the glasses by the rim (the drinking surface of the glasses) and placed them on the dining room table in front of the residents. On 06/23/14 at 2:00 p.m., the certified dietary manager was asked if the CNA's serving technique was in compliance with the facility policy. He stated, "No."	F 441		
F 456 SS=B	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and record review it was determined the facility failed to keep the cooking range grease trap in working condition. The kitchen had only one cooking range. The CDM (certified dietary manager) identified 67 residents who consumed food prepared in the kitchen. The facility had two residents with feeding tubes who consumed no food from the kitchen. Findings:	F 456		

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F 456	Continued From page 121 On 06/16/14 at 10:15 a.m., an initial tour of the kitchen was conducted. The grease trap, on the cooking range, was observed missing a handle. Grease was spilling out of the grease trap. It was running down the front of the range and pooling on some rags that had been placed on the floor to collect the grease. The rag on top of the pile of towels was greasy and was a blackish/brown color from the absorbed grease. On 06/19/14 at 7:40 a.m., the CDM (certified dietary manager) was interviewed about the grease trap. He stated it had been like that for about a month. He stated they could not clean the grease trap because they couldn't open it. He stated about a month ago he had turned in a work request to maintence to repair the handle on the grease trap.	F 456		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, and interviews, it as determined the facility failed to ensure a resident's call light at her bedside functioned	F 463		

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properly when activated for one (#20) of 25 sampled residents. The facility census was 69.

Findings:

On 06/16/14 at 12:25 p.m., the call light in resident #20's room was tested for operation. When activated, the call light did not sound.

On 06/16/14 at 4:58 p.m., resident #20 was asked about her call lights. She stated, "The one in the restroom works but not the one by the bed."

06/18/14 at 10:35 a.m., and on 06/19/14 at 10:51 a.m., the residents call light was tested to ensure it functioned properly. The light did not illuminate or buzz when activated.

On 06/20/14 at 2:50 p.m., an interview was conducted with the administrator. He was brought to the residents bedside and asked to activated the call light. He was observed to push the button several times but was unable to activate the call light. He was heard to say,"It's not able to, guess its not working."

He was asked how often call lights were checked for proper operation. He stated, "Monthly random lights are checked on the halls."

He was asked for documentation for the monitoring of the call light system.

The ADM stated, "I don't think he [maintence] logs it."

No documentation was provided prior to the end of the survey.

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F 465	Continued From page 123	F 465		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to maintain the facility in a safe and sanitary manner as evidenced by: a. Wax build-up and debris on the floors; b. Ceilings that were unpainted; c. Walls that were marred with missing paint; d. Walls with chips in the sheet rock and; e. A broken doorknob to a resident's room. Findings: 1. On 06/16/14 at 9:20 a.m., during a tour of the environment on Hall 600, the following was observed: Room 602 - The floor tiles in the room were observed to be dark and mottled with old wax. The floor contained excessive debris/trash on the floor. Room 603 - The ceiling inside the room to the left of the door, had an area measuring	F 465		

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approximately 2 foot x 3 1/2 foot which was unfinished. A 1 foot x 1 1/2 foot area of paint was missing from the wall, on the right side of the sink.

The walls beside the bed were marred. The bathroom did not have a toilet paper holder; the toilet paper was sitting on the back of the tank.

A bath pan was observed sitting on the floor in the corner of the bathroom. The resident was asked what the bath pan was used for. He stated it belonged to the resident who had lived in the room before him.

Room 606 - The corner wall by the sink was damaged and void of any paint.

Room 608 - The corner wall by the sink contained multiple areas of marred scratches and was partially painted.

Room 502. Broken Door Knob .

2. Resident #39 was admitted to the facility with diagnoses to include colostomy placement and diabetes. The resident was observed to be cognitively intact and able to be interviewed.

On 06/16/14, a residential screening was conducted with the resident.

The door to the resident's room was unable to be opened by two surveyors. The door knob latch would not release to open the door. The door knob was turned at a 360 angle which did release the door and allowe entry to the room.

The resident was sitting up in bed waiting for the

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door to be opened. She was asked how long the door knob had been broken. She stated, "Since I arrived."

She was asked if she had told anyone about the door knob. She stated, "I don't have to tell them, every time they try come in they have a hard time."

The door was re-checked on the following dates and times:

On 06/17/14 at 3:35 p.m., 06/18/14 at 9:00 a.m., and at 6/19/14 at 8:00 a.m. It remained difficult to open.

On 06/20/14 at 3:00 p.m., maintence worker #2, was observed working on hall 500. He was asked if he was aware the door knob to the resident's room wasn't functioning properly. He stated he was made aware of it that day and was "planning to repair it today."

At 3:30 p.m., the DON was asked if the facilty had a system in place which identified and reported items in need of repair. She stated maintence had a book on their door and staff was to complete "repair forms" when items were found to be non-functioning.

She was asked if she thought the system was effective. She stated, "Yes, for the most part, they do well." She was asked if she was aware of the door knob on room 502.

She stated she was aware the door knob was broken and had informed the maintenance man of the problem yesterday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375339	A. BUILDING _____ B. WING _____	C 06/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS REDEEMER HEALTH & REHAB	1530 NORTHEAST GRAND BLVD OKLAHOMA CITY, OK 73117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 468	Continued From page 126	F 468		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure handrails were securely attached to the wall for one (Hall #100) of six halls. The facility identified 5 residents who resided on the hall 100 and utilized the handrail. The facility census was 69. Findings: On 06/20/14 at 2:17 p.m., the handrails on Hall 100 between rooms 105/106 and the handrail next to room 107 were found to be loose and moved freely away from the wall. On 06/23/14 at 9:40 a.m., LPN (licensed practice nurse) #15 was asked how many residents used the handrails for assistance when they walked or ambulated down Hall 100. She stated there were four or five residents who used the handrails. She was asked who she would tell if the handrails needed repair? She stated maintenance. At 9:45 a.m., maintenance #1 was asked how he identified needed repairs. He stated there was a work-order book at the nurse's station. He would check the book every 30 minutes to an hour or staff would find him if the repair was critical. He was asked how the work was scheduled. He stated he would prioritize the work.	F 468		

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F 468	Continued From page 127 He was asked if he was aware the handrails on hall 100 were loose. He stated he had repaired the handrails near room 104 and on Hall 500. He was shown the handrails on Hall 100 near rooms 105, 106 and 107. He stated he had repaired another area of handrails. He further stated they had painted the hallway recently and the rails may not have been tightened correctly once the painting was finished. He stated he would repair the handrails.	F 468		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility: a. failed to ensure residents who were at risk for elopement were provided adequate supervision and interventions were put into place to prevent elopement of residents. This affected one (# 59) of three sampled residents whose records were reviewed for elopement risks. This resulted in an immediate jeopardy. The DON identified an additional seven residents who were at risk for elopement.	F 490		

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F 490	Continued From page 128 b. failed to ensure interventions were put into place and adequate supervision was provided to prevent falls for one (# 59) of five sampled residents who had experienced one or more falls since January 2014. This deficient practice resulted in actual harm to the resident due to sustaining a compression fracture of the spine. There were no other residents who had experienced falls during this time frame. Please refer to F323 in the 2567 (Statement of Deficiencies).	F 490		