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

PRINTED:9/8/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET** **ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, it was determined the facility failed to notify the physician: a) Of diastolic blood pressure readings over 90 for one (#1) of nine sampled residents who required blood pressure monitoring. b) Of low blood pressure readings for two (#5 and #9) of nine sampled residents who required blood pressure monitoring. This had the potential to affect 23 residents, identified by the DON, who required blood pressure monitoring. c) Of the increase in size of two pressure ulcers for one (#13) of four sampled residents who experienced pressure ulcers. This had the potential to affect 10 residents, identified by the Resident Census And Conditions Of Residents form, who experienced pressure ulcers. d) Of a pressure ulcer for one (#9) of four sampled residents who experienced pressure ulcers. This had the potential to affect all 65 residents who resided in the facility and who could experience skin integrity impairment. e) Of a FSBS less than 60 for one (#13) of three sampled residents who required FSBS be obtained. This had the potential to affect 14 residents, identified by the DON, who required FSBS be obtained. f) Of an elevated laboratory test value for one (#4) of nine sampled residents who required laboratory tests be obtained. This had the potential to affect 43 residents, identified by the DON, who required laboratory tests be obtained in the last three months. Findings: 1. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident was re-admitted to the facility on [DATE], following a hospitalization for metabolic [MEDICAL CONDITION] and dehydration. The resident was admitted on skilled services upon return to the facility. A nurse's note, dated 02/21/14 at 7:55 p.m., documented the resident's blood pressure was 158/96. There was no documentation the physician was notified of the elevated diastolic blood pressure. A significant change assessment, dated 02/22/14, documented the resident was severely impaired in cognition, exhibited symptoms of moderately severe depression and exhibited no behavioral symptoms. A nurse's note, dated 02/25/14 at 12:56 p.m., documented the resident's blood pressure as 157/97. A nurse's note at 9:22 p.m. documented the resident blood pressure was 148/96. A nurse's note, dated 03/03/14 at 1:19 p.m., documented the resident's blood pressure was 155/99. A nurse's note, dated 03/11/14 at 11:44 a.m., documented the resident's blood pressure was 160/96. A nurse's note, dated 03/12/14 at 1:41 p.m., documented the resident's blood pressure was 151/98. A nurse's note, dated 04/06/14 at 10:32 a.m., documented the resident's blood pressure was 174/102. At 11:43 a.m., the nurse's note documented the resident's blood pressure was 155/90. There was no documentation in the clinical record the physician was notified of the elevated diastolic blood pressures. The resident was not on any blood pressure medications. On 04/08/14 at 3:45 p.m., the DON was asked if the physician should have been notified when the resident's diastolic blood pressure was elevated. The DON stated, Yes. 2. Resident #9 was admitted on [DATE] with [DIAGNOSES REDACTED]. A significant change assessment, dated 03/28/14, documented the resident had severe impairment in cognition, exhibited minimal symptoms of depression and exhibited no behaviors. On 04/07/14 at 10:00 a.m., during the initial tour, CMA #3 reported the resident had a sore on his bottom. The CMA reported she did not know what treatment was being done for the resident. On 04/09/14 at 9:10 a.m., the resident was observed to receive treatment of [REDACTED]. The left heel had no red areas or breakdown. The right heel had an area approximately 1.5 cm in size with a dark circumference around a soft area. At 9:30 a.m., LPN #3 was asked to observe the resident's coccyx treatment. The LPN reported the resident did not have a treatment to his coccyx. The LPN was informed the resident's skin assessment form documented the resident had an area to his coccyx. The LPN reported she would obtain assistance to transfer the resident for the surveyor to observe his skin. LPN #3 and an unidentified CNA took the resident to his room and assisted him to a standing position. The resident's pants were pulled down. The resident had no red area or open area on his coccyx. The resident had an open area, stage II, on his left buttock near the anal opening. The LPN and the CNA reported they were not aware of the resident having a sore on his buttocks. At 10:30 a.m., LPN #2 was asked if she was aware the resident had skin breakdown on his buttocks. The LPN reported no knowledge of the resident's skin breakdown. The LPN reported LPN #3 performed the weekly skin checks. At 10:50 a.m., CNA #14 was asked if she observed skin breakdown on the resident's buttocks. The CNA reported she had noticed a place on the resident's buttocks this morning when toileting the resident. The CNA was asked if she had reported the open area to the nurse. The CNA reported she had not told anyone yet about the site. At 1:40 p.m., the DON was asked if the physician should have been contacted and orders obtained for treatment when the pressure ulcer was found. The DON stated, Yes. The DON was asked if the resident's heels should have been monitored for breakdown and the physician notified of the change in the right heel lesion. The DON stated, Yes. At 3:15 p.m., LPN #4 was asked if he was aware of an open area on the resident's buttock. The LPN reported the resident's son helped the resident to get ready for bed and the son had reported an open area on the resident's buttock. The LPN reported he did not get a chance to follow up on the son's report of an open area on the resident and did not examine the resident. At 3:45 p.m., LPN #4 reported he was in error when he reported the buttock wound was a new area. He reported the resident had the area on his buttock when he returned from the hospital. The LPN was asked why he documented on the wound sheet and in the nurse's notes the resident had a coccyx wound. The LPN stated, I got mixed up on the area. The LPN was asked if he notified the physician of the open area and received a treatment order at the time of admission. The LPN reported he had not. 3. Resident #9 was admitted on [DATE] for skilled services with [DIAGNOSES REDACTED]. A care plan, dated 02/17/14, documented the resident had [MEDICAL CONDITION] with [DIAGNOSES REDACTED]. One intervention documented, Monitor blood pressure. Notify physician of any abnormal readings. A re-admission comprehensive assessment, dated 03/28/14, documented the resident had severe cognitive impairment, exhibited minimal depression symptoms and exhibited no behaviors. The resident's current physician's orders, documented the resident was to receive the following medications for his [DIAGNOSES REDACTED]. [MEDICATION NAME] HCL 200 mg daily. [MEDICATION NAME] 12.5 mg twice a day, Hold if systolic blood pressure below 100. [MEDICATION NAME] 2.5 mg daily. [MEDICATION NAME] 20 mg daily. Xarelto 15 mg daily. The physician's orders did not have blood pressure parameters for holding the medication or notifying the physician for the medications, with the exception of the [MEDICATION NAME]. The nurses' notes contained documentation of the following blood pressures with systolic blood pressure below 100 with no physician notification: 02/11/14: 91/60 02/22/14: 96/58 02/27/14: 98/60 03/12/14: 87/61. On 04/08/14 at 3:45 p.m., the DON was asked if the resident should have blood pressure parameters in which to notify the physician. The DON reported any resident with a [DIAGNOSES REDACTED]. 4. Resident #4 had [DIAGNOSES REDACTED]. A care plan, initially dated 09/25/13, documented the resident had a [MEDICAL CONDITION] disorder. An intervention listed was for the staff to obtain and monitor laboratory/diagnostic work as ordered and to report the results to the physician and follow up as indicated. A laboratory report, dated 01/06/14, documented the resident's [MEDICATION NAME] level was high at 21.6 ug/ml. The reference range for [MEDICATION NAME] was documented as 10.0-20.0 ug/ml. The laboratory report had a stamp on it which indicated the form had been faxed to the physician's office.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) The resident's record had no entry, where a follow-up by the staff was obtained, on the elevated [MEDICATION NAME] for any further physician orders. The next scheduled [MEDICATION NAME] level was ordered to be obtained in July 2014. A quarterly assessment, dated 03/26/14, documented the resident was cognitively intact with mild depression and exhibited no behaviors. The resident required two person extensive assistance for bed mobility, transfer, dressing and personal hygiene. The resident required one person total assistance for bathing. The March 2014 physician orders documented the resident received [MEDICATION NAME] 100 mg one tablet three times a day. The physician orders documented the resident was to have a laboratory test for [MEDICATION NAME] ([MEDICATION NAME]) level every six months in January and July. On 04/09/14 at 10:20 a.m., the DON was asked if she would have expected the physician to be notified for follow-up on the elevated [MEDICATION NAME] level. The DON reported there should have been a follow-up notification to the physician on the elevated [MEDICATION NAME] level. The DON further reported the staff should have documented when the physician was notified and if there were no new orders. 5. Resident #5 had [DIAGNOSES REDACTED]. A care plan, initially dated 09/20/12, documented the resident was at risk for MI, [MEDICAL CONDITIONS] had [MEDICAL CONDITION] fib, [MEDICAL CONDITION] and [MEDICAL CONDITION]. An intervention listed was for the staff to give antihypertensive medications as ordered and monitor for side effects such as orthostatic [MEDICAL CONDITION], increased heart rate and effectiveness. Another intervention listed was for the staff to administer medications, [MEDICATION NAME] (both diuretics) and [MEDICATION NAME] (antihypertensive) as ordered. A nurse's note, dated 01/18/14 at 3:12 a.m., documented the resident's BP was 98/49. At 2:12 p.m., a nurse's note documented the resident's blood pressure was 95/54. A nurse's note, dated 02/08/14, documented the resident's blood pressure was 96/47. A nurse's note, dated 02/25/14 at 11:30 a.m., documented the resident's blood pressure was 92/61. A nurse's note, dated 03/03/14, documented the resident's blood pressure was 92/71. A nurse's note, dated 03/04/14 at 11:09 a.m., documented the resident's blood pressure was 94/62. A nurse's note, dated 03/07/14 at 10:15 a.m., documented the resident's blood pressure was 87/60. A nurse's note, dated 03/10/14 at 10:49 a.m., documented the resident's blood pressure was 97/76. None of the above blood pressures were reported to the physician. A significant change assessment, dated 03/26/14, documented the resident had severe cognitive impairment with minimal depression. The resident was totally dependent on two persons for bed mobility, transfer and personal hygiene. The March 2014 physician orders documented the resident was to receive [MEDICATION NAME] 25 mg one tablet BID. If the resident's pulse was below 60, the staff was to hold the medication and notify the physician. The resident was ordered to receive [MEDICATION NAME] 50 mg one tablet daily and [MEDICATION NAME] 40 mg one tablet daily. On 04/14/14 at 9:15 a.m., the DON was interviewed in regard to the resident's antihypertensive and diuretic medication use without physician notification of the lowered blood pressures. The DON reported she expected the physician to be notified of the lowered blood pressures. 6. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. A nurse's note, dated 02/25/14 at 10:09 p.m., documented, skin assessment done, resident has 0.5x0.2 to coccyx noted. resident has open areas noted to both heals (sic) left heel is 5.4x5.5, right heel is 7x3.5. no other open ares (sic) noted at this time. A Weekly Pressure Ulcer Report, dated 02/27/14, documented,.Coccyx resolved.Left heel 6.1x5.9x0.3cm stage II.Right heel 6.3x4.0x0.2 stage II. A Weekly Pressure Ulcer Report, dated 03/06/14, documented .In hospital.Left heel 6.1x5.9x0.3cm stage II.Right heel 6.3x4.0x0.2 stage II. A nurse's note, dated 03/10/14, documented the resident had been readmitted to the facility from the hospital. There was no documentation in the clinical record of the size of the pressure ulcers upon the resident's readmission to the facility. A care plan, dated 03/10/14, documented, The resident has (3) pressure ulcers on admit r/t chair bound, diabetes, [MEDICAL CONDITION] receiving [MEDICAL TREATMENT].On return from hospital has 2 pairs of Pressure relieving heel protectors, as a problem. A goal was for the resident's pressure ulcers to show signs of healing and remain free from infection. Interventions listed, .Treatments as ordered to pressure ulcers, monitor daily for effects. Notify physician and family of changes. A nurse's note, dated 03/13/14 at 2:44 p.m., documented, resident rt heel measurements [MEDICAL CONDITION], left heel measures [MEDICAL CONDITION], residents heels cleaned and dressed as ordered. A Weekly Pressure Ulcer Report, dated 03/13/14, documented, .right heel 4.0x1.9x0.2cm.left heel 4.3x5.5x0.3cm. A Weekly Pressure Ulcer Report, dated 03/20/14, documented, .right heel 3.5x1.7x0.2cm.left heel 3.7x4.8x0.2cm. A nurse's note, dated 03/27/14 at 2:45 p.m., documented, rt heel wound measurements [MEDICAL CONDITION], left heel measures [MEDICAL CONDITION], wound care done as ordered. There was no documentation in the clinical record the physician had been notified of the increase in size of the two pressure ulcers. A Weekly Pressure Ulcer Report, dated 03/27/14, documented, .right heel 4.0x2.0x0.2cm.left heel 6.3x5.7x0.3cm. There was no documentation on the weekly pressure ulcer report the physician had been notified of the increase in size of the two pressure ulcers. A computerized physician's order, dated 03/31/14, with a start date of 02/25/14, documented wound care--bilater heels.Topical-TREATMENT DAILY Everyday: cleanse bi-lateral heels with nss pat dry apply Santyl nickle (sic) thick to wound beds cover with gauze wrap with kerlix secure with tape daily. A March 2014 TAR, documented the resident received treatments to bilateral heels on 03/01/14 and 03/02/14. The resident was in the hospital until 03/10/14. The remaining 21 days contained no documentation the treatments had been completed as ordered. A nurse's note, dated 04/03/14 at 2:25 p.m., documented, .dressing to bil heel done as ordered rt heel wound measures 4.9x3.5x2, left heel measures [MEDICAL CONDITION] There was no documentation in the clinical record the physician had been notified of the continued increase in size of the two pressure ulcers over the past two weeks. A Weekly Pressure Ulcer Record, dated 04/03/14, documented, .Stage III rt heel [MEDICAL CONDITION] III lt heel [MEDICAL CONDITION] There was no documentation the physician had been notified of the continued increase in size of the two pressure ulcers over the past two weeks. A 30-day assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides of the lower extremities. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. On 04/07/14 at 3:00 p.m., the resident reported she had asked several times to be sent to the wound clinic for treatment to her heel ulcers. On 04/10/14 at 9:00 a.m., LPN #2 was asked if she had been aware of the resident asking to be sent out to the wound clinic. The LPN reported she had heard something about that but the resident had not mentioned it to her. The LPN reported she had not been assigned to the resident's hall in a long time. At 9:15 a.m., LPN #1 was asked if the resident had ever asked to be sent out to the wound clinic. The LPN stated, Not that I know of. At 2:45 p.m., Dr. (name deleted) was interviewed in regard to the resident's pressure ulcers. The physician was asked how she classified the wounds on the resident's heels. The physician reported the pressure ulcers were due to diabetes and the resident being very non-compliant. The physician was asked how the pressure wounds to the resident's heels were progressing. The physician stated, To be honest with you, I haven't looked at them, I saw her yesterday but didn't look at the wounds. I rely on the nurses. The physician was asked if the nurses had notified her of the wounds increasing in size over the last couple of weeks. The physician stated, Could have, I don't remember. The physician was asked if she had been made aware of the wounds increasing in size would she have ordered a treatment change. The physician stated, Whatever the nurses feel needs to be done. The physician reported she thought the resident was going to the wound clinic. There were no physician orders documented in the clinical record for the resident to be sent to the wound clinic for evaluation. At 3:15 p.m. the resident's pressure ulcers were observed by the physician and the surveyor. The measurements of the right heel was 5.5x3x0.6cm and the left heel was 8x5.8x1.2cm. The physician was asked the stage of the pressure ulcers. The physician stated, Stage III. The physician was then asked if she would change the treatment to the pressure ulcers. The physician then turned to the treatment nurse and the DON and asked what they have seen that works. The physician was asked if the resident would be sent to the wound clinic. The physician asked the DON what she thought. The DON reported the resident would be sent to the wound clinic for an evaluation. At 4:30 p.m., the resident was interviewed in regard to her pressure ulcers. The resident reported she had asked to go to the wound clinic as soon as she arrived at the facility. The resident reported she had asked LPN #1 and the physician. The resident reported she continued to ask LPN #1 up until approximately 2 weeks ago. On 04/11/14 at 10:30 a.m., LPN #1 was shown the nurse's note, dated 04/03/14, and the Weekly Pressure Ulcer Record, dated 04/03/14, and asked for clarification of the pressure sites. At that time, the LPN reported the correct size was documented on the nurse's note. The Weekly Pressure Ulcer Record, dated 04/03/14, with the correct sites and measurements, documented, Stage III Rt heel [MEDICAL CONDITION] III Lt heel [MEDICAL CONDITION] On 04/14/14 at 9:30 a.m., the DON was interviewed in regard to the pressure ulcers increasing in size over the past two weeks and was asked if she thought the nurses should have notified the physician and received a change in treatment. The DON stated, Yes. 7. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 03/10/14, documented the resident had diabetes mellitus, as a problem. A goal was for the resident to have no complications related to diabetes. One intervention listed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**
NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET ADA, OK 74820**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) was for the staff to monitor, document and report to the physician as needed s/s of [DIAGNOSES REDACTED]. A computerized physician's order, dated 03/31/14, documented, CHECK AND RECORD FSBS QID AND PRN call dr if below 60 and above 351-TREATMENT FOUR TIMES PER DAY Everyday. A 30-day assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides of the lower extremities. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. A TAR, dated April 2014, documented a FSBS of 58 on 04/04/14. There was no documentation in the clinical record the physician had been notified of the FSBS as ordered. On 04/14/14 at 9:30 a.m., the DON was shown the FSBS of 58 and asked if she thought the physician should have been notified. The DON stated, Yes, according to the parameters.
F 0164 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep each resident's personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined the facility failed to: a) Pull the privacy curtain during incontinent care and to ensure the door remained closed during care for one (#13) of six sampled residents who received incontinent care. This had the potential to affect 40 residents, identified on the Resident Census And Conditions Of Residents form, who were occasionally or frequently incontinent of bladder and 36 residents, identified on the same form, who were occasionally or frequently incontinent of bowel. b) Ensure privacy was provided during a skin observation of a resident's chest for one (#5) of three sampled residents who had experienced itching with a rash. This had the potential to affect all 65 residents who resided in the facility and required skin assessments. c) Pull the privacy curtain between residents during the provision of PEG tube care for one (#3) of one sampled resident who required PEG tube care. This had the potential to affect three residents, identified by the DON, who required PEG tube care. Findings: 1. Resident #5 had [DIAGNOSES REDACTED]. A care plan, initially dated 07/10/12, documented a goal was for the resident to have intact skin through the next review date of 04/06/14 and to have weekly skin assessments. A physician's orders [REDACTED]. A significant change assessment, dated 03/26/14, documented the resident had severe cognitive impairment with minimal depression. The resident was totally dependent on two persons for bed mobility, transfer and personal hygiene. The resident required two person extensive assistance for dressing and locomotion on and off the unit. On 04/07/14, during the initial tour, CMA #2 reported the resident had experienced a rash with itching on her chest and arms. On 04/10/14 at 2:40 p.m., CNA #8 and #9 were in attendance with the resident. The resident was in her wheelchair in the hallway. The surveyor asked to observe the resident's chest area and arms. The two CNAs did not take the resident to her room. In the hallway, CNA #9 pulled the resident's blouse upward to expose the resident's chest. The resident was trying to pull down her blouse as the CNA was raising the blouse upward. The resident's upper abdomen and chest area was exposed to hallway traffic. On 04/14/14 at 9:15 a.m., the DON was asked if she expected the staff to take the resident to her room and close the door rather than exposing the resident to hallway traffic. The DON stated, Yes. 2. Resident #3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 11/18/10, documented the resident was incontinent of bowel and bladder, as a problem. A goal was for the resident to remain free from skin breakdown due to incontinence. One intervention listed was for the staff to check the resident every two hours and wash, rinse and dry perineum after incontinent episodes. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact and was totally dependent on two persons assistance for transfer, bed mobility, dressing, hygiene and bathing. The resident was totally dependent of one person assistance for eating. The resident was always incontinent of bowel and bladder. The resident had functional limitation in ROM to the upper and lower extremities. On 04/09/14 at 8:40 a.m., CNA #12 and CNA #6 were observed to perform incontinent care for the resident. The privacy curtain had not been pulled to provide privacy in the event the door was opened. An unidentified staff member knocked on the resident's door and opened the door exposing the uncovered resident to the hallway. LPN #12 then pulled the privacy curtain and stated, I should have already pulled the curtain. At 9:25 a.m., the resident was observed during medication administration via the PEG tube. CMA #5 exposed the resident's abdomen to access the PEG tube. The CMA did not pull the privacy curtains to prevent exposure in the event of the roommate's or staff members' entrance to the room. An unidentified CNA knocked and entered the room without waiting for permission to enter, exposing the resident to the hallway. The CMA reported the resident's roommate entered and exited the room frequently during care provision. On 04/14/14 at 9:30 a.m., the DON was asked if she expected the privacy curtain to be pulled during provision care. The DON stated, Yes. 3. On 04/07/14 at 3:00 p.m., a group meeting was conducted with 12 alert and oriented residents. Several of the residents reported they would shut their doors for privacy and the staff would come and open the doors without asking the resident for permission. On 04/10/14 at 10:40 a.m., the ADM was informed of the issues regarding privacy. The ADM reported the issue would be taken care of.
F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and resident interviews, it was determined the facility failed to ensure: a) An alleged violation of resident to resident abuse was thoroughly investigated for three (#7, #4 and #2) of four sampled residents who experienced resident to resident abuse allegations. b) A misappropriation of property was reported immediately to the administrator and law enforcement; state and facility incident reports were completed and the allegations were thoroughly investigated for two (#7 and #13) of two sampled residents who had allegations of misappropriation of property. c) An alleged violation of staff to resident abuse was thoroughly investigated for one (#13) of one sampled resident who experienced an allegation of staff to resident abuse. This had the potential to affect all 65 residents who resided in the facility. Findings: 1. An abuse policy documented, .POLICY: It is the policy of this facility to maintain an abuse free environment. ABUSE is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. VERBAL ABUSE is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms aimed to residents or their families. MISAPPROPRIATION OF RESIDENT'S PROPERTY refers to the deliberate misplacement, exploitation, or wrongful or permanent use of a resident's belongings or money without the resident's consent. 5. INVESTIGATION: Any allegation of abuse will be investigated by the Administrator and the Director of Nursing. The Administrator and the Director of Nursing will, at a minimum. e. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident if necessary; f. Interview the resident's roommate, family members, and visitors as able and necessary; g. Interview other residents to whom the accused employee provides care or services. 7. REPORTING/RESPONSE: All alleged violations and all substantial incidents will be reported to the Oklahoma State Department of Health as described in number 5 above. Resident #7 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. A nurse's note, dated 12/03/13, documented, Resident filed a grievance at 8:30am Tuesday December 3, 2013. Resident stated that on Monday December 2, 2013 around 3:00pm she asked the CNA to look in a CD case that she had to get the $10.00 bill out that she had, resident stated she wanted to buy a present for someone. When the CNA looked in the CD case the $10.00 was not there. Resident stated she wished that someone had not taken her money but that next time she will lock it in the top drawer of her bed table. A care plan, dated 03/20/13, documented the resident enjoyed going to the dining room for meals, as a problem. The goal was for the resident to eat all her meals in the dining room. An intervention listed was for the staff to assist the resident to the dining room as needed. A nurse's note, dated 01/25/14, documented, REPORTED BEING SLAPPED IN BACK IN DINING ROOM BY ANOTHER RESIDENT. NO C/O OF INJURY. SKIN WDI. NO DISCOLORATION PRESENT. OTHER RESIDENT TAKEN TO HER ROOM. WILL CONT TO MONITOR. A corresponding incident report documented, While in dining room (resident name deleted) went up to (resident name deleted) and hit her on her back. A quarterly assessment, dated 03/12/14, documented the resident was cognitively intact and demonstrated no moods or behaviors. On 04/09/14 at 3:00 p.m., the ADM was asked for the investigation of the resident's missing money and corresponding state and facility incident reports. The ADM was asked for the investigation of the resident to resident abuse. The ADM reported he had not known of the missing money and it was unusual for the resident or staff not to tell him. The ADM reported he did not have an investigation of the resident to resident abuse or the missing money. The ADM and the corporate nurse reported the facility should have conducted a thorough investigation of both events, completed incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**
NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET ADA, OK 74820**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0225

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 3)
reports and notified local law enforcement of the missing money.

2. Resident #4 had [DIAGNOSES REDACTED]. A nurse's note, dated 01/27/14 at 12:39 p.m., documented, I was in resident's room and resident told me that another resident came into her room in he (sic) middle of the night and was trying to get in bed with her. she told resident that he could not get in bed with her and he got mad and slapped her across the face. resident then said she hollered out for an aide to come to help her get resident out of room. aide came and removed resident from her room. I looked at residents face and shows no signs of redness. I asked resident if she was hurting from where he hit her and she denied having pain. physician notified and family notified. aides told to make sure to keep other resident out of her room. peri care given and shows no obvious signs of injuries, resident denies having any type of intercouse (sic) with other resident. The investigative report documented the actual incident occurred on the prior 11:00 p.m.-7:00 a.m. shift. During the night shift, while CNA #8 was making rounds, he heard the resident call out for help. The CNA found a newly admitted male resident trying to get into the bed with the resident. The CNA redirected the male resident out of the room. The male resident went with the CNA willingly. The resident did not report to the CNA she had been slapped. An incident report was completed and sent to the OSDH. The final report form documented the male resident involved had been sent out of the facility later the same day to be evaluated and treated at a psychiatric hospital. The male resident involved was placed on 1:1 observation and care until he exited the facility for his evaluation. During the investigation, three staff members were interviewed regarding the incident. CNA #8 reported the resident did not mention being slapped to him. The resident was interviewed by the facility staff again concerning the incident. The resident was examined by the physician and no evidence of sexual assault was found. There was no documentation to indicate other residents were interviewed to determine if the male resident had harmed any other resident. No thorough investigation was conducted. A quarterly assessment, dated 03/26/14, documented the resident was cognitively intact with mild depression and exhibited no behaviors. The resident required two person extensive assistance for bed mobility, transfer, dressing and personal hygiene. The resident required one person total assistance for bathing. The assessment documented the resident had an indwelling urinary (suprapubic) catheter and was always incontinent of bowel. On 04/09/14 at 3:45 p.m., the ADM was interviewed. The ADM was asked if any other residents were interviewed. The ADM reported he knew staff spoke with other residents, but he did not know what happened to the documentation. The ADM reported he did not have documentation concerning other resident interviews. The ADM reported he would instruct the staff to keep any further documentation for investigations.

3. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. A grievance/complaint report form, dated 02/27/14, documented the resident had reported to SS/AD #1 about a missing cell phone. The report documented the facility staff searched the resident's room and the roommate's belongings. The CNAs, housekeeping and laundry staff were to continue to search for the missing cell phone. The resident requested the police be called because she needed a police report to file a missing cell phone with the cell phone insurance. The report documented the resolution of the grievance/complaint was the resident filed a loss of cell phone with her cell phone insurance. The insurance replaced the missing cell phone. A nurse's note, dated 02/27/14, documented, .resident has filed grievance over cell phone missing, resident whole room searched top to bottom w/no luck of finding cell phone. A complete investigation was not completed by the facility staff concerning the missing cell phone. An incident report was not completed and sent to the OSDH concerning the missing cell phone. A 30-day assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides to lower extremities. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. On 04/10/14 at 8:00 a.m., the office manager was asked for the incident report and investigation concerning the resident's missing cell phone. On 04/11/14 at 1:05 p.m., the ADM was asked for the incident report and investigation concerning the resident's missing cell phone. The ADM reported he could not find it but was still looking. On 04/14/14 at 9:55 a.m., the ADM was asked again for the incident report and investigation report concerning the missing cell phone. The ADM reported he could not find either the incident report or the investigation report. The ADM was asked if an investigation should have been completed along with an incident report being sent to the OSDH. The ADM nodded. 4. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. An incident report, dated 03/14/14, documented the resident had complained to SS/AD #2 of allegations of abuse. The incident report documented the resident had reported CNA #7 flung me down into the sling and jerked me around while getting me up to get dressed.she hid my call light. There was no documentation in the clinical record or on the incident report other staff or residents were interviewed in regard to the staff member and the allegations of abuse. A 30-day assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides to lower extremities. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. On 04/09/14 at 1:55 p.m., the ADM was questioned in regard to an investigation being completed for the allegation of abuse involving a staff member and a resident. The ADM reported he was on vacation at that time and the corporate nurse may be able to help. At 2:05 p.m. via telephone, the corporate nurse was questioned in regard to the investigation of an allegation of abuse involving a staff member and the resident. The corporate nurse was asked if other staff and residents had been questioned about the staff member named in the allegation. The corporate nurse stated, I told her (the DON) to. I think she did but I am not sure. There was no documentation containing an investigation where other staff and residents were interviewed concerning the allegation. 5. Resident #2 had been admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. An initial assessment, dated 08/18/13, documented the resident required extensive assistance with bed mobility, total assistance for transfers, did not ambulate, required extensive assistance with dressing and hygiene, required total assistance with bathing, was incontinent of bowel and required an indwelling urinary catheter. A nurse's note, dated 08/27/13 at 3:09 p.m., documented Aides reported that after lunch approx 1300 (1:00 p.m.), this resident reported that her roommate (Resident #22) slapped her on the face, (Resident #2's name deleted)stated that she was trying to open the room door and her roommate pushed the door shut and slapped her on the right side of her face, (Resident's #2's name deleted) stated that it didn't hurt but it did scare her, Dr .notified and I tried to call daughter.but received no answer at this time. At 3:57 p.m., a nurse's note documented, .Resident's daughter returned call and was notified of conflict with roommate and that she (Resident #22) was moved to another room. An incident report for resident #22 documented Reported to charge nurse by aide that this resident (Resident's name deleted) slapped her roommate (Resident #2's name deleted) Immediate Action Taken Roommate was evaluated for injuries, none observed Mental Status Oriented to Person Predisposing Physiological Factors Confused Impaired Memory Predisposing Situation Factors Resident to Resident contact. A reportable incident report, dated 08/28/13, documented immediate action taken was for resident #22 to be moved to another room. There was no documentation of an investigation to determine if resident #2's roommate had hit other residents. There was no documentation to include whether the new roommate had been notified or was at risk of being hit by the resident when moved to another room. On 04/14/14 at 9:40 a.m., the DON was notified of the lack of an investigation regarding the resident to resident altercation. She reported a through investigation should have been completed.

F 0226

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on record review and staff and resident interviews, it was determined the facility failed to ensure, as documented on the facility's policy on abuse: a) An alleged violation of resident to resident abuse was thoroughly investigated for three (#7, #4 and #2) of four sampled residents who experienced resident to resident abuse allegations. b) A misappropriation of property was reported immediately to the administrator and law enforcement; a state and facility incident reports were completed and the allegations were thoroughly investigated for two (#7 and #13) of two sampled residents who had allegations of misappropriation of property. c) An alleged violation of staff to resident abuse was thoroughly investigated for one (#13) of one sampled resident who experienced an allegation of staff to resident abuse. This had the potential to affect all 65 residents who resided in the facility. Findings: 1. An abuse policy documented, .POLICY: It is the policy of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET** **ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) this facility to maintain an abuse free environment. ABUSE is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. VERBAL ABUSE is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms aimed to residents or their families. MISAPPROPRIATION OF RESIDENT'S PROPERTY refers to the deliberate misplacement, exploitation, or wrongful or permanent use of a resident's belongings or money without the resident's consent. 5. INVESTIGATION: Any allegation of abuse will be investigated by the Administrator and the Director of Nursing. The Administrator and the Director of Nursing will, at a minimum. e. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident if necessary; f. Interview the resident's roommate, family members, and visitors as able and necessary; g. Interview other residents to whom the accused employee provides care or services. 7. REPORTING/RESPONSE: All alleged violations and all substantial incidents will be reported to the Oklahoma State Department of Health as described in number 5 above. Resident #7 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. A nurse's note, dated 12/03/13, documented, Resident filed a grievance at 8:30am Tuesday December 3, 2013. Resident stated that on Monday December 2, 2013 around 3:00pm she asked the CNA to look in a CD case that she had to get the $10.00 bill out that she had, resident stated she wanted to buy a present for someone. When the CNA looked in the CD case the $10.00 was not there. Resident stated she wished that someone had not taken her money but that next time she will lock it in the top drawer of her bed table. A care plan, dated 03/20/13, documented the resident enjoyed going to the dining room for meals, as a problem. The goal was for the resident to eat all her meals in the dining room. An intervention listed was for the staff to assist the resident to the dining room as needed. A nurse's note, dated 01/25/14, documented, REPORTED BEING SLAPPED IN BACK IN DINING ROOM BY ANOTHER RESIDENT. NO C/O OF INJURY. SKIN WDI. NO DISCOLORATION PRESENT. OTHER RESIDENT TAKEN TO HER ROOM. WILL CONT TO MONITOR. A corresponding incident report documented, While in dining room (resident name deleted) went up to (resident name deleted) and hit her on her back. A quarterly assessment, dated 03/12/14, documented the resident was cognitively intact and demonstrated no moods or behaviors. On 04/09/14 at 3:00 p.m., the ADM was asked for the investigation of the resident's missing money and corresponding state and facility incident reports. The ADM was asked for the investigation of the resident to resident abuse. The ADM reported he had not known of the missing money and it was unusual for the resident or staff not to tell him. The ADM reported he did not have an investigation of the resident to resident abuse or the missing money. The ADM and the corporate nurse reported the facility should have conducted a thorough investigation of both events, completed incident reports and notified local law enforcement of the missing money per the facility's abuse policy. 2. Resident #2 had been admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. An initial assessment, dated 08/18/13, documented the resident required extensive assistance with bed mobility, total assistance for transfers, did not ambulate, required extensive assistance with dressing and hygiene, required total assistance with bathing, was incontinent of bowel and required an indwelling urinary catheter. A nurse's note, dated 08/27/13 at 3:09 p.m., documented Aides reported that after lunch approx 1300 (1:00 p.m.), this resident reported that her roommate (Resident #22) slapped her on the face, (Resident #2's name deleted) stated that she was trying to open the room door and her roommate pushed the door shut and slapped her on the right side of her face, (Resident's #2's name deleted)stated that it didn't hurt but it did scare her, Dr .notified and I tried to call daughter.but received no answer at this time. At 3:57 p.m., a nurse's note documented, .Resident's daughter returned call and was notified of conflict with roommate and that she (Resident #22) was moved to another room. An incident report for resident #22 documented Reported to charge nurse by aide that this resident (Resident's name deleted) slapped her roommate (Resident #2's name deleted) Immediate Action Taken Roommate was evaluated for injuries, none observed Mental Status Oriented to Person Predisposing Physiological Factors Confused Impaired Memory Predisposing Situation Factors Resident to Resident contact. A reportable incident report, dated 08/28/13, documented immediate action taken was for resident #22 to be moved to another room. There was no documentation of an investigation to determine if resident #2's roommate had hit other residents. There was no documentation to include whether the new roommate had been notified or was at risk of being hit by the resident when moved to another room. On 04/14/14 at 9:40 a.m., the DON was notified of the lack of an investigation regarding the resident to resident altercation. She reported a through investigation should have been completed as directed by the facility abuse policy. 3. Resident #4 had [DIAGNOSES REDACTED]. A quarterly assessment, dated 03/26/14, documented the resident was cognitively intact with mild depression and exhibited no behaviors. The resident required two person extensive assistance for bed mobility, transfer, dressing and personal hygiene. The resident required one person total assistance for bathing. The assessment documented the resident had an indwelling urinary (suprapubic) catheter and was always incontinent of bowel. A nurse's note, dated 01/27/14 at 12:39 p.m., documented, I was in resident's room and resident told me that another resident came into her room in he (sic) middle of the night and was trying to get in bed with her. she told resident that he could not get in bed with her and he got mad and slapped her across the face. resident then said she hollered out for an aide to come to help her get resident out of room. aide came and removed resident form her room. I looked at residents face and shows no signs of redness. I asked resident if she was hurting from where he hit her and she denied having pain. physician notified and family notified. aides told to make sure to keep other resident out of her room. peri care given and shows no obvious signs of injuries, resident denies having any type of intercouse (sic) with other resident. The investigative report documented the actual incident occurred on the prior 11:00 p.m.-7:00 a.m. shift. During the night shift while CNA #8 was making rounds, he heard the resident call out for help. The CNA found a newly admitted male resident trying to get into the bed with the resident. The CNA redirected the male resident out of the room. The male resident went with the CNA willingly. The resident did not report to the CNA she had been slapped. An incident report was completed and sent to the OSDH. The final report form documented the male resident involved had been sent out of the facility later the same day to be evaluated and treated at a psychiatric hospital. The male resident involved was placed on 1:1 observation and care until he exited the facility for his evaluation. During the investigation, three staff members were interviewed regarding the incident. CNA #8 reported the resident did not mention being slapped to him. The resident was interviewed again by staff concerning the incident. The resident was examined by the physician and no evidence of sexual assault was found. There was no documentation to indicate other residents were interviewed to determine if the male resident had harmed any other resident. No thorough investigation was conducted per the facility's abuse policy. The abuse policy documented staff and other residents would be interviewed. The abuse policy was not followed for this incident. On 04/09/14 at 3:45 p.m., the ADM was interviewed. The ADM was asked if any other residents were interviewed. The ADM reported he knew staff spoke with other residents, but he did not know what happened to the documentation. The ADM reported he did not have documentation concerning other resident interviews. The ADM reported he would instruct the staff to keep any further documentation for investigations and to follow the abuse policy. 4. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. A grievance/complaint report form, dated 02/27/14, documented the resident had reported to SS/AD #1 about a missing cell phone. The report documented the facility staff searched the resident's room and the roommate's belongings. The CNAs, housekeeping and laundry staff were to continue to search for the missing cell phone. The resident requested the police be called because she needed a police report to file a missing cell phone with the cell phone insurance. The report documented the resolution of the grievance/complaint was the resident filed a loss of cell phone with her cell phone insurance. The insurance replaced the missing cell phone. A nurse's note, dated 02/27/14, documented, .resident has filed grievance over cell phone missing, resident whole room searched top to bottom w/no luck of finding cell phone. A complete investigation was not completed by the facility concerning the missing cell phone. An incident report was not completed and sent to the OSDH concerning the missing cell phone. A 30-day assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides to lower extremities. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. On 04/10/14 at 8:00 a.m., the office manager was asked for the incident report and investigation concerning the resident's missing cell phone. On 04/11/14 at 1:05 p.m., the ADM was asked for the incident report and investigation concerning the resident's missing cell phone. The ADM reported he could not find it but was still looking. On 04/14/14 at 9:55 a.m., the ADM was asked again for the incident report and investigation report concerning the missing cell phone. The ADM reported he could not find either the incident report or the investigation report. The ADM was asked if an

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0226

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 5)
investigation should have been completed along with an incident report being sent to the OSDH as directed by the facility abuse policy. The ADM nodded. 5. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. An incident report, dated 03/14/14, documented the resident had complained to SS/AD #2 of allegations of abuse. The incident report documented the resident had reported CNA #7 flung me down into the sling and jerked me around while getting me up to get dressed.she hid my call light. There was no documentation in the clinical record or on the incident report other staff or residents were interviewed in regard to the staff member and the allegations of abuse. A 30-day assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides to lower extremities. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. On 04/09/14 at 1:55 p.m., the ADM was questioned in regard to an investigation being completed on the allegation of abuse involving a staff member and a resident. The ADM reported he was on vacation at that time and the corporate nurse may be able to help. At 2:05 p.m. via telephone, the corporate nurse was questioned in regard to the investigation of an allegation of abuse involving a staff member and the resident. The corporate nurse was asked if other staff and residents had been questioned about the staff member named in the allegation as directed by the facility abuse policy. The corporate nurse stated, I told her (the DON) to. I think she did but I am not sure. There was no documentation containing an investigation where other staff and residents were interviewed concerning the allegation.

F 0241

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation and staff and resident interview, it was determined the facility failed to ensure staff members knocked, asked permission to enter and waited for a response prior to entering the room for three (#5, #8 and #25) of 23 sampled residents who required staff to enter their rooms. This had the potential to affect all 65 residents who resided in the facility. Findings: 1. Resident #8 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. An initial assessment, dated 03/17/14, documented the resident was severely impaired with cognition and demonstrated no moods or behaviors. The resident required extensive assistance of two persons to transfer, dress and perform personal hygiene. The resident required total assistance of one person to bathe. The resident did not ambulate in the room or corridor during the look back period. The resident had impairment on one lower extremity and was frequently incontinent of bowel and bladder. A care plan, dated 03/26/14, documented the resident was at risk for skin breakdown, due to being frequently incontinent of bowel and bladder, as a problem. The goal was for the resident to be free of skin breakdown through the next review date. An intervention listed was for the staff to perform incontinent care with each incontinent episode. On 04/08/14 at 1:00 p.m., CNA #5 and CNA #6 were observed to knock on the resident's door while entering the room. The CNAs did not ask for permission to enter or wait for the resident to respond. At 4:00 p.m., CNA #11 was observed to knock on the resident's door while entering the resident's room. The CNA did not ask for permission to enter, identify himself or wait for the resident to respond. On 04/14/14 at 9:40 a.m., the DON and ADM were asked if they expected the staff to knock, ask for permission to enter, identify themselves and wait for a response. Both the DON and ADM nodded their heads.
2. On 04/07/14 at 12:55 p.m., RN #1 was observed administering medications for resident #5. The door to the resident's room was open. The RN retrieved the resident's medications off the cart and entered the resident's room without knocking before entering. On 04/10/14 at 8:30 a.m., RN #1 was notified of not knocking and then entering the resident's room. She reported it had been a hectic day and she forgot to knock. On 04/14/14 at 9:35 a.m., the DON was asked if the staff should knock and wait for permission before entering the resident's room. She stated Yes, they should. 3. On 04/07/14 at 5:25 p.m., CMA #4 was observed administering medications for resident #25. The CMA retrieved the resident's medications from the medication cart, then entered the resident's room without knocking or asking for permission to enter the room. On 04/14/14 at 9:35 a.m., the DON was asked if the staff should knock and wait for permission to enter the resident's room. She stated Yes, they should.
4. On 04/08/14 at 4:55 p.m., CNA #11 was observed to walk into room [ROOM NUMBER] without knocking. On 04/14/14 at 9:35 a.m., the DON was asked if the staff should knock and wait for permission to enter the resident's room. She stated Yes, they should.

F 0248

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide activities to meet the interests and needs of each resident.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, record review and staff interviews, it was determined the facility failed to provide activities of interest for three (#1, 3 and #8) of three sampled residents. This had the potential to affect five residents, identified by the DON, who required one on one activities be provided. Findings: 1. Resident # 3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 03/01/13, documented the resident was very limited on the tasks he could perform d/t contractures, as a problem. A goal documented the resident would have one on one activities twice a week. Interventions listed were for the SS/AD to visit with the resident three times a week, encourage other staff to visit with him, ask the resident if he would like to watch television and talk with the resident about fishing and old cars. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact and was totally dependent on two persons assistance for transfer, bed mobility, dressing, hygiene and bathing. The resident was totally dependent on one person assistance for eating. The resident was always incontinent of bowel and bladder. The resident had functional limitation in ROM to the upper and lower extremities. The clinical record contained no documentation of one on one activities for the months of January 2014, February 2014 or March 2014. There was no observation of one on one activities throughout the survey. On 04/14/14 at 9:45 a.m., the ADM was interviewed regarding the individualized activities for the resident. The ADM was informed of activities not being observed for the resident. The ADM nodded his head. 2. On 04/07/14 at 3:00 p.m., a group meeting was conducted with 12 alert and oriented residents. The group was questioned in regard to the activities. The group reported the activity program lacked organization. The group reported they never knew when the activities were going to occur because the calendar was never followed. The group reported the activity staff changed often. The group reported there were not enough activities to keep them busy. The group also reported there were no activities of interest for the male residents. On 04/10/14 at 10:40 a.m., the ADM was informed of the concerns of the group about the facility activity program. The ADM reported he was in the process of hiring a new SS/AD.

3. Resident #8 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. An initial assessment, dated 03/17/14, documented the resident was severely impaired with cognition and demonstrated no moods or behaviors. The resident required extensive assistance of two persons to transfer, dress and perform personal hygiene. The following items were very important to the resident: care of personal belongings, bedtime choices, family involvement in care, ability to use the phone in private, locking personal items up, keeping up with the news, ability to go outside and doing favorite activities. A care plan, dated 03/26/14, contained no documentation of activities of interest for the resident. There was no facility activity assessment for the resident in the medical record. There were no activity notes. On 04/08/14 at 12:40 p.m., the resident was observed in his room. The resident was sitting in his W/C. The TV in his room was off. At 1:50 p.m., the Intermediate Overseer was interviewed regarding the resident's individualized activities. The staff member reported the facility did not have an activity director at this time and one was supposed to start on Friday. She reported they had volunteers to do group activities, but no one was doing one on one activities. On 04/09/14 at 7:15 a.m., the resident was observed in his room. The resident was sitting in his W/C. The TV in his room was off. At 3:40 p.m., the resident was in his bed with his eyes open. The TV was off. The resident was looking up at the ceiling. On 04/10/14 at 9:00 a.m., the resident was observed in his room. The resident was sitting in his W/C. The TV in his room was off. On 04/11/14 at 4:30 p.m., the resident was in his bed with his eyes open. The TV was off. The resident was looking up at the ceiling. On 04/14/14 at 9:45 a.m., the ADM was interviewed regarding the individualized activities for the resident. The ADM was informed of the lack of an activity assessment and activities not being observed for the resident. The ADM nodded his head.

4. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident's care plan, dated 02/18/13, documented the resident was dependent on the staff for activities, social interaction related to the resident's disease process and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0248 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) cognitive deficits and the resident enjoyed visits from family and friends. A significant change assessment, dated 02/22/14, documented the resident was severely impaired in cognition, exhibited symptoms of moderately severe depression and exhibited no behavioral symptoms. The resident required total assistance with transfers, dressing, eating, hygiene and bathing. An activities progress note, dated 02/22/14, documented, .Monthly Party for February. There was cake, punch, cookies, sandwhiches (sic), chips and dip, candy, we also had live music. Residents were crowned King and Queen of the valentines party and runner up's. There was dancing, laughing, and singing. The note did not document the resident attended or participated in the party. The clinical record contained no documentation the resident received one-on-one activities, or of any activities, during the past six months. On 04/07/14 at 3:20 p.m., the resident was observed during care. The resident was lying in bed, facing the wall. The television was on. On 04/09/14 at 3:40 p.m., the resident's family member was interviewed. The family member reported the resident liked to watch television and to read. The family member reported the resident was not a very social person before admission to the facility. The family member reported the resident was not able to read books due to her condition. The family member was asked if the resident would enjoy having books read to her. The family member stated, She would probably love it. On 04/14/14 at 10:00 a.m., the ADM was notified activities were not provided for the resident, except for a television in her room. The ADM and the Intermediate Overseer reported a volunteer was conducting some activities for the residents but no individual room activities were conducted. The ADM reported the facility had several activity directors in the past several months and just hired a new AD/SS director.
F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide housekeeping and maintenance services.** Based on record review, observation and interview, it was determined the facility failed to ensure floors, doors, walls, window screens, toilet seats and a fire blanket were in good repair. This had the potential to affect all 65 residents who resided in the facility. Findings: On 04/08/14 at 8:30 a.m., an environmental tour of the facility was conducted. The laminate flooring, on the ramp from South Hall to Circle Hall, was missing a large gap of laminate. The laminate flooring of all the hallways contained small circular areas of missing laminate. The south exit door from Circle Hall had gapped areas along the lower one-half of the door frame from which sunlight was visible and was a potential area for pests to enter. The bathroom/shower room on Circle Hall had a squeaky door. The oval commode had a round toilet seat, which did not fit properly and could cause pinching. On South Hall, the paint along the crown molding, on the south side of the hall, was separated from the wall and peeling off the wall. The laundry room and the conference room/library room had brown water stained ceiling tiles. On 04/10/14 at 9:00 a.m., an environmental tour of the outside courtyard was conducted with a maintenance staff member. Three residents were observed to be sitting in the courtyard and smoking cigarettes. The fire blanket box was observed to be dirty and dusty. The fire blanket in the box was wet and smelled like mold. The maintenance staff member reported he would replace the fire blanket. The window screens for rooms #201 and #303 contained slits which were potential areas for insects to enter. On 04/11/14 at 2:00 p.m., the ADM was notified of the findings and reported the areas would be corrected.
F 0258 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Maintain comfortable sound levels.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff and resident interviews, it was determined the facility failed to maintain comfortable sound levels. This had the potential to affect all 65 residents who resided in the facility. Findings: On 04/07/14 at 3:00 p.m., a group meeting was conducted with 12 alert and oriented residents. The group was questioned about the noise level in the facility. All of the residents reported the facility was generally noisy during the day time hours and at night. Most of the residents complained about the laundry barrels going up and down the hallways. On 04/08/14 at 5:30 a.m., a laundry worker was observed to push a wheeled laundry barrel down the hall. After the worker passed room [ROOM NUMBER] with the loud barrel, the resident began yelling out. The resident had not yelled out prior to the passing of the laundry barrel. At 8:45 a.m., a resident asked to speak with the surveyor. As the resident was speaking, she stopped in mid-sentence. The resident was prompted to finish her thought. The resident stated, Wait a minute and let her pass. At that time, a laundry worker passed, pushing a wheeled laundry barrel which made a loud noise during transit. The resident stated, That is so loud. On 04/09/14 at 5:15 a.m., a laundry worker pushed a wheeled laundry barrel down the hall. The barrel made a loud sound as it was being pushed. On 04/14/14 at 9:55 a.m., the ADM, DON and the corporate nurse were notified of the concerns of the noise level. The ADM reported the noise level would be addressed. On 04/14/14 at 2:00 p.m., the surveyor was walking down North Hall. Several residents were observed to be lying in bed with their eyes closed. A laundry worker pushed a wheeled laundry barrel down the hall. The barrel made a loud sound as it was being pushed.
F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined the facility failed to accurately document on the residents' assessments: a) A pressure sore for one (#2) of four sampled residents with pressure sores. This had the potential to affect 10 residents, identified by the Resident Census And Conditions Of Residents form, with pressure sores. b) A high risk for pressure sores for one (#1) of four sampled residents with pressure sores. This had the potential to affect 10 residents identified by the Resident Census And Conditions Of Residents form, with pressure sores. c) The level of ADL assistance for one (#3) of nine sampled residents requiring assistance with ADLs. This had the potential to affect all 65 residents who resided in the facility. Findings: 1. Resident #2 had been admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. The wound skin assessment forms, dated 08/14/13, documented the following: date of onset: 08/14/13 Lt heel stage II 3.3 depth .1 exudate type/amount mod (moderate) clear wound bed beefy red surrounding skin color pink surrounding tissue/wound edges pale macerated. date of onset: 08/14/13 Rt heel stage II .6 x .6 depth 0 exudate type/amount min (minimum) clear wound bed pink. An initial assessment, dated 08/18/13, documented the resident required extensive assistance with two person for bed mobility, total assist with two person for transfers, did not ambulate, required extensive assistance with dressing and hygiene, required total assist with bathing, was incontinent of bowel and required an indwelling urinary catheter. The resident was at high risk for pressure sores with skin and ulcer treatments for Turning and Repositioning Program. The assessment did not address the stage II pressure sores on the left and right heel. On 04/14/14 at 9:35 a.m., the DON and the corporate nurse were notified of the incorrect assessment regarding the pressure sores. The DON reported she would check on it. 2. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 02/28/13, documented the resident had potential for impaired skin integrity related to limited mobility, incontinence of bowel and bladder, confusion and memory loss. A quarterly assessment, dated 11/20/13, documented the resident was not at risk for developing pressure ulcers. A Braden Scale Assessment, dated 02/19/14, documented the resident was at high risk for pressure ulcers. A significant change assessment, dated 02/22/14, documented the resident was severely impaired in cognition, exhibited symptoms of moderately severe depression and exhibited no behavioral symptoms. The resident required total assistance with transfers, dressing, eating, hygiene and bathing. The assessment documented the resident was not at risk for developing pressure ulcers. A 30-day readmission assessment, dated 03/19/14, documented the resident was not at risk for developing pressure ulcers. On 04/08/14 at 3:20 p.m., the resident was observed during care. The resident was incontinent of bowel and bladder and required two staff assistance for turning and repositioning. At 3:50 p.m., the two MDS coordinators were asked if the resident's assessment should reflect the resident's risk for pressure ulcers. MDS coordinator #1 stated, Yes. We will make a correction right now. 3. Resident #3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 11/18/10, documented the resident required total assistance with all ADLs, as a problem. A goal was for the staff to ensure the resident was neat and clean in appearance and able to rest comfortably. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact and was totally dependent on two persons assistance for transfer, bed mobility, dressing, hygiene and bathing. The resident was totally dependent of one person assistance for eating. The resident was always

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**
NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET** **ADA, OK 74820**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) incontinent of bowel and bladder. The resident had functional limitation in ROM to the upper and lower extremities. The resident required a PEG tube for nutrition. A quarterly assessment, dated 03/18/14, documented the resident was cognitively intact and required extensive assistance of two persons for dressing and hygiene and extensive assistance of one person for eating. The MDS coordinator #2 was shown the two assessments and asked if the resident had improved in the areas of dressing, hygiene and eating or should the quarterly assessment reflect the resident required total assistance. The MDS coordinator stated, Yes, it should. He relies on us for dressing and PEG feeding.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, it was determined the facility failed to ensure a comprehensive care plan: a) Included activities of interest, weight bearing status and an individualized toileting plan for one (#8) of nine sampled residents. b) Included pressure ulcers for one (#2) of three sampled residents who experienced pressure ulcers. This had the potential to affect all 65 residents who resided in the facility and required comprehensive care plans be completed. Findings: 1. Resident #8 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. An initial assessment, dated 03/17/14, documented the resident was severely impaired with cognition and demonstrated no moods or behaviors. The resident required extensive assistance of two persons to transfer, dress and perform personal hygiene. The resident required total assistance of one person to bathe. The resident did not ambulate in the room or corridor during the look back period. The resident had impairment on one lower extremity and was frequently incontinent of bowel and bladder. A care plan, dated 03/26/14, documented the resident was a 1-2 person extensive assist with ADL care due to a [MEDICAL CONDITION], as a problem. The goal was for the resident to work with PT/OT to increase his level of ADL ability through the next review date. An intervention listed was for two persons to assist the resident with transfers. The care plan did not document the resident's weight bearing status. The care plan did not document any activities of interest for the resident or an individualized toileting plan for the resident. On 04/14/14 at 9:15 a.m., MDS coordinator #1 and the DON were interviewed regarding the resident's care plan. The DON reported the resident's weight bearing status should be documented on the care plan for the staff. The MDS coordinator reported the activities of interest and, if the resident was on a toileting plan, it should have been documented on the care plan. The MDS coordinator reported she did not know the resident had a toileting plan. The DON reported the resident's bowel and bladder assessment documented he was a candidate for a toileting plan. The DON reported the facility should have included all three items in the comprehensive care plan. 2. Resident #2 had been admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. The wound skin assessments, dated 08/14/13, documented the following: date of onset: 08/14/13 Lt heel stage II 3.3 depth .1 exudate type/amount mod (moderate) clear wound bed beefy red surrounding skin color pink surrounding tissue/wound edges pale macerated. date of onset: 08/14/13 Rt heel stage II .6 x .6 depth 0 exudate type/amount min (minimum) clear wound bed pink. An initial assessment, dated 08/18/13, documented the resident required extensive assistance with two person for bed mobility, total assist with two person for transfers, did not ambulate, required extensive assistance with dressing and hygiene, required total assist with bathing, was incontinent of bowel and required an indwelling urinary catheter. The resident was a high risk for pressure sores with skin and ulcer treatments for Turning and Repositioning Program. The care plan, dated 08/27/13, documented the goal was for the resident to have intact skin, free of redness, blisters or discoloration by review date. Interventions were for a Braden Scale Assessment weekly for the first 4 weeks then quarterly or more often as needed, to monitor the nutritional status, to avoid positioning the resident on the sacrum, use pillows for positioning and to float heels. The care plan did not address the stage II pressure sores on the left and right heel. On 04/14/14 at 9:35 a.m., the DON and the corporate nurse were notified of the incorrect care plan regarding the pressure sores. The DON reported she would check on it.
F 0280 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, it was determined the facility failed to update the care plan: a) To include a UTI [MEDICAL CONDITION] for one (#1) of four sampled residents who experienced UTIs. b) To reflect the PEG tube feeding only status for one (#3) of one sampled resident who required PEG tube feedings. This had the potential to affect all 65 residents who resided in the facility and required care plan updates. Findings: 1. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 02/28/13, documented the resident had potential for UTI related to a history of dehydration. A hospital discharge summary, dated 02/19/14, documented the resident was discharged from the hospital with improved metabolic [MEDICAL CONDITION]; improved dehydration;[MEDICAL CONDITION], urinary tract infection, positive for E. coli; resolved acute kidney injury due to dehydration; [DIAGNOSES REDACTED] due to oral intake and severe progressive dementia. A significant change assessment, dated 02/22/14, documented the resident was severely impaired in cognition, exhibited symptoms of moderately severe depression and exhibited no behavioral symptoms. The resident required total assistance with transfers, dressing, eating, hygiene and bathing. The care plan contained no updates to reflect the resident's [DIAGNOSES REDACTED]. coli. No further interventions were initiated to address the infection. On 04/14/14 at 9:30 a.m., the DON and the corporate nurse were asked if the care plan should have been updated to include the infections. The DON stated, Yes. I see what you mean. 2. Resident # 3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 11/18/10, documented, Impaired swallowing and Potential for Fluid Imbalance.r/t [MEDICAL CONDITION]/Requires PEG tube for food/adequate fluids, as a problem. A goal was for the resident to be free of aspiration. One intervention listed, Resident had swallow study performed on 3-26-07, at residents request he can have teaspoons full of pureed foods, Nectar thick liquids allowed, may have 2-3 cc of water po at times only when he is sitting up, oral feeding for pleasure only will monitor for aspiration, no sticky foods. The care plan had not been updated to reflect the current physician's orders [REDACTED]. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact and was totally dependent on two persons assistance for transfer, bed mobility, dressing, hygiene and bathing. The resident was totally dependent of one person assistance for eating. The resident was always incontinent of bowel and bladder. The resident had functional limitation in ROM to the upper and lower extremities. The resident required a PEG tube for nutrition. A computerized physician's orders [REDACTED]. On 04/08/14 at 11:50 a.m., the MDS coordinator #2 was shown the care plan and the current physician's orders [REDACTED]. The MDS coordinator stated, Yes, I guess it should.
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, it was determined the facility failed to: a) Obtain blood pressure parameters in which to contact the physician for eight (#1, 2, 4, 5, 7, 8, 9 and #10) of eight sampled residents who required physician ordered blood pressure readings to be taken. This had the potential to affect 23 residents, identified by the DON, who required blood pressures be taken. b) Complete weekly skin assessments with monitoring for one (#4) of nine sampled residents, who required weekly skin assessments be conducted. This had the potential to affect all 65 residents who resided in the facility and required skin assessments to be conducted. c) Assess and monitor one (#10) of four sampled residents who had experienced and complained of itching. This had the potential to affect all 65 residents who resided in the facility. d) Provide a suprapubic urinary catheter irrigation correctly for one (#4) of one sampled resident who required a suprapubic catheter irrigation. This had the potential to affect one resident, identified by the DON, who had a suprapubic urinary catheter. e) Obtain FSBS as ordered by the physician for two (#7 and #13) of two sampled residents who required FSBSs. This had the potential to affect 14 residents, identified by the DON, who required physician ordered FSBSs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) f) Obtain blood pressure and pulse as physician ordered for one (#7) of two sampled residents who required blood pressure and pulse as ordered This had the potential to affect 23 residents, identified by the DON, who had blood pressure and pulse readings ordered by the physician. Findings: 1. A policy titled, Catheter Irrigation, Open System, documented, .The following equipment and supplies will be necessary when performing this procedure: Sterile catheter irrigation tray;.sterile drape.Steps in the Procedure.Put on sterile gloves. Place the sterile drape under the catheter. Place the sterile collection basin under the catheter on the sterile drape. Draw 30 mls of the prescribed solution into the irrigating syringe. Disconnect the catheter from the drainage tubing . Cover the open end of the drainage tubing with the sterile protector cap.allow the catheter to drain into the sterile collection basis via gravity. Resident #4 had [DIAGNOSES REDACTED]. A care plan, initially dated 04/08/11, documented the resident had a suprapubic catheter d/t bladder retention. A quarterly assessment, dated 03/26/14, documented the resident was cognitively intact with mild depression and exhibited no behaviors. The resident required two person extensive assistance for bed mobility, transfer, dressing and personal hygiene. The resident required one person total assistance for bathing. The assessment documented the resident had an indwelling urinary catheter (suprapubic) and was always incontinent of bowel. The March 2014 physician orders documented the resident's suprapubic catheter was to be irrigated daily and prn with sterile H2O with a Toomey syringe until clear. On 04/07/14 at 2:00 p.m., LPN #1 and RN #1 was observed to administer the resident's suprapubic catheter irrigation. LPN #1 had a tray prepared with a paper towel as a drape and a syringe was lying on the paper towel. Two bottles of sterile water were available for the irrigation. The nurses donned clean, unsterile gloves. When the catheter was disconnected, the RN held the drainage tubing without placing a protector cap on it and the LPN held the catheter. The LPN placed the syringe tip into the catheter and then poured the sterile water into the syringe to gravity drain. The LPN then picked up the plunger of the syringe and pushed the water into the catheter. The LPN held a urinal in one hand and allowed the fluid return from the catheter drain into the urinal. The LPN again irrigated the catheter the same way and allowed the fluid return to drain into the urinal. There was no sterile irrigation kit used for the suprapubic catheter irrigation and the staff did not utilize sterile gloves or procedure. The staff did not utilize a sterile basin for the fluid return to drain. On 04/14/14 at 9:15 a.m., the DON was asked how she expected a suprapubic catheter to be irrigated. The DON reported she expected the irrigation to be provided as a sterile procedure. 2. Resident #4 had [DIAGNOSES REDACTED]. A care plan, initially dated 06/27/13, documented the resident was at risk for [MEDICAL CONDITION], MI or [MEDICAL CONDITION] r/t hypertension. Interventions listed were for the staff to take the resident's blood pressure weekly, monthly and prn and to report any s/sx of malignant hypertension. A quarterly assessment, dated 03/26/14, documented the resident was cognitively intact with mild depression and exhibited no behaviors. The March 2014 physician orders documented the resident received two medications (antihypertensives) for blood pressure. The resident received [MEDICATION NAME] 10 mg one tablet daily and [MEDICATION NAME] 25 mg one tablet BID. The resident also received a diuretic medication, [MEDICATION NAME] 20 mg one tablet daily (which could cause [MEDICAL CONDITION]). There were no blood pressure parameters set when to contact the physician if the blood pressure was low or high or when to hold the antihypertensives. On 04/09/14 at 10:20 a.m., the DON was asked if she expected the staff to obtain blood pressure parameters to ensure when to notify the physician and when to hold the medications. The DON stated, Staff should get parameters. 3. Resident #4 had [DIAGNOSES REDACTED]. A care plan, initially dated 09/25/13, documented the resident had a potential for impaired skin integrity r/t impaired mobility, generalized weakness, poor appetite and incontinence of bowel. The resident had a history of [REDACTED]. The goal was for the resident to have no skin breakdown and be free of redness/irritation through the review date of 03/24/14. Interventions listed were for the staff to follow facility policies for prevention/treatment of [REDACTED]. A quarterly assessment, dated 03/26/14, documented the resident was cognitively intact with mild depression and exhibited no behaviors. The resident required two person extensive assistance for bed mobility, transfer, dressing and personal hygiene. The resident required one person total assistance for bathing. The assessment documented the resident had an indwelling urinary catheter and was always incontinent of bowel. The assessment documented the resident was at risk for developing pressure ulcers. The assessment identified moisture associated skin damage as a skin problem for the resident. The March 2014 physician orders documented the resident was to have skin evaluations weekly on Wednesday mornings. A nurse's note, dated 03/05/14 at 1:59 p.m., documented the weekly skin assessment was completed and the resident had slight redness to the buttocks with no open areas and to continue the current treatment. No other entries were made in March which concerned the resident's weekly skin assessments. On 04/08/14 at 2:00 p.m., LPN #1 provided the resident's treatment to her buttocks. The resident was repositioned to the right side and one area of linear shearing was observed on each of the resident's buttocks. The LPN reported the area to the resident's buttocks would resolve and open again periodically. The resident's left heel was observed to be reddened. On 04/09/14, LPN #2 gave the surveyor a skin assessment form, dated 04/09/14. At 1:35 p.m., MDS coordinator #2 stated (in regard to the March skin assessments), Couldn't find one. On 04/11/14 at 9:00 a.m., LPN #2 was asked if she might know where the resident's March skin assessments were. The LPN stated, Honestly, they probably weren't done. On 04/14/14 at 9:15 a.m., the DON was asked what she expected of the staff in regard to skin assessments. The DON reported she expected weekly skin assessments to be done. 4. Resident #5 had [DIAGNOSES REDACTED]. A care plan, initially dated 09/20/12, documented the resident was at risk for MI, [MEDICAL CONDITIONS] had [MEDICAL CONDITION] fib, [MEDICAL CONDITION] and [MEDICAL CONDITION]. An intervention listed was for the staff to give antihypertensive medications as ordered and monitor for side effects such as orthostatic [MEDICAL CONDITION], increased heart rate and effectiveness. Another intervention listed was for the staff to administer medications, [MEDICATION NAME] (both diuretics) and [MEDICATION NAME] (antihypertensive) as ordered. The resident had experienced lowered blood pressures on the following dates. A nurse's note, dated 01/18/14 at 3:12 a.m., documented the resident's BP was 98/49. At 2:12 p.m., a nurse's note documented the resident's blood pressure was 95/54. A nurse's note, dated 02/08/14, documented the resident's blood pressure was 96/47. A nurse's note, dated 02/25/14 at 11:30 a.m., documented the resident's blood pressure was 92/61. A nurse's note, dated 03/03/14, documented the resident's blood pressure was 92/71. A nurse's note, dated 03/04/14 at 11:09 a.m., documented the resident's blood pressure was 94/62. A nurse's note, dated 03/07/14 at 10:15 a.m., documented the resident's blood pressure was 87/60. A nurse's note, dated 03/10/14 at 10:49 a.m., documented the resident's blood pressure was 97/76. There were no blood pressure parameters set in which to notify the physician or to hold the antihypertensive medications. A significant change assessment, dated 03/26/14, documented the resident had severe cognitive impairment with minimal depression. The resident was totally dependent on two persons for bed mobility, transfer and personal hygiene. The March 2014 physician orders documented the resident was to receive [MEDICATION NAME] 25 mg one tablet BID. If the resident's pulse was below 60, the staff was to hold the medication and notify the physician. The resident was ordered to receive [MEDICATION NAME] 50 mg one tablet daily and [MEDICATION NAME] 40 mg one tablet daily. On 04/09/14 at 10:20 a.m., the DON was asked if she expected the staff to obtain blood pressure parameters to ensure when to notify the physician and when to hold the medications. The DON stated, Staff should get parameters. 5. Resident #10 had been admitted to the facility on [DATE], with medical [DIAGNOSES REDACTED]. An initial assessment, dated 03/28/14, documented the resident had no cognitive/decision making deficits, required moderate assistance with transfers, dressing, hygiene, supervision only with eating, supervision with ambulation, required extensive assistance with bathing, was continent of bowel and occasionally incontinent of bladder. On 04/07/14, during the initial nursing tour, RN #2 identified the resident as being alert and oriented. The resident was observed with a bruised purple/red area to the neck and chest. The resident reported she was itching all over. The surveyor asked the resident if she had reported the itching to staff. The resident stated, Everyday for the last week. At that time, RN #2 reported she would check on the rash and itching. On 04/08/14, the facility obtained a physician's order for [MEDICATION NAME]-By mouth Dose: 25 mg Order Date 4/8/2014 PRN itching. The MARs from 04/01/14 through 04/11/14, were reviewed. There was no documentation of any PRN medications given to relieve the resident's itching. The nurses' notes from 04/07/14 through 04/11/14, were reviewed. There was no documentation regarding the resident's itching. On 04/11/14 at 8:50 a.m., LPN #2 was asked if the resident had been assessed for the itching. She reported the [MEDICATION NAME] had not been in the facility until the ninth and she would check to see if the resident had received the medication. At 11:15 a.m., LPN #2 was observed administering medications for the resident. She reported she was giving the [MEDICATION NAME] at the time of the observation. On 04/14/14 at 9:35 a.m., the DON and corporate nurse were notified of the resident's complaints of itching. The DON reported the medication should have been given immediately when obtained. 6. Resident #10 had been admitted to the facility on [DATE], with medical [DIAGNOSES REDACTED]. An initial assessment, dated 03/28/14, documented the resident had no cognitive/decision making deficits, required moderate assistance with transfers, dressing, hygiene, supervision only with eating, supervision with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0309

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 9)
ambulation, required extensive assistance with bathing, was continent of bowel and occasionally incontinent of bladder. A care plan, dated 04/03/14, documented the resident [MEDICAL CONDITIONS]. Interventions included to monitor blood pressure weekly and to notify the physician of any abnormal readings. The resident had computerized physicians' orders for April 2014, for the following: [MEDICATION NAME] 0.1mg tab By mouth PRN. Unspecified Essential Hypertension [MEDICATION NAME] ER 30 mg tablet Extended Release 24 hour by mouth Daily. Hypertension [MEDICATION NAME] 5 mg table By mouth-Daily Unspecified Essential Hypertension. Blood Pressure.Fri: Weekly Unspecified Essential Hypertension. The physicians' orders did not contain blood pressure parameters in which to call the physician. On 04/14/14 at 9:35 a.m., the DON and corporate nurse were notified of the lack of blood pressure parameters for the resident. The DON reported, if the resident was on blood pressure monitoring, there should be parameters in place.

7. Resident #7 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. A care plan, dated 09/15/11, documented the resident was at risk for [MEDICAL CONDITION], MI or [MEDICAL CONDITION] related to hypertension, as a problem. The goal was for the resident not to have any new [MEDICAL CONDITION], MI or [MEDICAL CONDITION] through the next review date An intervention listed was for the staff to give antihypertensive medications as ordered by the physician. Another problem documented the resident was on a special diet for diabetes mellitus. The goal was for the resident to maintain her glucose levels through the next review date. An intervention listed was for the staff to perform FSBS as ordered by the physician and to notify the physician of any abnormal results. A computerized physician's order, with an original order date of 09/01/11, documented, Dilitiazem HCL ER Beads 360MG Capsule Extended Release 24 hours - Daily Everyday: 1 CAP DAILY TAKE BLOOD PRESSURE AND PULSE BEFORE GIVING HOLD IF SYSTOLIC B/P BELOW 90 OR IF PULSE BELOW 60 AND NOTIFY CHARGE NURSE.UNSPECIFIED ESSENTIAL HYPERTENSION [MEDICATION NAME] 100 MG Tablet by mouth Daily Everyday: 1 TAB DAILY HOLD MEDICATION IF PULSE BELOW 60 AND NOTIFY CHARGE NURSE.UNSPECIFIED ESSENTIAL HYPERTENSION. The physician orders contained no B/P parameters in which to notify the physician. A computerized physician's order, with an original order date of 12/02/13, documented, FSBS--CHECK AND RECORD . FSBS-twice daily Everyday: B/S (breakfast/supper) BID. The resident's February 2014 TAR was reviewed. The TAR had 56 opportunities to document the resident's FSBS and 18 opportunities were blank. The resident's February 2014 MAR indicated [REDACTED]. Three opportunities were blank for the B/P and pulse and one opportunity had a documented B/P without a pulse. The resident's March 2014 TAR was reviewed. The TAR had 62 opportunities to document the resident's FSBS and 32 opportunities were blank. The resident's March 2014 MAR indicated [REDACTED]. Two opportunities were blank for the B/P and pulse. A quarterly assessment, dated 03/12/14, documented the resident was cognitively intact and demonstrated no moods or behaviors. The resident's April 2014 TAR was reviewed. The TAR had 18 opportunities to document the resident's FSBS. Six opportunities were blank. The resident's April 2014 MAR indicated [REDACTED]. One opportunity was blank for the B/P and pulse. On 04/09/14 at 5:15 p.m., the DON was interviewed regarding the lack of B/P parameters being ordered for the resident. The DON reported any resident with antihypertensive medications should have B/P parameters in which to notify the physician. The DON reported she would ensure parameters would be obtained. At that time, the DON was shown the resident's MARs and TARs. The DON reported there was no way to know if the staff had performed the FSBSs, B/Ps and pulses, as ordered by the physician. The DON reported she would in-service the staff. 8. Resident #8 was admitted on 03/10/14 with numerous [DIAGNOSES REDACTED]. A computerized physician's order, with an original order date of 03/10/14, documented, Carvedilol 6.25 mg tablet by mouth-twice daily Everyday: take one tablet po BID UNSPECIFIED ESSENTIAL HYPERTENSION.HCTZ 25 mg tablet by mouth-DAILY Everyday: take one tablet po daily UNSPECIFIED ESSENTIAL HYPERTENSION. The physician orders contained no B/P parameters in which to notify the physician. An initial assessment, dated 03/17/14, documented the resident was severely impaired with cognition and demonstrated no moods or behaviors. A care plan, dated 03/26/14, documented the resident had a history of [REDACTED]. The goal was for the resident to be free of S/S [MEDICAL CONDITION] the next review date. An intervention listed was for the staff to give antihypertensive medications as ordered by the physician. Another intervention listed was for the staff to monitor/document/report to the physician any S/S of hypertension. On 04/09/14 at 5:15 p.m., the DON was interviewed regarding the lack of B/P parameters being ordered for the resident. The DON reported any resident with antihypertensive medications should have B/P parameters in which to notify the physician. The DON reported she would ensure parameters would be obtained.

9. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A physician's order, dated 02/19/14, documented, BLOOD PRESSURE--CHECK AND RECORD.DAILY Specific days of week: Fri: WEEKLY UNSPECIFIED ESSENTIAL HYPERTENSION. No parameters were ordered in which to notify the physician. A nurse's note, dated 02/21/14 documented the resident's blood pressure reading was 158/96. A significant change assessment, dated 02/22/14, documented the resident was severely impaired in cognition, exhibited symptoms of moderately severe depression and exhibited no behavioral symptoms. The resident experienced the following variations in blood pressure readings: 02/25/14: 157/95 and 148/95 02/28/14: 98/54 03/03/14: 155/99 03/04/14: 172/88 03/11/14: 160/96 03/12/14: 151/98 04/06/14: 174/102 and 155/90. On 04/08/14 at 3:45 p.m., the DON was asked if the resident should have blood pressure parameters in which to notify the physician. The DON reported any resident with a [DIAGNOSES REDACTED]. 10. Resident #9 was admitted on [DATE] for skilled services with [DIAGNOSES REDACTED]. A re-admission comprehensive assessment, dated 03/28/14, documented the resident had severe cognitive impairment, exhibited minimal depression symptoms and exhibited no behaviors. The resident's computerized physician's orders, printed 03/31/14, documented the resident was to receive the following medications for his [DIAGNOSES REDACTED]. [MEDICATION NAME] HCL 200 mg daily. [MEDICATION NAME] 12.5 mg twice a day, Hold if systolic blood pressure below 100. [MEDICATION NAME] 2.5 mg. daily. [MEDICATION NAME] 20 mg daily. Xarelto 15 mg daily. The physician's orders did not have blood pressure parameters for holding the medication or notifying the physician for the medications, with the exception of the [MEDICATION NAME]. On 04/08/14 at 3:45 p.m., the DON was asked if the resident should have blood pressure parameters in which to notify the physician. The DON reported any resident with a [DIAGNOSES REDACTED].

11. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. A TAR, dated February 2014, contained 10 areas where the FSBS should have been completed. A care plan, dated 03/10/14, documented the resident had diabetes mellitus, as a problem. A goal was for the resident to have no complications related to diabetes. One intervention listed was to monitor, document and report to physician as needed S/S of [DIAGNOSES REDACTED]. A computerized physician's order, dated 03/31/14 with a start date of 02/25/14, documented, CHECK AND RECORD FSBS QID AND PRN call dr if below 60 and above 351-TREATMENT FOUR TIMES PER DAY Everyday. A TAR, dated March 2014, contained 90 areas where the FSBS should have been completed. An assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. A TAR, dated April 2014, contained 11 areas where the FSBS should have been completed, as of 04/09/14. On 04/14/14 at 9:30 a.m., the DON was questioned in regard to the FSBS documentation areas being incomplete. The DON was asked if the FSBS should have been completed. The DON stated, Yes.

F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff and resident interviews, it was determined the facility failed to: a) Ensure female residents did not have facial hair for six (#1, 12, 13, 17, 19 and #20) of 19 sampled female residents. b) Ensure fingernails were maintained, cleaned and clipped for five (#1, 3, 16, 17 and #22) of 23 sampled residents. This had the potential to affect 54 residents, identified by the DON, who required ADL assistance. Findings: 1. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 03/10/14, documented the resident had an ADL self care performance deficit, as a problem. A goal was for the resident to improve the current level of function in bed mobility, transfers, dressing, toilet use and personal hygiene. One intervention listed was for the resident's personal hygiene and oral care be performed by the staff. A 30-day assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides to lower extremities. On 04/07/14 at 3:00 p.m., the resident was observed to have chin hairs. On 04/10/14 at 9:45 a.m., the resident was observed to have chin hairs. The resident was asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET** **ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0312

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 10)
if the facial hair bothered her. The resident reported, yes, it bothered her and she did not like it. The resident reported her sister normally brings in some tweezers and helps her with the problem. The resident also reported she had not had a bath in over a week. At 4:30 p.m., the resident was observed to have chin hairs. 2. On 04/07/14 at 11:45 a.m., female resident #17 was observed sitting at the dining room table. The resident had multiple, lengthy chin hairs and chipped finger nail polish. 3. On 04/07/17 at 12:05 p.m., female resident #19 was observed sitting at the dining room table. The resident had chin hairs. 4. On 04/07/17 at 12:05 p.m., female resident #20 was observed sitting at the dining room table. The resident had chin hairs. 5. On 04/07/14 at 5:55 p.m., female resident #12 was observed sitting at the dining room table. The resident had dark colored hair across the top of her lip. On 04/14/14 at 9:30 a.m., the DON was questioned in regard to the facial hair on some of the female residents. The DON was asked who was responsible for ensuring the female residents' facial hair was removed. The DON reported the aides were to ensure the residents' grooming was completed with a.m. care. 6. Resident #16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A care plan dated, 06/27/11, documented the resident had an ADL self care performance deficit r/t [MEDICAL CONDITION], as a problem. A goal was for the staff to assist resident with care. One intervention listed was Bathing: LPN-Check nail length and trim and clean on bath day and as necessary. A quarterly assessment dated [DATE], documented the resident was moderately impaired with cognition, required extensive assistance with transfer, bed mobility, dressing and hygiene. The resident was totally dependent on staff for bathing. On 04/07/14 at 12:20 p.m., the resident was sitting at the dining room table. A family member held up the resident's hand. The residents fingernails were long and jagged. The family member reported she had asked for the resident's fingernails to be trimmed for the past three weeks. 7. On 04/07/14 at 5:55 p.m., female resident #22 was observed sitting at the dining room table. The resident was observed to have chipped finger nail polish. On 04/14/14 at 9:30 a.m., the DON was questioned in regard to the fingernail maintenance for the residents. The DON was asked who was responsible for ensuring the residents' fingernails to be cleaned and trimmed. The DON reported the CNAs check and clean nails with AM care. The DON reported, if the resident was diabetic, the nurses were responsible for clipping the nails. 8. Resident #3 was admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 11/18/10, documented the resident needed
total assistance with all ADLs r/t [MEDICAL CONDITION], as a problem. A goal was for the resident to receive total care from the staff and be neat and clean in appearance. One intervention listed was documented, Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact, was totally dependent with two persons assistance for transfer, bed mobility, dressing, eating, hygiene and bathing. The resident was always incontinent of bowel and bladder. On 04/07/14 at 2:10 p.m., CNA #5 and CNA #6 checked the resident for incontinence. The resident's toe nails were observed to be long and jagged. The resident's fingernails were long and jagged and brown colored debris was under his middle finger on his right hand. The CNAs were asked who cleaned and clipped the resident's nails. CNA #5 stated, The nurses clips his nails and we clean them when he lets us. Sometimes the resident pulls his hands away and won't let us clean them. On 04/14/14 at 9:30 a.m., the DON was questioned in regard to the fingernail and toe nail maintenance. The DON was asked who was responsible for ensuring the residents' fingernails and toe nails to be cleaned and trimmed. The DON reported the CNAs check and clean nails with AM care. The DON reported, if the resident was diabetic, the nurses were responsible for clipping the nails.
9. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 02/28/13, documented the resident had
self-care deficit related to limited mobility, confusion, impaired memory and cognition. Interventions included to check the resident's nail length, trim and clean on bath day A significant change assessment, dated 02/22/14, documented the resident was severely impaired in cognition, exhibited symptoms of moderately severe depression and exhibited no behavioral symptoms. The resident required total assistance with transfers, dressing, eating, hygiene and bathing. On 04/09/14 at 8:50 a.m., the resident was observed seated in a wheelchair, in the hallway. The resident was observed to have long chin hairs and to have debris under her fingernails. The DON approached the resident and stated, You need your nails done. On 04/10/14 at 9:30 a.m., the resident was observed sitting in her recliner in her room. The resident continued to have long chin hairs. The resident's fingernails were free of debris. On 04/14/14 at 8:00 a.m., the resident was observed sitting in a wheelchair in her room. The resident continued to have long chin hairs. At 9:30 a.m., the DON was asked who was responsible for the female resident's chin hair removal and nail care. The DON reported the CNAs should assist the resident's with chin hair removal. She reported the CNAs were to clean and trim the residents' fingernails on bath days and as needed.

F 0314

Level of harm - Actual harm

Residents Affected - Some

Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, record review and staff and resident interviews, it was determined the facility failed to: a) Notify the physician and obtain new orders when two pressure ulcers increased in size and stage for one (#13) of four sampled residents. This resulted in harm to the resident. b) Identify, notify the physician or obtain orders for one pressure sore on the resident's buttock and failed to assess and monitor the pressure ulcers on the resident's heels for one (#9) of four sampled residents. This resulted in harm to the resident. This had the potential to affect all 65 residents who resided in the facility and could develop skin breakdown. Findings: 1. Resident #13 was admitted on [DATE], with [DIAGNOSES REDACTED].
A nurse's note, dated 02/25/14 at 10:09 p.m., documented, skin assessment done, resident has 0.5x0.2 to coccyx noted. resident has open areas noted to both heals (sic) left heel is 5.4x5.5, right heel is 7x3.5. no other open ares (sic) noted at this time. A Weekly Pressure Ulcer Report, dated 02/27/14, documented,.Coccyx resolved.Left heel 6.1x5.9x0.3cm stage II.Right heel 6.3x4.0x0.2 stage II. A Weekly Pressure Ulcer Report, dated 03/06/14, documented .In hospital.Left heel 6.1x5.9x0.3cm stage II.Right heel 6.3x4.0x0.2 stage II. A nurse's note, dated 03/10/14, documented the resident had been readmitted to the facility from the hospital. There was no documentation in the clinical record of the size of the pressure ulcers upon the residents readmission to the facility. A care plan, dated 03/10/14, documented, The resident has (3) pressure ulcers on admit r/t chair bound, diabetes, [MEDICAL CONDITION] receiving [MEDICAL TREATMENT].On return from hospital has 2 pairs of Pressure relieving heel protectors, as a problem. A goal was for the resident's pressure ulcers to show signs of healing and remain free from infection. Interventions listed, .Treatments as ordered to pressure ulcers, monitor daily for effects. Notify physician and family of changes. A nurse's note, dated 03/13/14 at 2:44 p.m., documented, resident rt heel measurements [MEDICAL CONDITION], left heel measures [MEDICAL CONDITION], residents heels cleaned and dressed as ordered. A Weekly Pressure Ulcer Report, dated 03/13/14, documented, .right heel 4.0x1.9x0.2cm.left heel 4.3x5.5x0.3cm. A Weekly Pressure Ulcer Report, dated 03/20/14, documented, .right heel 3.5x1.7x0.2cm.left heel 3.7x4.8x0.2cm. A nurse's note, dated 03/27/14 at 2:45 p.m., documented, rt heel wound measurements [MEDICAL CONDITION], left heel measures [MEDICAL CONDITION], wound care done as ordered. There was no documentation in the clinical record the physician had been notified of the increase in size to the two pressure ulcers. A Weekly Pressure Ulcer Report, dated 03/27/14, documented, .right heel 4.0x2.0x0.2cm.left heel 6.3x5.7x0.3cm. There was no documentation on the weekly pressure ulcer report the physician had been notified of the increase in size to the two pressure ulcers. A computerized physicians order, dated 03/31/14, with a start date of 02/25/14, documented wound care--bilater heels.Topical-TREATMENT DAILY Everyday: cleanse bi-lateral heels with nss pat dry apply Santyl nickle (sic) thick to wound beds cover with gauze wrap with kerlix secure with tape daily. A March 2014 TAR, documented the resident received treatments to bilateral heels on 03/01/14 and 03/02/14. The resident was then out of the facility until 03/10/14 in the hospital. The remaining 21 days contained no documentation the treatments had been completed as ordered. A nurse's note, dated 04/03/14 at 2:25 p.m., documented , .dressing to bil heel done as ordered rt heel wound measures 4.9x3.5x2, left heel measures [MEDICAL CONDITION] There was no documentation in the clinical record the physician had been notified of the continued increase in size of the two pressure ulcers over the past two weeks. A Weekly Pressure Ulcer Record, dated 04/03/14, documented, .Stage III rt heel [MEDICAL CONDITION] III lt heel [MEDICAL CONDITION] There was no documentation the physician had been notified of the continued increase in size of the two pressure ulcers over the past two weeks. A 30-day assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides to lower extremities. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. On 04/07/14 at 9:10 p.m., resident #13 was interviewed. The resident reported she felt her pressure ulcers on her heels were getting worse. The resident reported she had gone to a wound clinic prior to admission and reported she believed the wounds needed

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

PRINTED:9/8/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0314

Level of harm - Actual harm

Residents Affected - Some

(continued... from page 11)
debridement. The resident reported she had asked staff to send her to a wound clinic. The resident stated, I have asked repeatedly to see Dr. (name deleted). The resident reported she was told by staff she would have to wait until the 27th of April to see the physician. On 04/10/14 at 9:00 a.m., LPN #2 was asked if she had been aware of the resident asking to be sent out to the wound clinic. The LPN reported she had heard something about that but the resident had not mentioned it to her. The LPN reported she had not been assigned to the residents hall in a long time. At 9:15 a.m., LPN #1 was asked if the resident had ever asked to be sent out to the wound clinic. The LPN stated, Not that I know of. At 2:45 p.m., Dr. (name deflated) was interviewed in regard to the resident's pressure ulcers. The physician was asked how she classified the wounds on the resident's heels. The physician reported pressure due to diabetes and the resident being very non-compliant. The physician was asked how the pressure wounds to the resident's heels were progressing. The physician stated, To be honest with you I haven't looked at them. I saw her yesterday but didn't look at the wounds. I rely on the nurses. The physician was asked if the nurses had notified her of the wounds increasing in size over the last couple of weeks. The physician stated, Could have I don't remember. The physician was asked if she had been made aware of the wounds increasing in size would she have ordered a treatment change. The physician stated, Whatever the nurses feel needs to be done. The physician reported she thought the resident was going to the wound clinic. There were no physician orders documented in the clinical record for the resident to be sent to the wound clinic for evaluation. At 3:15 p.m. the resident's pressure ulcers were observed by the physician and the surveyor. The measurements of the right heel was 5.5x3x0.6cm and the left heel was 8x5.8x1.2cm. The physician was asked the stage of the pressure ulcers. The physician stated, Stage III. The physician was then asked if she would change the treatment to the pressure wounds. The physician then turned to the treatment nurse and the DON and asked what they had seen that worked. The physician was asked if the resident would be sent to the wound clinic. The physician asked the DON what she thought. The DON reported the resident would be sent to the wound clinic for an evaluation. At 4:30 p.m., the resident was interviewed in regard to her pressure ulcers. The resident reported she had asked to go to the wound clinic as soon as she arrived at the facility. The resident reported she had asked LPN #1 and the physician. The resident reported she continued to ask LPN #1 up until approximately 2 weeks ago. On 04/11/14 at 10:30 a.m., LPN #1 was shown the nurse's note, dated 04/03/14, and the Weekly Pressure Ulcer Record, dated 04/03/14, and asked for clarification of the pressure sites. At that time, the LPN reported the correct size was documented on the nurse's note.
The Weekly Pressure Ulcer Record, dated 04/03/14, with the correct sites and measurements, documented, Stage III Rt heel [MEDICAL CONDITION] III Lt heel [MEDICAL CONDITION] An April 2014, TAR contained blank areas in documentation on 04/07/14
and 04/10/14, when the treatments should have been completed. On 04/14/14 at 9:30 a.m., the DON was interviewed in regard to the pressure ulcers increasing in size over the past two weeks and was asked if she thought the nurses should have notified the physician and received a change in treatment. The DON stated, Yes.

2. Resident #9 was admitted on [DATE] for skilled services and had [DIAGNOSES REDACTED]. A care plan, dated 02/17/14, documented the resident had the potential to develop pressure ulcers related to the resident being chair bound and required assistance with transfers. It documented the resident had no skin breakdown noted on admission. The interventions documented for the staff to conduct weekly skin checks on the resident and document the results and for the staff to follow facility policies/protocols for the prevention/treatment of [REDACTED]. The March 2014 treatment sheet documented, skin check weekly on Friday Order Date 2/7/2014 3-11 EVENING SHIFT Every Fri. The treatment sheet contained no initials to indicate the resident's skin was assessed during the month of March. The resident was readmitted to the facility, on 03/21/14, following a three day hospitalization . A nurse's note, dated 03/21/14 at 6:55 p.m., documented, res ret'd (returned) to facility to same room to cont with same meds and treatments assisted to dining room for pm meal denies any pain or discomfort res noted with 2cmx3cm stage 2 to coccyx has order for [MEDICATION NAME] A Weekly Pressure Ulcer Record,
dated 03/21/14, documented the resident had a stage II 2cm X 3cm X 0.2 cm area on his coccyx with no exudate and with a pink wound bed. The record contained no further documentation of the size or appearance of the wound for the following weeks. The clinical record contained no documentation of the coccyx wound receiving treatment. A re-admission comprehensive assessment, dated 03/28/14, documented the resident had severe cognitive impairment, exhibited minimal depression symptoms and exhibited no behaviors. The resident required limited assistance with transfers, extensive assistance with ambulation, dressing, personal hygiene, toileting and bathing. The resident was occasionally incontinent of urine and bowel. The computerized physician's orders, printed 03/31/14, documented, apply skin prep to bi-lat (bilateral) heels every shift-EVERY SHIFT Everyday soft heels. The order start date was documented as 03/26/14. The clinical record contained no original physician's order for the treatment to the resident's heels. The nurses' notes contained no documentation of the assessment of the resident's heels and no indications for treatment. The clinical record contained no Weekly Pressure Ulcer Record for tracking of the heel areas. The April 2014 treatment sheet contained no section in which to document weekly skin assessment for the resident. On 04/07/14 at 10:00 a.m., during the initial tour, CMA #3 reported the resident had a sore on his bottom. The CMA reported she did not know what treatment was being done for the resident. On 04/09/14 at 9:10 a.m., the resident was observed to receive treatment of [REDACTED]. The left heel had no red areas or breakdown. The right heel had an area approximately 1.5 cm in size with a dark circumference around a soft area. At 9:30 a.m., LPN #3 was asked to observe the resident's coccyx treatment. The LPN reported the resident did not have a treatment to his coccyx. The LPN was informed the resident's skin assessment form documented the resident had an area to his coccyx. The LPN reported she would obtain assistance to transfer the resident for the surveyor to observe his skin. While the LPN went to obtain assistance, the resident was asked if his bottom hurt. The resident shifted his buttocks in the wheelchair and stated, No. LPN #3 and an unidentified CNA took the resident to his room and assisted him to a standing position. The resident's pants were pulled down. The resident had no red area or open area on his coccyx. The resident had an open area, stage II, on his left buttock near the anal opening. The LPN and the CNA reported they were not aware of the resident having a sore on his buttocks. At 10:30 a.m., LPN #2 was asked if she was aware the resident had skin breakdown on his buttocks. The LPN reported no knowledge of the resident's skin breakdown. The LPN reported LPN #3 performed the weekly skin checks. At 10:40 a.m., LPN #3 was asked when the last skin assessment had been performed for the resident. The LPN reported she did not remember when the resident was last checked. The LPN stated, I don't think he is on checks. The LPN reported she had only been working at the facility for the past two weeks. The LPN was asked if she did weekly skin assessments on the resident. The LPN stated, Not on him. She reported the treatment book did not have a section for the resident to have weekly skin assessments. The LPN reported she had not measured and monitored the resident's heel areas. At 10:50 a.m., CNA #14 was asked if she observed skin breakdown on the resident's buttocks. The CNA reported she had noticed the resident had a place on his bottom when she assisted him with toileting that morning. The CNA was asked if she had reported the open area to the nurse. The CNA reported she had not told anyone yet about the site. At 1:40 p.m., the DON was asked why the resident was not on weekly skin assessments. The DON stated, Everyone needs weekly skin checks. The DON was informed the resident's current physician orders did not include weekly skin assessment orders. The DON reported she would investigate to why the skin assessments were left off the orders. The DON was asked if the physician should have been contacted and orders obtained for treatment when the pressure ulcer was found. The DON stated, Yes. The DON was asked if the resident's heels should have been monitored for breakdown and the physician notified of the change in the right heel lesion. The DON stated, Yes. At 3:15 p.m., LPN #4 was asked if he was aware of an open area on the resident's buttock. The LPN reported the resident's son helped the resident to get ready for bed last night and the son had reported to the LPN of an open area on the resident's buttock. The LPN reported he did not get a chance to follow-up on the son's report of an open area on the resident and did not examine the resident. At 3:45 p.m., LPN #4 reported he was in error when he reported the buttock wound was a new area. He reported the resident had the area on his buttock when he returned from the hospital. The LPN was asked why he documented on the wound sheet and in the nurse's notes the resident had a coccyx wound. The LPN stated, I got mixed up on the area. The LPN was asked if he notified the physician of the open area and received a treatment order at the time of admission. The LPN reported he had not. On 04/10/14 at 3:15 p.m., the DON and corporate nurse were asked how they monitored the residents for treatment and management of pressure ulcers. The DON reported she completed a skin summary report weekly based on the skin assessment records. She reported she submitted the information to the corporate nurse for review. The corporate nurse reported she reviewed the report and made suggestions for treatment. The DON and corporate nurse were asked how they could monitor the effectiveness of treatment and monitoring if the licensed nurses did not fill out weekly pressure ulcer records or obtain treatments for the areas. The DON and corporate nurse reported they would have to work on the problem.

F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that each resident who enters the nursing home without a catheter is not**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 12) **given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, it was determined the facility failed to ensure: a) All areas of the perineum and buttocks were cleansed of urine and feces for three (#8, #3 and #1) of four sampled residents who required incontinent care after each incontinent episode. This had the potential to effect 40 residents, identified by the Resident Census And Conditions Of Residents form, who were occasionally or frequently incontinent of bladder and 36 residents, identified by the Resident Census And Conditions Of Resident form, who were occasionally or frequently incontinent of bowel. b) An individualized toileting plan was developed and implemented when the bowel and bladder assessment documented the resident was a good candidate for a toileting plan for one (#8) of one sampled resident who was a good candidate for a toileting plan. This had the potential to effect two residents, identified by the Resident Census And Conditions Of Residents form, who were on a bladder training program. Findings: 1. A facility policy, Urinary Continence and Incontinence-Assessment and Management documented, 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence.4. As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include: a. Voiding patterns (frequency, volume, nighttime or daytime, quality of stream etc.). Another facility policy, Urinary Incontinence, documented, .4. As appropriate, based on assessment of the category and causes of incontinence the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status. Resident #8 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. A Bowel and Bladder Program Screener form documented the resident was a candidate for scheduled toileting or timed voiding. An initial assessment, dated 03/17/14, documented the resident was severely impaired with cognition and demonstrated no moods or behaviors. The resident required extensive assistance of two persons to transfer, dress and perform personal hygiene. The resident required total assistance of one person to bathe. The resident did not ambulate in the room or corridor during the look back period. The resident had impairment on one lower extremity and was frequently incontinent of bowel and bladder. A care plan, dated 03/26/14, documented the resident was at risk for skin breakdown, due to being frequently incontinent of bowel and bladder, as a problem. The goal was for the resident to be free of skin breakdown through the next review date. An intervention listed was for the staff to perform incontinent care with each incontinent episode. A nurse's note, dated 03/26/14, documented, .resident cont w/being incont of B +B, he knows when he feels the need to go but just cant hold it, resident unsure if this happen before or after fx lft hip. On 04/08/14 at 1:00 p.m., CNA #5 and CNA #6 were observed to perform incontinent care for the resident. The resident was incontinent of bowel and bladder. CNA #6 was observed to cleanse the resident's perineum and thighs on both sides of the penis and scrotum. CNA #5 turned the resident to his side and CNA #6 was observed to cleanse the resident's anal area and buttocks of feces. The CNA had used all the wipes she had taken out for the procedure. CNA #6 changed gloves and retrieved a clean brief and applied barrier cream to the resident's buttocks. The surveyor asked the CNA's if they were finished with the procedure. Both CNAs nodded their head. The surveyor then asked CNA #6 if she would obtain additional wipes. The CNA left the room and returned with a new box of wipes. The CNA opened the wipes and donned gloves. The surveyor then asked CNA#5 to turn the resident on his side. The surveyor then showed CNA #6 additional feces on the resident's scrotum and the perineum. The CNA then completely cleansed the areas of the feces. Upon completion of the care, the CNAs were asked if they had ever toileted the resident or tracked his bowel and bladder pattern. Both CNAs shook their heads no. CNA #6 reported they performed incontinent care for the resident every two hours. On 04/08/14 at 11:35 a.m., the DON was interviewed regarding the lack of a toileting plan being completed for the resident. The DON reported she would ask the staff about it. She reported she had only been in the facility for two weeks. At 2:00 p.m., the DON returned to the surveyor and reported she had spoken to the ADM and the facility had never tracked a resident's bowel and bladder pattern. The DON was asked if she was sure they had not done an individualized toileting schedule. The DON stated, I'm not sure. But I'll talk to corporate. On 04/14/14 at 1:30 p.m., the DON was interviewed regarding the resident's incontinent care. The DON reported the resident's penis should have been cleansed of urine and the resident's scrotum and perineal area should have been completely cleansed of urine and feces. 2. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 02/28/13, documented the resident was incontinent of bowel and bladder related to [MEDICAL CONDITION], dementia, confusion and impaired memory. The interventions included were for the staff to check the resident every two hours for incontinence and for the staff to cleanse the resident's perineum. A significant change assessment, dated 02/22/14, documented the resident was severely impaired in cognition, exhibited symptoms of moderately severe depression and exhibited no behavioral symptoms. The resident required total assistance with transfers, dressing, eating, hygiene and bathing. The resident was always incontinent of bowel and bladder function. On 04/07/14 at 3:20 p.m., the resident was observed during incontinent care by CNA #3 and CNA #4. The CNAs donned gloves. CNA #3 cleansed the resident's perineal area. The CNAs turned the resident to her right side. The resident had been incontinent of bowel. As the CNAs were cleansing the resident, the resident urinated. CNA #3 completed the cleansing of the resident's buttocks. CNA #4 applied moisture barrier to the resident's buttocks wearing the same gloves worn during the procedure. CNA #3 applied a disposable adult brief to the resident, wearing the same contaminated gloves worn to cleanse the resident. The CNAs did not cleanse the resident's front perineal area after the resident urinated a second time. On 04/08/14 at 3:45 p.m., the DON was asked if the CNAs should have recleansed the resident's perineum after voiding. The DON stated, Yes. The DON was asked if the CNAs should change their gloves during the incontinent care. The DON stated, Yes. 3. Resident # 3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 11/18/10, documented the resident had total bowel and bladder incontinence, as a problem. A goal was for the resident to remain free from skin breakdown due to incontinence. Interventions listed were for the staff to check the resident every two hours for incontinence and to retract the foreskin and wash with soap and water. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact and was totally dependent on two persons assistance for transfer, bed mobility, dressing, hygiene and bathing. The resident was totally dependent of one person assistance for eating. The resident was always incontinent of bowel and bladder. The resident had functional limitation in ROM to the upper and lower extremities. On 04/09/14 at 8:40 a.m., CNA #12 and CNA #6 were observed to perform incontinent care for the resident. The foreskin of the penis was not cleansed by the CNAs during the incontinent care. CNA #12 was asked if there was anything she would do differently. The CNA stated, No. The CNA was asked if she normally cleansed the resident's foreskin. The CNA reported she thought she had cleaned the resident's foreskin. On 04/14/14 at 9:30 a.m., the DON was asked if she expected the foreskin to be cleaned during incontinent care. The DON stated, Yes.
F 0318 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to provide restorative services for three (#2, 3 and #4) of three sampled residents who had physician ordered restorative services to be provided. This had the potential to affect 11 residents, identified by the DON, who were to receive physician ordered restorative services. Findings: 1. Resident #4 had [DIAGNOSES REDACTED]. The resident's clinical record was reviewed and the last restorative note was dated 01/24/14. A quarterly assessment, dated 03/26/14, documented the resident was cognitively intact with mild depression and exhibited no behaviors. The resident required two person extensive assistance for bed mobility, transfer, dressing and personal hygiene. The resident required one person total assistance for bathing. The assessment documented the resident had no impairment in both her upper and lower extremities. The resident's March 2014 physician orders [REDACTED]. The physician's orders [REDACTED]. The resident had been ordered to receive fine motor skills to bilateral hands with the appropriate equipment three times weekly. The resident's March 2014 restorative services record was reviewed. The record documented the resident received AROM to bilateral upper/lower extremities seven times during the month. The resident's ADL record was reviewed from April 1-April 8, 2014. There was one entry out of nine days the resident had received restorative services. The resident had not received restorative services as ordered. On 04/08/14 at 10:10 a.m., MDS coordinator #1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET** **ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0318 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 13) asked who was providing restorative services to the residents. The MDS coordinator reported the CNAs were to be giving ROM with resident care. The MDS coordinator reported the restorative staff member had been off with her back. The MDS coordinator was then asked how long the restorative aide had been off work. The MDS coordinator stated, Quite some time. On 04/08/14 at 3:50 p.m., the resident was interviewed and was asked about the restorative services she had received. The resident stated, Don't come in anymore, in regard to the restorative service staff. The resident was asked when the staff last provided her with her joint range of motion exercises. The resident reported it had been a long time. The resident was then asked if she felt her joint motion had declined and the resident shook her head, no. On 04/09/14 at 11:45 a.m., the DON was asked to tell the surveyor about the current restorative services. The DON (who was new to the facility) knew the restorative person was off work with an injury. The DON reported there was a need to designate a person to be trained in the interim to provide restorative services. 2. Resident #2 had been admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. An initial assessment, dated 08/18/13, documented the resident required extensive assistance with two person assist for bed mobility, total assist with two person assist for transfers, did not ambulate, required extensive assistance with dressing and hygiene, required total assist with bathing, had limitation in range of motion bilaterally in the lower extremities, was incontinent of bowel and required an indwelling urinary catheter. A nurse's note, dated 08/23/13, documented, Readmit to SNF. A care plan, dated 08/27/13, documented the resident had limited physical mobility r/t neurological deficits, Acute [MEDICATION NAME] [DIAGNOSES REDACTED] was non ambulatory with decreased sensation numbness to bilateral legs. Interventions included a two person assist with transfers using a mechanical lift, related to being unable to stand or bear weight. Another intervention was for the staff to monitor, document and report signs and symptoms of immobility, contractures forming or worsening and fall related injury. On 04/08/14 at 11:30 a.m., MDS coordinator #1 was asked when the resident had been taken off skilled services. She reported the resident had been discharged from skilled services on 11/07/13. The medical record was reviewed. There was no documentation the resident was receiving restorative services or basic ROM exercises. On 04/09/14 at 2:30 p.m., the DON was asked if the resident was receiving any range of motion or restorative services. She reported she would check. She reported the restorative staff was off with an injury. On 04/14/14 at 9:35 a.m., the DON was asked if she had found any documentation of restorative services or basic ROM being provided. She reported the resident was not receiving those services. 3. Resident #3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 08/02/12, documented the resident had a potential for falls/injury r/[MEDICAL CONDITIONS], as a problem. A goal was for the resident to be free from fall or injury due to his weakened state. One intervention listed, Restorative Program: (1) AAROM to bilateral upper and lower extremities to residents tolerance x 10 reps 5 x week. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact and was totally dependent on two persons assistance for transfer, bed mobility, dressing, hygiene and bathing. The resident was totally dependent of one person assistance for eating. The resident was always incontinent of bowel and bladder. The resident had functional limitation in ROM to the upper and lower extremities. A restorative therapy note, dated 1/24/14 at 9:35 a.m., documented the resident refused to participate in any restorative exercises. This was the last documented note regarding restorative services found in the clinical record. A computerized physician's orders [REDACTED]. On 04/08/14 at 2:10 p.m., CMA #3 and CNA #6 were asked who performed restorative care for the resident. Both reported the restorative aide but she had been off for a while. The two were asked who had been performing restorative care in her absence. CMA #3 reported she thought physical therapy provided the exercises. The CMA and CNA were asked if they performed any type of ROM therapy for the resident. Both stated, No. At 3:00 p.m., the OT and OTA were asked if they were performing ROM therapy for the resident. They both reported they were not aware of any treatments from the therapy department for the resident. At 3:45 p.m., the DON was questioned in regard to the restorative services. The DON reported the ADM had told her the CNAs were responsible for the restorative treatment while the restorative aide was out on sick leave. The DON was asked if the CNAs were aware of their duties to perform ROM exercises. The DON stated, The ADM told me they had been told.
F 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, it was determined the facility failed to: a) Check placement of a PEG tube before administering medications for one (#3) of one sampled resident who required a PEG tube. This had the potential to affect two residents, identified by the facility Resident Census And Conditions Of Resident form who required PEG tubes. b) Raise the head of the bed to a 45 degree angle before administering medications for one (#3) of one sampled resident who required a PEG tube. This had the potential to affect two residents, identified by the facility Resident Census And Conditions Of Resident form, who required PEG tubes. Findings: Resident #3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 11/18/10, documented the resident had impaired swallowing and potential for fluid imbalance, dehydration r/[MEDICAL CONDITION] required PEG tube for food/adequate fluids, as a problem. A goal was for the resident to be free of S/S fluid imbalance/dehydration and aspiration. Interventions listed, .check for tube placement and gastric contents/residual volume.Elevate HOB 15-30 degrees at all times. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact and was totally dependent on two persons assistance for transfer, bed mobility, dressing, hygiene and bathing. The resident was totally dependent of one person assistance for eating. The resident was always incontinent of bowel and bladder. The resident had functional limitation in ROM to the upper and lower extremities. The resident required a PEG tube for nutrition. A physician's orders [REDACTED]. On 04/09/14 at 9:25 a.m., CMA #3 was observed administering medications to the resident via a PEG tube. The CMA attempted to administer the medications. The CMA reported only licensed staff could check for placement. The CMA attempted to instill water into the tubing to flush it. The tubing was clogged. She put the call light on to obtain help to unclog the tube. At 9:45 a.m., LPN #2 brought a declogger into the room. She lowered the resident flat on the bed to unclog the tube. After the tube was unclogged, the LPN left the room. At 9:50 a.m., CMA #3 administered the medications without raising the head of the bed to a 30-45 degree angle or checking placement of the tube. On 04/10/14 at 2:30 p.m., LPN #2 was asked who was responsible for checking the feeding tube placement. She reported, when the LPNs administered medications, they checked placement and were responsible for checking the placement on all shifts. She was asked about communication with the CMAs when they administered the medications and the LPNs checked placement. She reported there were problems with the CMAs asking if placement had been checked before administering the PEG medications. On 04/14/14 at 9:35 a.m., the DON and the corporate nurse were asked if the PEG tube placement should have been verified. The DON stated, Yes. The DON was asked if the head of the bed should have been raised before the medications were administered. She stated, Yes.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 04/10/14, an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to ensure residents were transferred or lifted in a manner to prevent injuries. The Oklahoma State Department of Health was notified and verified the existence of the IJ situation. At 2:05 p.m., the ADM and the DON were notified of the IJ situation. At 4:15 p.m., an acceptable plan of removal was presented to the survey team. The facility's plan of removal documented the following: Immediate Jeopardy Plan Of Removal for Resident Current & Correct Transfer Status 1. All current residents will have a head to toe RN assessment. 2. Assessment Data will be updated on the resident care plan and in POC to ensure accuracy. 3. Licensed Nurses will be re-educated by a member of the therapy department and signed off on before they will be able to train other staff members. 4. All nursing staff will be re-educated on proper lifting techniques, the proper use of mechanical lifts, referencing POC for the resident's transferring status. 5. All nursing staff will be re-educated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) immediately and will not be able to return to duty until they have received the re-education with return demonstration. 6. Completion as of Friday, April 11, 2014 at 12 pm of all available nursing staff. Staff from all shifts were interviewed regarding proper transfers. Observations of proper transfers by staff on all shifts were observed. The staff was aware of POCs for the residents and transferred residents properly. The IJ was removed on 04/11/14 at 5:00 p.m. when it was determined all corrective actions were in place. The deficiency remained at the level of actual harm which was not immediate jeopardy, at a pattern. Based on record review, observation and staff interviews, it was determined the facility failed to: a) Ensure one (#2) of six sampled residents was transferred properly and without injury according to the care plan. This had the potential to affect 62 residents, identified by the Resident Census And Conditions Of Residents form, who required transfer assistance. b) Ensure one (#5) of two sampled residents, who required sit to stand lifts, were not lifted by a sit to stand lift when lethargic. This had the potential to affect seven residents, identified by the DON, who required sit to stand lifts for transfers. c) Ensure a wheelchair was in the locked position and two staff were in attendance before a transfer was completed for one (#8) of six sampled residents who required assistance with transfers and utilized wheelchairs. This had the potential to affect 62 residents, identified by the Resident Census And Conditions Of Residents form, who required transfer assistance. d) Ensure the facility used a maxi lift for transfers for one (#13) of four sampled residents who required maxi lifts for transfers. This had the potential to affect 11 residents, identified by the DON, who required maxi lifts for transfers. e) Ensure eye drops were not left unattended on the medication cart for one (#5) of four sampled residents observed during the medication pass. This had the potential to affect all 65 residents who resided in the facility. f) Ensure water temperatures did not exceed 120 degrees Fahrenheit for one (South shower room and bathroom sink) of three shower rooms with sinks. This had the potential to affect 24 residents, identified by the South Hall shower list, who used the South shower room and bathroom sink. Findings: 1. Resident #2 had been admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. An initial assessment, dated 08/18/13, documented the resident required extensive assistance with two person assist for bed mobility, total assistance with two person assist for transfers, did not ambulate, required extensive assistance with dressing and hygiene, required total assist with bathing, was incontinent of bowel and required an indwelling urinary catheter. A care plan, dated 08/27/13, documented the resident had limited physical mobility r/t neurological deficits, Acute Transverse [DIAGNOSES REDACTED], was non-ambulatory with decreased sensation numbness to bilateral legs. Interventions included a two person assist with transfers using a mechanical lift related to being unable to stand or bear weight. Another intervention was for the staff to monitor, document and report signs and symptoms of immobility, contractures forming or worsening and fall related injury. The Braden Scale For Predicting Pressure Sore Risk, dated 08/28/13, 09/05/13 and 09/12/13, documented the following: Activity degree of physical activity Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. Mobility ability to change and control body position Very limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. An incident report, dated 11/05/13, documented While CNA's were transferring resident with sit to stand lift today, the belt slid up on resident and when it did she felt little popping sensation and had pain on left side. The Immediate Action Taken documented, instructed cnas proper placement of belt on sit to stand lift, and proper transfer. The nurses' notes documented.11/5/2013 10:45 a.m., pt says she felt a pop in her ribs when she used the lift this morning and her ribs on the left side are kind of sore now, doctor called new order for xray, called and left msg (message) for daughter to call me back. 11/5/2013 11:56 sooner mobile here at this time to xray resident left rib cage 11/5/2013 12:45 xray showed lateral left seventh rib minimally displaced fracture, no pleural collection or pneumothorax results faxed to dr (Name deleted) family informed. On 04/08/14 at 3:45 p.m., CNA #1 and CNA #2 were observed transferring the resident from the bed to the wheelchair. The wheelchair was placed at the side of the bed. The wheels were in an unlocked position. The CNA's assisted the resident to sit on the side of the bed. CNA #2 placed a gait belt around the resident's waist. CNA #1 placed her hands underneath the resident's legs, at the knees. CNA #2 placed her hands under the gait belt and lifted the resident to the wheelchair. At that time, the wheelchair rolled backwards. CNA #2 lost her grip on the gait belt and lifted the resident under the arms, placing the resident's upper body weight on the resident's shoulders. CNA #1 continued to lift the resident under the knees. As the wheelchair continued to roll back, the resident was observed with her body almost to the floor, still being lifted under the arms. The CNAs then lifted the resident into the wheelchair. At that time, CNA #1 reported she usually used a towel under the resident's knees. She stated, It works better when you do it that way. A current CNA care plan, printed out on 04/10/14 at 10:45 a.m. documented, transferring-2 person assist with maxi lift. On 04/11/14 at 11:10 a.m., CNA #1 was asked how she should have transferred the resident. She reported she should have used the sit to stand lift, but had been using the towel and under the shoulders to lift the resident. She was asked if she knew what the care plan directed her to do for transfers. She stated, I don't know what it says. The other girl was telling me what to do. On 04/14/14 at 9:35 a.m., the DON and the corporate nurse were asked how the resident should have been transferred. The DON reported the resident should have been transferred by the maxi lift. The corporate nurse reported the resident should be transferred as directed by the care plan. 2. Resident #13 was admitted on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 03/10/14, documented the resident had an ADL self care deficit, as a problem. A goal was for the resident to improve current level of function. One intervention listed was the resident required two staff participation with transfers with the use of a mechanical maxi lift. The resident was non-weight bearing to bilateral legs. An assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides to lower extremities. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. On 04/11/14 at 9:05 a.m., as the surveyor passed the south shower room, CNA #9 was overheard to state, It was a good thing I came around when I did. Isn't anyone helping you? The resident was observed suspended in a sit-to-stand lift, holding onto the handle of the lift, knees bent and the lift sling under the resident's underarms. CNA #9 assisted CNA #10 to transfer the resident into an electric wheelchair. Two other staff members were asked to assist the CNAs to position the resident in the wheelchair. At 9:40 a.m., CNA #9, was questioned in regard to assisting the resident using the sit to stand lift. The CNA stated, I was going into use the bathroom and saw that (CNA #10-name deleted) had the resident up in the sit to stand lift. The CNA was then asked if CNA #10 had anyone assisting her. CNA #9 stated, No other aide was assisting. At 9:45 a.m., the resident was questioned in regard to the CNA transferring her. The resident reported the CNA had asked for help, but no one would help her and I really needed to go to the bathroom. The resident was asked how the CNAs normally transferred her. The resident reported using the sit to stand lift. At 9:55 a.m., CNA #10 was asked if she received the facility inservice about proper resident transfer assistance. The CNA reported she had attended the inservice yesterday. The CNA was asked how the resident was to be transferred. The CNA reported she used the sit-to-stand lift on the resident. At 10:20 a.m., the ADM and the DON were notified of the improper transfer of the resident. The ADM reported the staff should be following the current care plan. 3. Resident #8 was admitted on [DATE], with numerous [DIAGNOSES REDACTED]. An initial assessment, dated 03/17/14, documented the resident was severely impaired with cognition and demonstrated no moods or behaviors. The resident required extensive assistance of two persons to transfer, dress and perform personal hygiene. The resident required total assistance of one person to bathe. The resident did not ambulate in the room or corridor during the look back period. The resident had impairment on one lower extremity and was frequently incontinent of bowel and bladder. A care plan, dated 03/26/14, documented the resident was a 1-2 person extensive assist with ADL care due to a fractured hip, as a problem. The goal was for the resident to work with PT/OT to increase his level of ADL ability through the next review date. An intervention listed was for two persons to assist the resident with transfers. On 04/08/14 at 4:00 p.m., CNA #11 was observed to knock on the resident's door while entering the resident's room. The CNA assisted the resident to sit on the side of the bed. The CNA moved the W/C to the side of the bed. The CNA locked the W/C brakes and reached around the resident to assist the resident to stand. The resident's knees were bent. The CNA moved the resident to sit in the W/C. The W/C's left tire moved and the W/C turned sideways. The CNA had to assist the resident to step two more steps backwards to reach the W/C and use one hand to stabilize the chair. At 4:50 p.m., the DON was informed of the transfer observation. The DON reported the CNA should have used a gait belt and had another staff member present. The DON reported the W/C should have been checked prior to the transfer to ensure it locked. The DON reported the W/C locks would be addressed immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0323

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 15)
4. Resident #5 had [DIAGNOSES REDACTED]. A care plan, initially dated 07/13/11, documented the resident had a potential for falls/injury r/t vision problems, gait/balance problems, limited mobility, osteoporosis and routine pain medications. The goal was for the resident to sustain no injury from falls though the review date of 04/06/14. An intervention listed was for the staff to lift the resident with the Sit-to-Stand lift. The same care plan documented the resident had an ADL self care performance deficit r/t limited mobility, unsteady gait and blindness. One intervention documented the resident required two person assistance with gait belt and use of the Sit-to-Stand lift and to report changes to the charge nurse. A care plan, initially dated 09/20/12, documented the resident had a problem of [REDACTED]. The care plan focus documented, Using the Sit-To-Stand lift is the safest and best way to lift the resident. One intervention listed was for the staff to lift the resident using the Sit-to-Stand lift and to make sure the resident kept her hands on the side bars and not the top of the bars if she could. The staff were to watch for the support belt riding up her back and readjust. A care plan, dated 09/25/13, documented the resident had a progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making and thought process related to short term memory loss. The care plan documented the resident had a potential for impaired communication r/t hearing deficit. One documented goal was for the resident to be able to repeat back information as understood and display the appropriate response to the situation. One intervention listed was for the staff to observe and report changes in cognitive status. A nurse's note, dated 03/10/14 at 12:50 p.m., documented, resident became lethargic at lunch time. cna used sit to stand and resident was unable to hold on and slipped down to floor. assisted resident to bed x3 assist. resident is still lethargic at this time.instructed cna not to use sit to stand on any resident that unable to hold on.91/67 (blood pressure). The resident sustained [REDACTED]. The incident report, dated 03/10/14, documented one CNA assisted the resident to utilize the sit-to-stand lift when the resident experienced the fall. A significant change assessment, dated 03/26/14, documented the resident had severe cognitive impairment with minimal depression. The resident was totally dependent on two persons for bed mobility, transfer and personal hygiene. The resident had not ambulated in the look back period and required two person extensive assistance for locomotion on and off the unit. The resident was mobile per wheelchair. The resident required a mechanical lift for transfers. The resident had range of motion impairment of both lower extremities. On 04/14/14 at 9:15 a.m., the DON was asked if she expected staff to place a resident in a Sit-to-Stand lift when the resident was lethargic. The DON reported the staff should have notified the charge nurse to assess if the resident had the ability to properly use the lift or not when the resident was lethargic or hypotensive. The DON further reported all residents were being assessed for the appropriate lift method to use and the staff were being in-serviced, with return demonstrations, to which mechanical lift and manual lift methods were to be used. 5. On 04/08/14 at 8:30 a.m., an environmental tour of the facility was conducted. The water temperature in the South Hall shower stall was 122.7 degrees F. A female resident entered the shower room. The resident was asked if she used the shower without supervision. The resident reported she used the shower without assistance, but she was supposed to ask for assistance. The female resident was asked if the water in the shower was too hot. The female resident reported if the water became too hot she just adjusted the cold water. A male resident exited the bathroom area of the shower room. The resident reported he had just shaved. The water temperature in the South Hall shower bathroom's sink was 135.7 degrees F. The male resident was asked if the water temperature in the sink was usually very hot. The resident reported the water could get hot. The resident was asked what he would do when the water became too hot. The resident stated, Just turn on the cold water, of course. The DON was asked for a list of residents who used the South Hall shower and bathroom without assistance. Five residents were identified. The residents were interviewed and reported they would adjust the water temperature as needed. LPN #1 was asked if there were any residents who ever wandered into the shower stall or bathroom. The LPN reported one resident wandered in her wheelchair and had not been seen in the shower room. A maintenance staff member was informed of the water temperature being too hot and was asked for the water temperature log. The maintenance staff member provided the maintenance log book. The maintenance staff member reported the facility's maintenance supervisor was not available due to a hospitalization . The staff member reported he did not know which areas the maintenance supervisor tested , in regard to the shower areas. The maintenance log book contained no specific documentation of water temperatures in the shower areas and bathrooms. On 04/09/14 at 8:30 a.m., the water temperature in the South Hall bathroom sink was 135.1 degrees F. The ADM was notified of the water temperature. The ADM reported he would have the maintenance staff member from another facility, who was in the facility today, readjust the water temperature, again. At 9:30 a.m., the South Hall bathroom sink was 135.7 degrees F. The maintenance staff member was notified the water temperature was still elevated. The maintenance staff member reported he had adjusted the temperature and would investigate if the sink was on a different water heater. The ADM was informed the water temperature remained elevated after the adjustments. The ADM reported the bathroom was a new addition and could be on a different water heater. At 11:00 a.m., the water temperature in the South Hall bathroom sink was 109.9 degrees F. The ADM reported the water temperature log book would be revised to document each area separately. 6. Resident #5 had [DIAGNOSES REDACTED]. The resident's current computerized physician's orders [REDACTED]. Muro128.5 % Ointment Ophthalmic-three times per day Everyday: Apply 1 drop to left eye TID Macular Degeneration of Retina Unspecified. Refresh Tears 0.5% Solution Ophthalmic-four times per day Everyday: Administer one drop to each eye QID. On 04/07/14 at 12:15 p.m., RN #1 was observed administering medications. She placed the Muro and Refresh eye drop containers on top of the cart. The RN reported the resident was not in her room and she would wait there until the resident came back to the room. At 12:25 p.m., the medication cart was observed unattended, with the eye medications still on the top of the medication cart. At that time, RN #1 was observed coming out of another resident's room. She reported she had an emergency and had to leave the medication cart. On 04/07/14 at 3:30 p.m., the DON and ADM were notified of the medication left unattended on the medication cart. The ADM reported the facility would get it fixed.

F 0325

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on record review, observation and interviews, it was determined the facility failed to implement interventions for weight loss in a timely manner for one (#1) of one sampled resident who experienced significant weight loss. This had the potential to affect all 65 residents who resided in the facility. Findings: A facility policy titled, Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, documented the following: 1. The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time.The Physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factor for developing impaired nutrition. Such monitoring may include: a. Evaluating the care plan to determine if the interventions are being implemented and whether they are effective.The Physician, with input from the staff, will determine the most appropriate intervals for weight assessments. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A dietary manager progress note, dated 02/11/13, documented the resident's weight as 166.2 pounds and the resident was a slow eater and needed assistance. A RD progress note, dated 02/22/13, documented the resident's weight as 162 pounds. The note documented, Has lost a little wt since admission-could be related to decreased [MEDICAL CONDITION]-also texture changed to pureed to increase po. The resident's estimated daily calorie requirements were documented as 1841 kcals and estimated fluid requirements as1841 ml. A care plan goal, dated 02/28/13, documented, Will consume enough foods/fluids to maintain weight and meet nutritional needs, tolerates prescribed diet, Lab WNL on Lab days. The interventions on the care plan included for the RD to evaluate and make diet change recommendations PRN and for the staff to weigh the resident monthly and monitor for significant weight loss/gain. A RD progress note, dated 03/29/13, documented the resident's weight as 161 pounds and height as 68 inches. The note documented, Would continue appropriate nutrition plan-expect wt changes secondary to [MEDICAL CONDITION] dx. Will monitor. The dietary progress notes documented the following: 04/18/13: Monthly weight 165.4# 05/29/13: Monthly weight 160.6# 06/25/13: Monthly weight 162.2# 08/27/13: Monthly weight 158.3# 09/03/13: Resident family requesting that resident have a health shake with supper meal. 10/22/13 : Monthly weight 154.7#; resident has slow loss monthly, we continue health shake with supper we may need to up that to lunch as well, will monitor next weight and make changes if needed. 11/26/13: Monthly weight 157.3# 12/19/13: Monthly weight 149#; scale were calibrated and resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0325

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 16)
was weighed x 3 to check for accuracy. We'll put on weekly x4 weeks and monitor. The resident had eight pounds loss compared to the previous month. 12/31/13: Weekly weight on 12/23 142.2#, on 12/21 143.5, weight is decreasing. Resident is brought to the dining room early where she is assisted and to allow extra time for eating. 01/02/14: Resident is receiving super cereal with breakfast health shakes with lunch and supper. We will try her on a magic cup to see if she will eat for extra calories. 01/06/14: Weekly weight 139#, resident continues to get fortified foods and being fed meals. The resident had lost 10 additional pounds. No other interventions or assessments were implemented by nursing or dietary. 01/16/14: Weekly weight 140.2# A RD progress note, dated 01/21/14, documented, wt 140#-overall wt loss. She receives multiple nutrition interventions. Noted-she is now receiving one on one feeding assistance-per CDM (certified dietary manager), begin feeding resident early so she has plenty of time to eat. Wound (sic) continue the supplements too. Agree with interventions. The resident had lost 26.2 pounds since admission. The resident was admitted to the hospital on [DATE] with [DIAGNOSES REDACTED]. The resident returned to the facility on [DATE] for skilled services with [DIAGNOSES REDACTED]. A
significant change assessment, dated 02/22/14, documented the resident was severely impaired in cognition, exhibited symptoms of moderately severe depression and exhibited no behavioral symptoms. The resident required total assistance with transfers, dressing, eating, hygiene and bathing. The resident was always incontinent of bowel and bladder function. The dietary progress notes, dated 02/25/14, documented the resident's weight as 141.2 pounds. A care plan note by the then DON, dated 02/26/14, documented the brother attended the care plan meeting and expressed concerns about the resident's hydration status and eating assistance. The note documented the resident's brother had requested one particular staff member to feed the resident. The note documented, .we could not meet the one request about having one particular staff member exclusively feeding his sister.we offered to have said employee 'train' co-workers on her technique. Brother became very upset and stated.we were denying his sister of the one resource that could help her.Resident eats when she feels like it, we have used numerous employees and they assist resident usually 1 1/2 to 2 hours per each meal with feedings. some days she eats 100% some days she doesn't want to eat. A dietary progress note, dated 03/31/14, documented, Monthly weight 136.5#; resident is slowing (sic) losing monthly, she continues to be fed all meals but does require extra time to assist. The resident had lost 18.4 pounds in the past five months, resulting in an 11.89% weight loss. This would be considered a severe weight loss for the time frame. The resident had lost 29.7 pounds since admission, which was a 17.87% weight loss in 13 months. The March 2014 computerized physician's orders [REDACTED]. The March 2014 nurses' progress notes did not consistently document the resident's meal intake. The nurses' notes documented the resident usually ate the most percentage of the evening meal. On 04/08/14, during the noon meal, the resident was observed to be fed by a staff member. At 3:20 p.m., the DON was asked for documentation of the resident's meal and fluid intake due to the surveyors not having access to the facility's intake records on the computer. On 04/09/14 at 9:00 a.m., the DM was asked about the resident's weight loss and if the physician was aware the resident had a weight loss. The DM reported the resident was being fed meals and received super cereal and supplements. The DM reported the physician was aware the resident was losing weight and the family did not want a feeding tube. At 10:00 a.m., MDS coordinator #2 reported she would have to copy and paste the fluid intake amounts and the computer system would only show the past 30 days of information. The facility was unable to produce the meal intake records for the resident for the time of the resident's weight loss. At 3:40 p.m., the resident's family member was interviewed. The family member reported the resident liked oriental food and had terrible eating habits at home. He reported the resident liked sweets and snacked during the day. He reported he would not agree to a feeding tube for the resident. The family member reported the resident was not a social person. The family member reported he visited during the evening meal and would feed the resident. The family member reported one CMA was able to get the resident to eat and he had requested the CMA to feed the resident or to train the other aides on how she got the resident to eat. He reported the former DON became angry with him and nothing was done about teaching the CNAs how to assist the resident. On 04/10/14 at 12:30 p.m., the DM reported she had contacted the RD in regard to resident's weight loss. The DM provided the documentation by the RD, dated 04/10/14 at 11:50 a.m., Was contacted by CDM, resident's re-weigh was with additional wt loss. Would consider adding an additional magic cups to nutrition plan and enc additional kcal containing thickened fluid as tolerated. At 2:40 p.m., the physician was asked if she was aware of the resident's weight loss. The physician reported she was aware the resident was losing weight. The physician was asked if the interventions were adequate. The physician reported the resident cannot swallow and the family had refused feeding tube placement. The physician reported the interventions were all they could do without placing a feeding tube. On 04/11/14 at 8:30 a.m., the DM was asked if she was aware of the resident's preferences for sweets and snacks. She reported the resident was offered snacks between meals and she was aware the resident liked her tea to be sweetened. The resident was not observed to be taken to the dining room or served meals at an earlier time, during the survey, per the care plan. No documentation was provided to substantiate the resident's meal and supplement intake amounts. No evaluation of the nursing staff's ability to assist the resident with eating was conducted. No assessment of the resident's current likes and dislikes was conducted. The resident had lost 29.7 pounds since admission, which was a 17.87% weight loss in 13 months, without effective interventions put in place.

F 0327

Level of harm - Actual harm

Residents Affected - Few

Give each resident enough fluids to keep them healthy and prevent dehydration.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on record review, observation and interviews, it was determined the facility failed to ensure adequate hydration was provided to prevent a hospitalization for dehydration for one (#1) of one sampled resident, who experienced dehydration and hospitalization . This had the potential to affect six residents, identified by the DON, who required fluid intake monitoring. Findings: Resident #1 was admitted on [DATE], with [DIAGNOSES REDACTED]. A RD's progress note, dated 02/22/13,
documented the resident's estimated daily calorie requirements were 1841 kcals (kilocalories) and estimated fluid requirements were 1841 ml. The nurse's progress notes, dated 01/03/14, documented the resident continued on an antibiotic for a UTI. The January 2014 nurses' progress notes documented the following fluid intake total amounts: 01/03/14: 120 mls. 01/04/14: 480 ml. 01/08/14: 520 ml. 01/09/14: 1540 ml. 01/10/14: 360 ml. 01/11/14: 1440 ml. 01/12/14: 1840 ml. 01/13/14: 60 ml. 01/14/14: 50 ml. 01/15/14: 440 ml. 01/17/14: 580 ml. 01/18/14: 690 ml. 01/19/14: 30 ml. 01/20/14: 1360 ml. 01/21/14: 180 ml. 01/22/14: 1560 ml. 01/23/14: 1320 ml. 01/24/14: 1220 ml. 01/25/14: 1440 ml. 01/26/14: 60 ml. 01/27/14: 1580 ml. 01/28/14: 1420 ml. 01/29/14: 1400 ml. 01/31/14: 50 ml. The resident's average daily fluid intake documented in the nurses' notes for January was 808.75 ml. The January 2014 CNA documentation was not available to surveyors for determination of further intake. The February 2014 nurses' progress notes documented the following fluid intake amounts: 02/01/14: 50 ml. 02/02/14: 1450 ml. 02/03/14: 780 ml. A nurse's note, dated 02/03/14 at 7:52 p.m., documented, Resident not like herself, residents brother here and asked if we could please send her to the hospital to be evaluated, resdent (sic) no coherent, drooling on herself and skin turgor very poor. Dr. (name deleted) called and she said to send her to (hospital name deleted). ems called. they arrived at 19:15 (7:15 p.m.) to pick up resident. A nurse's note, at 9:44 p.m., documented, spoke with (hospital name deleted) ER (emergency room), they are admitting resident for dehydration. A hospital discharge summary, dated 02/19/14, documented: .DISCHARGE Diagnosis: [REDACTED]. #1: Metabolic [MEDICAL CONDITION]--improved. #2:
Dehydration--improved. #3: [MEDICAL CONDITION], urinary tract infection, positive for E. coli, extended spectrum beta-lactamase. #4: Acute kidney injury due to dehydration--resolved. #5: [DIAGNOSES REDACTED] due to oral intake. #6: Severe progressive dementia. The resident returned to the facility on [DATE] for skilled services with a [DIAGNOSES REDACTED]. The February 2014 fluid intake amounts were not accessible for the surveyors to review. The MDS dated [DATE], documented the resident's cognitive skills for daily decision making were moderately impaired and she was totally dependant on one staff person for eating and drinking. A care plan, dated 02/24/14, documented the resident was at risk for aspiration and had potential for less than body requirements.Recent hospitalization due to decline in condition.refusing to open mouth to eat and liquids. A care plan goal documented, Will consume enough foods/fluids to maintain weight and meet nutritional needs, tolerates prescribed diet, Lab WNL on Lab days. One intervention documented for the charge nurse to monitor every shift that nectar thick water was at the bedside. A care plan note by the then DON, dated 02/26/14, documented the brother attended the care plan meeting and expressed concerns about the resident's hydration status and eating assistance. The note documented, .he is really concerned about resident's hydration status and eating.brother stated the reason she was in the hospital was due to not being given liquids.sheet was placed in residents room to list all liquids offered and amount consumed. The February and March 2014 nurses' notes did not consistently document the amount of fluid intake the resident received. The March 2014 combined totals for fluid intake with meals and between meals, as provided by the facility from the CNA documentation, was as follows: 03/12/14: 1840 ml. 03/13/14: 820 ml. 03/14/14: 1420 ml. 03/15/14: 1720 ml. 03/16/14: 3140 ml. 03/17/14: 1350 ml. 03/18/14: 2170 ml. 03/19/14: 2780 ml. 03/20/14: 1520 ml. 03/21/14: 1740 ml. 03/22/14: 2130 ml. 03/23/14: 2620 ml. 03/24/14: 1280 ml. 03/25/14: 860 ml. 03/26/14: 960 ml. 03/27/14:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0327 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 17) 240 ml. A nurse's note, dated 03/27/14 at 10:19 p.m. documented the resident drank 680 ml of fluid, which would bring the resident's documented intake total to 940 ml. 03/28/14: 720 ml. 03/29/14: 2340 ml. 03/30/14: 1980 ml. 03/31/14: 1410 ml. The resident's documented fluid intake for March was below 1000 ml. for five of the twenty days of documentation provided. The April 2014 combined totals for fluid intake with meals and between meals, as provided by the facility from the CNA documentation, was as follows: 04/01/14: 720 ml. 04/02/14: 840 ml. 04/03/14: 810 ml. 04/04/14: 1440 ml. 04/05/14: 2950 ml. 04/06/14: 2530 ml. The resident's documented fluid intake for three days in April 2014 were below 1000 ml. The resident's fluid intake requirements were not re-evaluated by the dietitian or the nursing staff. On 04/07/14 at 3:20 p.m., the resident was observed during incontinent care provided by CNA #3 and CNA #4. Following the incontinent care and repositioning the resident, the CNAs did not offer the resident a drink of fluid. Two full glasses of fluid were on the resident's overbed table. A clipboard with a sheet to document the resident's fluid intake was noted on the resident's overbed table. The fluid intake sheet did not contain documentation of intake amounts for every day of the current month. On 04/08/14 at 9:30 a.m., the resident was observed during transfer assistance. Following the transfer, the CNAs did not offer the resident a drink of fluid. A full styrofoam glass of thickened fluid was on the resident's bedside table. At 3:20 p.m., the DON was asked for the documentation of fluid intake for the resident, due to the surveyors not having access to the CNAs documentation. At 4:00 p.m., MDS coordinator #2 reported the computer program would only let her look back for the past 30 days. She reported she could copy and paste the information to a program to allow her to print the information. On 04/14/14 at 9:30 a.m., the DON was asked which residents were monitored for intake and output amounts. The DON reported any resident on tube feedings, with indwelling urinary catheters, on [MEDICAL TREATMENT] and with [DIAGNOSES REDACTED]. The DON was asked who monitored the resident's fluid intake. The DON reported the charge nurses were to review the CNAs documentation of the residents' meal and fluid intake. The DON was asked how she knew if the charge nurses were monitoring the resident's intake. The DON reported she was not aware of any problems with the charge nurses monitoring the residents.
F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, it was determined the facility failed to ensure the medication error rate was below 5%, as evidenced by a medication error rate of 13% for four (#5, #24, #25 and #26) of 10 sampled residents, during the observation of the administration of 30 medications. This had the potential to affect all 65 residents who resided in the facility. Findings: 1. Resident #5's current computerized physician's orders [REDACTED]. On 04/07/14 at 12:55 p.m., RN #1 was observed administering the Muro eye ointment to the resident. The RN placed a ribbon of ointment to the lower lids of both eyes. The ribbon was not placed inside of the right lower eyelid but was clumped at the outside of the right eyelid. The ribbon was not placed inside of the left lower eyelid but was clumped at the outside of the left eye The RN had administered the medication to both of the resident's eyes instead of the left eye, as ordered. After administering the ribbon of ointment, the RN used a Kleenex and removed the ointment still on the resident's eye lids. On 04/10/14 at 8:30 a.m., RN #1 was notified of the ribbon ointment not coving the lower lids. She reported she knew it hadn't gone all the way across the lids. 2. Resident #24's current computerized physician's orders [REDACTED]. On 04/07/14, CMA #1 was observed administering medications to the resident. The resident was administered the [MEDICATION NAME] at 5:10 p.m., in the dining room. No food was at the table. The resident did not eat until 5:30 p.m. 3. Resident #25's current computerized physician's orders [REDACTED]. The QID times for medications were documented in the facility's pharmacy policy, as 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. On 04/07/14, CMA #1 was observed administering medications for the resident. The resident was administered the Proair inhaler at 5:25 p.m. 4. Resident #25's current computerized physician's orders [REDACTED]. On 04/07/14 at 9:40 a.m., LPN #3 was observed administering medications for the resident. The glass of water administered with the medications was between a third and half full. On 04/07/14 at 3:30 p.m., the DON and ADM were notified of the medication errors. The ADM reported the facility would get them fixed.
F 0334 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop policies and procedures for influenza and pneumococcal immunizations.** Based on record review and staff interview, it was determined the facility failed to ensure residents received education regarding the benefits and potential side effects before offering the influenza immunization for six (#1, #2, #3, #4, #5, and #7) of six sampled residents who received the influenza immunization. This had the potential to affect all 65 residents who resided in the facility and had the influenza vaccination available. Findings: The medical records were reviewed for residents #1, #2, #3 #4, #5 and #7. The residents' records documented the residents had received the influenza vaccination in October 2013. The residents' medical records contained no documentation the residents had received education regarding the benefits and potential side effects before offering the influenza immunization for the present year. On 04/09/14 at 4:30 p.m., the corporate nurse was interviewed regarding the documentation of the education the residents had received prior to offering the influenza immunization. The corporate nurse reported the facility was unaware they had to educate the residents annually prior to the vaccination. At 4:35 p.m., the corporate nurse reported the facility would address the issue.
F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** Based on observation, record review, resident and staff interviews, it was determined the facility failed to ensure adequate staff to meet the residents' needs in the provision of ADL care, medication administration and restorative services. This had the potential to affect all 65 residents who resided in the facility. Findings: 1. The October 2013 resident council meeting minutes documented the residents were not being turned or even checked throughout the night, call lights were not being answered in a timely manner on the evening shift and beds were not being made during the day. The November 2013 resident council meeting minutes documented the call lights were still not being answered in a timely manner, due to staff shortage. The residents requested more staff members to be on the floor to include nurses and CNAs. The residents reported showers were not being completed on all shifts. The January 2014 resident council meeting minutes documented water pitchers were not being filled with fresh water during the evening and night shifts. The February 2014 resident council meeting minutes documented water pitchers were still not being filled with fresh water on the evening and night shifts. On 04/07/04 at 11:45 a.m., observations were made of five female residents who had facial hair and three who had chipped nail polish. At 12:20 p.m., a family member reported a resident's fingernails had been long and jagged for the past three weeks and the staff had been asked to trim the fingernails. An observation at the time found the resident's fingernails to be long and jagged. At 2:55 p.m., resident #7 reported she did not get her morning medications until 1:00 p.m. At 3:00 p.m., a confidential resident group interview was conducted with 12 alert and oriented residents. During the interview, the resident group was asked about staffing and the provision of the residents' needs. The consensus of the group reported call lights were not answered in a timely manner to include all shifts. The resident group reported they had not received their baths or showers as scheduled. The residents in the group agreed showers were not being given as scheduled and they had missed their baths/showers. The residents reported they were only receiving one bath/shower a week. The resident group was asked if there was anything else the group would like to discuss. The residents reported they were not receiving their medications on time. Two of the residents reported pain medications were not given in a timely manner and would miss some of their doses due to being too close together. The resident group reported some residents would be left in incontinent briefs for long periods of time and some of the staff would tell them to go in their incontinent brief when they had asked to be toileted. On 04/09/14 at 3:25 p.m., three confidential staff reported the facility had been short of staff more lately. The three reported they have to assist the CNAs more often because there are not enough CNAs on the shift. The three reported the residents were also requiring more assistance. On 04/10/14 at 8:15 a.m., a resident reported he had asked for pain medication at 4:40 a.m. and still had not received the medication. At 4:30 p.m., a confidential interview was conducted with a cognitively intact, alert and oriented resident. The resident reported baths and showers had not been given in a timely manner. The resident reported she had only had one shower the past week. The resident also reported pain medications were not given on time and doses were missed because the medication would be given too close

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**
NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET** **ADA, OK 74820**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 18) together. The facility did not meet minimal required state mandated staffing requirements for eight shifts during the past month. On 04/14/14 at 9:55 a.m., the ADM, DON and the corporate nurse were informed of the issues regarding staffing. The ADM nodded his head. 2. On 04/07/14 at 8:40 p.m., a confidential interview was conducted with a CNA. The CNA reported on the evening shift, there was usually one CNA per hall. The CNA reported there was one to four residents on the hall where she worked which had to be monitored closely. The CNA reported one resident was up and down multiple times and took a lot of attention/care. The CNA reported she felt another CNA needed to be on each hall. The CNA left the interview since one resident was yelling, Help me, help, I need help. At 8:45 p.m., another confidential interview was conducted with two CNAs. The CNAs both reported the residents reported to them more help was needed. The CNAs were asked if they could get their showers completed as scheduled. The CNAs reported sometimes they could get baths completed, but it was difficult if they were the only CNA on the hall. The CNAs reported while bathing a resident, other residents' call lights would go off. The CNAs reported it would take them awhile to answer the call lights. One of the CNAs was asked if they had enough help to meet the residents needs. The CNA stated, We really don't. Problem here lately. At 8:50 p.m., an LPN was asked about the usual staffing on the 3:00 p.m. to 11:00 p.m. shift. The LPN reported there was usually one CNA on each of the three halls. There were two LPNs usually scheduled for the shift. At 9:10 p.m., a confidential interview was conducted with an alert and oriented resident. The resident reported she had been in the facility for one month. The resident stated, Here lately been one (CNA) to hall. The resident stated, Can't hardly get showers when call lights are going off while they're in the shower. The resident was asked if her showers were provided as scheduled. The resident reported she received one shower a week. On 04/08/14 at 5:40 a.m., a confidential interview was conducted with a CNA. The CNA reported, when she had worked in the last month, there were two nights (11:00 p.m. to 7:00 a.m.) in which there were two CNAs in the facility to cover three halls. The CNA reported there were some newly admitted residents who required heavier care. She reported one resident required more one on one care and was awake all the time. The CNA reported she had reported these issues to the charge nurse and was told they were aware. The CNA reported during in-services the staff were told the facility was legally not short staffed. The CNA reported one to four residents on the hall took most of the care time during the night. The CNA stated, I don't think it's a matter of legal as it is resident needs. 3. A review of the Resident Council Meeting Minutes for October 2013, documented under old business, The residents said that the med passes are still running behind, causing them to be in pain before they get their medicine. On 04/07/14 at 3:00 p.m., the group meeting was conducted with 12 alert and oriented residents. One of the questions asked of the group, was if there was anything else about their life in the facility they would like to discuss. The group reported the medications were still not administered on time. On 04/08/14, LPN #4 was observed passing the 8:00 a.m. medications for resident #26 at 9:40 a.m. On 04/09/14, CMA #5 was observed passing the 8:00 a.m. medications for resident #3 at 9:50 a.m. On 04/11/14, LPN #2 was observed passing the 8:00 a.m. medications for resident #10 at 11:15 a.m. At that time, the LPN was asked if she was still passing medications. She reported she had approximately six residents which had not received their 8:00 a.m., medications. She reported for the last few months the LPNs were responsible for administering medications, doing the treatments, assessing and monitoring the residents. She was asked how often the medications were late. She stated, Everyday. We just can't get it done. On 04/07/14 at 3:30 p.m., the DON and ADM were notified of the late medications. The DON reported they would look into it. 4. The facility failed to provide restorative services for three (#2, 3 and #4) of three sampled residents who had physician ordered restorative services to be provided. a) On 04/08/14 at 11:30 a.m., MDS coordinator #1 was asked when resident #2 had been taken off skilled services. She reported the resident had been discharged from skilled services on 11/07/13. The medical record was reviewed. There was no documentation the resident was receiving restorative services or basic ROM exercises after being discharged from OT and PT services. On 04/09/14 at 2:30 p.m., the DON was asked if the resident was receiving any range of motion or restorative services. She reported she would check. She reported the restorative staff was off with an injury. b) On 04/08/14 at 2:10 p.m., CMA #3 and CNA #6 were asked who performed restorative care for resident #3. Both reported the restorative aide, but she had been off for a while. The two were asked who had been performing restorative care in her absence. CMA #3 reported she thought physical therapy provided the exercises. The CMA and CNA were asked if they performed any type of ROM therapy for the resident. Both stated, No. At 3:00 p.m., the OT and OTA were asked if they were performing ROM therapy for the resident. They both reported they were not aware of any treatments from the therapy department for resident #3. At 3:45 p.m., the DON was questioned in regard to the restorative services. The DON reported the ADM had told her the CNAs were responsible for the restorative treatment while the restorative aide was out on sick leave. The DON was asked if the CNAs were aware of their duties to perform ROM exercises. The DON stated, The ADM told me they had been told. c) On 04/08/14 at 3:50 p.m., resident #4 was interviewed and was asked about the restorative services she had received. The resident stated, Don't come in anymore, in regard to the restorative service staff. The resident was asked when the staff last provided her with her joint range of motion exercises. The resident reported it had been a long time. The resident was then asked if she felt her joint motion had declined and the resident shook her head, no. On 04/09/14 at 11:45 a.m., the DON was asked to tell the surveyor about the current restorative services. The DON (who was new to the facility) knew the restorative person was off work with an injury. The DON reported there was a need to designate a person to be trained in the interim to provide restorative services.
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Store, cook, and serve food in a safe and clean way** Based on observation and staff interview, it was determined the facility failed to ensure a food item was sealed, boxes were not stacked on the floor, the cleanliness of the microwave and of a tote lid, one dietary staff member's hair was completely covered and cross contamination did not occur during the serving line and the preparation of pureed foods. This had the potential to affect 63 residents, identified by the dietary manager, who received their meals from the dietary department. Findings: On 04/07/14 at 9:45 a.m., an environmental tour was conducted in the kitchen with the dietary manager. The following observations were made. The inside upper wall of the microwave contained food debris. One package of hot dog buns was not sealed securely in the dry storage area. Two unopened cardboard boxes were stacked on the floor in the dry storage area. A lid to a tote container had a sticky, syrup-like substance spilled on top which could attract pests. At that time, the DM threw away the package of hot dog buns and reported she would take care of the other issues. At 11:00 a.m., dietary aide #1 was observed to prepare the pureed peas and carrots for lunch. The dietary aide placed her bare fingers inside the upper lip of the Robo coupe container to remove the lid. The dietary aide held her bare thumb into the serving container when transferring the pureed food from the Robo coupe. At 11:50 a.m., cook #1 was observed to hold a hand held signature device handed to her from a delivery man. The cook then went directly to the serving line without washing her hands. Cook #1's hair was pulled back and her hairnet only covered the back half of her hair. The front section of her hair was not covered when observed at the serving line. At 12:10 p.m., cook #1 was observed to cross the kitchen to obtain a piece of bread. The cook opened the bread wrapper and handled a slice of bread with her bare hands and placed it in a wax paper sleeve. The cook went directly back to the serving line and did not wash her hands. At 5:10 p.m., another pureed food preparation was observed. Cook #2 placed his bare fingers inside the upper lip of the Robo coupe container to remove the lid. The dietary aide held his bare thumb into the serving pan when transferring the pureed food from the Robo coupe. During the evening meal serving observation, cook #2 left the serving line to throw away spilled lettuce from the serving counter. The cook opened the lid of the trash container with his bare hand, returned to the serving line without washing his hands and handled the serving utensils, plate lids and soup bowls with his thumb holding the inside of the bowls. Cook #2, during the serving time, left the line and went to the dishwasher to retrieve a clean scoop. The cook opened the dishwasher with his bare hands. The cook returned directly to the serving line and continued serving without washing his hands. On 04/09/14 at 3:30 p.m., the DM was notified of the above observations. The DM reported all the areas would be addressed.
F 0385 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that a doctor approves a resident's admission in writing and that each resident remains under the care of a doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the physician did not supervise the wound care for one (#13) of three sampled residents, who experienced pressure ulcers. This had the potential to affect 10 residents, identified by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0385

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 19)
the DON, who received pressure ulcer care from the identified physician. Findings: Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. A nurse's note, dated 02/25/14 at 10:09 p.m., documented, skin assessment done, resident has 0.5x0.2 to coccyx noted. resident has open areas noted to both heals (sic) left heel is 5.4x5.5, right heel is 7x3.5. no other open ares (sic) noted at this time. A Weekly Pressure Ulcer Report, dated 02/27/14, documented,.Coccyx resolved.Left heel 6.1x5.9x0.3cm stage II.Right heel 6.3x4.0x0.2 stage II. A Weekly Pressure Ulcer Report, dated 03/06/14, documented .In hospital.Left heel 6.1x5.9x0.3cm stage II.Right heel 6.3x4.0x0.2 stage II. A nurse's note, dated 03/10/14, documented the resident had been readmitted to the facility from the hospital. There was no documentation in the clinical record of the size of the pressure ulcers upon the resident's readmission to the facility. A care plan, dated 03/10/14, documented, The resident has (3) pressure ulcers on admit r/t chair bound, diabetes, [MEDICAL CONDITION] receiving [MEDICAL TREATMENT].On
return from hospital has 2 pairs of Pressure relieving heel protectors, as a problem. A goal was for the resident's pressure ulcers to show signs of healing and remain free from infection. Interventions listed, .Treatments as ordered to pressure ulcers, monitor daily for effects. Notify physician and family of changes. A nurses note, dated 03/13/14 at 2:44 p.m., documented, resident rt heel measurements [MEDICAL CONDITION], left heel measures [MEDICAL CONDITION], residents
heels cleaned and dressed as ordered. A Weekly Pressure Ulcer Report, dated 03/13/14, documented, .right heel 4.0x1.9x0.2cm.left heel 4.3x5.5x0.3cm. A Weekly Pressure Ulcer Report, dated 03/20/14, documented, .right heel 3.5x1.7x0.2cm.left heel 3.7x4.8x0.2cm. A nurse's note, dated 03/27/14 at 2:45 p.m., documented, rt heel wound measurements [MEDICAL CONDITION], left heel measures [MEDICAL CONDITION], wound care done as ordered. There was no documentation in the
clinical record the physician had been notified of the increase in size to the two pressure ulcers. A Weekly Pressure Ulcer Report, dated 03/27/14, documented, .right heel 4.0x2.0x0.2cm.left heel 6.3x5.7x0.3cm. There was no documentation on the weekly pressure ulcer report the physician had been notified of the increase in size to the two pressure ulcers. A computerized physician's order, dated 03/31/14, with a start date of 02/25/14, documented, wound care--bilater heels.Topical-TREATMENT DAILY Everyday: cleanse bi-lateral heels with nss pat dry apply Santyl nickle (sic) thick to wound beds cover with gauze wrap with kerlix secure with tape daily. A March 2014 TAR, documented the resident received treatments to bilateral heels on 03/01/14 and 03/02/14. The resident was then out of the facility until 03/10/14 in the hospital. The remaining 21 days contained no documentation the treatments had been completed as ordered. A nurse's note, dated 04/03/14 at 2:25 p.m., documented , .dressing to bil heel done as ordered rt heel wound measures 4.9x3.5x2, left heel measures [MEDICAL CONDITION] There was no documentation in the clinical record the physician had been notified of the continued increase in size of the two pressure ulcers over the past two weeks. A Weekly Pressure Ulcer Record, dated 04/03/14, documented, .Stage III rt heel [MEDICAL CONDITION] III lt heel [MEDICAL CONDITION] There was no documentation the
physician had been notified of the continued increase in size of the two pressure ulcers over the past two weeks. A 30-day assessment, dated 04/07/14, documented the resident was cognitively intact, required extensive assistance with two persons for transfer, bed mobility, dressing and hygiene and required extensive assistance with one person for bathing. The resident was frequently incontinent of bowel and occasionally incontinent of bladder. The resident had impairments on both sides to lower extremities. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. On 04/10/14 at 2:45 p.m., Dr. (name deflated) was interviewed in regard to the resident's pressure ulcers. The physician was asked how she classified the wounds on the resident's heels. The physician reported the pressure ulcers were due to diabetes and the resident being very non-compliant. The physician was asked how the pressure wounds to the resident's heels were progressing. The physician stated, To be honest with you, I haven't looked at them. I saw her yesterday but didn't look at the wounds. I rely on the nurses. The physician was asked if the nurses had notified her of the wounds increasing in size over the last few weeks. The physician stated, Could have, I don't remember. The physician was asked, if she had been made aware of the wounds increasing in size, would she have ordered a treatment change. The physician stated, Whatever the nurses feel needs to be done. The physician reported she thought the resident was going to the wound clinic. There were no physician orders documented in the clinical record for the resident to be sent to the wound clinic for evaluation. At 3:15 p.m., the resident's pressure ulcers were observed by the physician and the surveyor. The measurements of the right heel was 5.5x3x0.6cm and the left heel was 8x5.8x1.2cm. The physician was asked the stage of the pressure ulcers. The physician stated, Stage III. The physician was then asked if she would change the treatment to the pressure wounds. The physician then turned to the treatment nurse and the DON and asked what they have seen that works. The physician was asked if the resident would be sent to the wound clinic. The physician asked the DON what she thought. The DON reported the resident would be sent to the wound clinic for an evaluation. At 4:30 p.m., the resident was interviewed in regard to her pressure ulcers. The resident reported she had asked to go to the wound clinic as soon as she arrived at the facility. The resident reported she had asked LPN #1 and the physician. The resident reported she continued to ask LPN #1 up until approximately 2 weeks ago to go to the wound clinic.

F 0425

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on record review and staff interview, it was determined the facility failed to ensure pain medication effectiveness was consistently completed for one (#8) of nine sampled residents who had pain medication ordered by the physician. This had the potential to affect all 65 residents who resided in the facility. Findings: Resident #8 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. An initial assessment, dated 03/17/14, documented the resident was severely impaired with cognition and demonstrated no moods or behaviors. The resident required extensive assistance of two persons to transfer, dress and perform personal hygiene. The resident required total assistance of one person to bathe. The resident did not ambulate in the room or corridor during the look back period. The resident had impairment on one lower extremity and was frequently incontinent of bowel and bladder. The resident had received PRN pain medication during the look back period. A care plan, dated 03/26/14, documented the resident had occasional pain due to fracture of the left hip, as a problem. The goal was for the resident to verbalize adequate relief of pain. An intervention listed was for staff to provide analgesia for the resident as ordered and to monitor/document the effectiveness of the medication. The March 2014 MAR indicated [REDACTED]. The PRN sheet documented the effectiveness of the medication had been assessed five of the 10 times. The resident had also received Tylenol 325 mg two tablets by mouth three times for the month. There was no documentation the effectiveness of the Tylenol had been assessed. The April 2014 MAR indicated [REDACTED]. There was no documentation the effectiveness of the pain medication had been assessed. On 04/14/14 at 9:45 a.m., the DON and the ADM were asked if the pain medication effectiveness should have been assessed and documented. The DON reported the pain medication effectiveness should have been assessed.

F 0441

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Have a program that investigates, controls and keeps infection from spreading.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, record review and staff interview, it was determined the facility failed to: a) Ensure contaminated gloves had not come in contact with clean items and the staff completed handwashing between resident care for one (#1) of nine sampled residents who required infection control be maintained during care. This had the potential to affect all 65 residents who resided in the facility. b) Track and trend a UTI on the infection control log for two (#1 and #4) of three sampled residents who experienced a UTI. This had the potential to affect 21 residents, identified by the DON, who experienced a UTI in the past three months. c) Handwashing was conducted between exits and entrances into a resident's room and contaminated items were not touched with bare hands for one (#4) of one sampled resident. This had the potential to affect all 65 residents who resided in the facility. d) Ensure staff did not touch sandwiches with their bare hand while cutting them for two (#19 and #21) of two sampled residents who required sandwiches be cut in half. This had the potential to affect 18 residents, identified by the DON, who required meal assistance. e) Ensure staff did not touch ten medications with bare hands for one (#26) of ten sampled residents who were observed to receive medications during the medication pass. This had the potential to affect all 65 residents who resided in the facility and received medications. f) Ensure the staff did not reach into a clean wipe container with contaminated gloves during the provision of care for one (#8) of eight sampled residents who required incontinent care. This had the potential to affect 40 residents, identified on the Resident Census And Conditions Of Residents form, who were occasionally or frequently incontinent of bladder and 36 residents, identified on the same form, who were occasionally or frequently incontinent of bowel. Findings: 1. Resident #4 had [DIAGNOSES REDACTED]. A care plan, initially dated 04/08/11, documented the resident had a suprapubic catheter due to urine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**	STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 20) retention. The goal was for the resident to show no s/sx of urinary infection through the review date of 03/24/14. Interventions listed were for the staff to monitor and record UTIs and treat as ordered. A urine culture laboratory report, dated 03/07/14, documented the resident had a UTI with four organisms isolated. The organisms were Proteus mirabillis, Escherichia coli, [MEDICATION NAME] species and Morganella morganii. Each organism cultured had a colony count of greater than 100,000. A quarterly assessment, dated 03/26/14, documented the resident was cognitively intact with mild depression and exhibited no behaviors. The resident required two person extensive assistance for bed mobility, transfer, dressing and personal hygiene. The resident required one person total assistance for bathing. The assessment documented the resident had an indwelling urinary (suprapubic) catheter and was always incontinent of bowel. The March 2014 Infection Control Log was reviewed. There was no entry of the resident's UTI of being tracked and trended on the infection control log. On 04/09/14 at 10:20 a.m., the DON was asked if she would have expected the resident's UTI to be tracked and trended on the infection control log. The DON stated, Yes. 2. Resident #4 had [DIAGNOSES REDACTED]. A quarterly assessment, dated 03/26/14, documented the resident was cognitively intact with mild depression and exhibited no behaviors. The resident required two person extensive assistance for bed mobility, transfer, dressing and personal hygiene. The resident required one person total assistance for bathing. The assessment documented the resident had an indwelling urinary catheter and was always incontinent of bowel. The March 2014 physician orders [REDACTED]. On 04/08/14 at 2:00 p.m., RN #1 and LPN #1 were observed to provide an irrigation of the resident's suprapubic catheter. Near the beginning of the procedure, the LPN asked the RN if she had any alcohol swabs. The RN was holding the resident's catheter tubing with her gloved hand. The RN proceeded to empty both her uniform pockets, with the gloved hand, of multiple items and placed them on the resident's top bed covers. During the procedure, the RN had cleaned the catheter drainage tubing, which she was holding, with an alcohol pad. The RN removed contaminated gloves to exit the room to retrieve clean gloves. Upon re-entering the room, the RN was observed not to wash her hands or sanitize her hands before regloving. After the irrigation, RN #1 was observed to touch a pillowcase, which had dried feces on it, with her bare hands. After she touched the soiled pillowcase, the RN applied clean gloves to remove the pillowcase. After the suprapubic catheter irrigation, the two nurses assisted the resident to reposition on her right side. The LPN cleansed two sheared areas of the resident's buttocks. The LPN gloved one hand and applied [MEDICATION NAME] to the areas. The LPN then touched the resident's linens and skin with the contaminated gloves. On 04/09/14 at 10:20 a.m., the DON was asked if she expected the staff to wash their hands between exiting a room and then regloving. The DON stated, Absolutely. The DON reported she expected the staff to wash their hands before giving and after completing care. The DON was asked if she expected staff to handle contaminated items with bare hands. The DON stated, No. The DON was asked if she expected staff to handle clean items with contaminated gloves. The DON stated, No. 3. On 04/07/14 at 6:00 p.m., during the evening meal in the dining room, the following observations were made. CMA #1 was observed to place her bare hand on top of resident #19's sandwich, to hold it in place, while cutting the sandwich in half. An unidentified CNA was observed to place her bare hand on top of resident #21's sandwich, to hold it in place, while cutting the sandwich in half. On 04/09/14 at 10:20 a.m., the DON was asked what her expectation was when staff assisted in the dining room in cutting residents' food. The DON reported the staff should not touch the residents' food. The DON reported the staff should use a fork to stabilize the food while cutting with a knife. 4. On 04/08/14 at 9:40 a.m., LPN #4 was observed administering medications for resident #26. Ten oral medications were administered to the resident. The LPN removed each medication individually from the blister pack. Instead of punching the medications and holding them over the medicine cup, she punched each medication out, took her bare fingers and placed each medication in the medication cup. On 04/14/14 at 9:35 a.m., the DON and the corporate nurse were notified of the LPN touching the medications with her bare fingers. The DON reported the LPN should not have handled the medications with her bare hands. 5. Resident #8 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. A facility Bowel and Bladder Program Screener form documented the resident was a candidate for scheduled toileting or timed voiding. An initial assessment, dated 03/17/14, documented the resident was severely impaired with cognition and demonstrated no moods or behaviors. The resident required extensive assistance of two persons to transfer, dress and perform personal hygiene. The resident required total assistance of one person to bathe. The resident did not ambulate in the room or corridor during the look back period. The resident had impairment on one lower extremity and was frequently incontinent of bowel and bladder. A care plan, dated 03/26/14, documented the resident was at risk for skin breakdown, due to being frequently incontinent of bowel and bladder, as a problem. The goal was for the resident to be free of skin breakdown through the next review date. An intervention listed was for the staff to perform incontinent care with each incontinent episode. On 04/08/14 at 1:00 p.m., CNA #5 and CNA #6 were observed to perform incontinent care for the resident. The resident was incontinent of bowel and bladder. CNA #5 and #6 performed the incontinent care and CNA #6 had used all of the wipes in the container. The CNA removed her gloves, left the room and returned with a new box of wipes. The CNA opened the wipes and donned gloves. CNA #5 turned the resident on his side. There was additional feces on the resident's scrotum and the perineum. The CNA then took out wipes from the container and cleansed the areas. The CNA used all the wipes which were not in the container and then used the same contaminated gloves to remove additional wipes to finish the incontinent care. On 04/14/14 at 9:30 a.m., the DON was interviewed regarding the CNA using contaminated gloves to obtain additional wipes from the wipe container. The DON reported the staff should never use contaminated gloves to obtain clean wipes from a clean container. The DON reported she would in-service the staff. 6. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 02/28/13, documented the resident was incontinent of bowel and bladder related to Alzheimer's disease, dementia, confusion and impaired memory. The interventions included for the staff to check the resident every two hours for incontinence and for the staff to cleanse the resident's perineum. A significant change assessment, dated 02/22/14, documented the resident was severely impaired in cognition, exhibited symptoms of moderately severe depression and exhibited no behavioral symptoms. The resident required total assistance with transfers, dressing, eating, hygiene and bathing. The resident was always incontinent of bowel and bladder function. On 04/07/14 at 3:20 p.m., the resident was observed during incontinent care by CNA #3 and CNA #4. The CNAs donned gloves. CNA #3 cleansed the resident's perineal area. The CNAs turned the resident to her right side. The resident had been incontinent of bowel. As the CNAs were cleansing the resident, the resident voided. The CNA #3 completed the cleansing of the resident's buttocks. CNA #4 applied moisture barrier to the resident's buttocks wearing the same gloves worn during the procedure. CNA #3 applied a disposable adult brief to the resident, wearing the same contaminated gloves worn to cleanse the resident. The CNAs changed gloves. The CNAs removed the resident's soiled bed linens, applied clean bed linens, readjusted the resident in bed and collected the soiled linens while wearing the same contaminated gloves. CNA #4 removed the bag of soiled linens and carried them to the soiled linen area. CNA #3 removed her gloves and entered the next resident's room without washing her hands or using hand sanitizer. On 04/08/14 at 3:45 p.m., the DON was asked if the CNAs should change their gloves during the incontinent care and before touching clean items. The DON stated, Yes. The DON was asked if the CNAs should wash their hands between resident care. The DON stated, Yes. 7. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 02/28/13, documented the resident had potential for UTI related to a history of dehydration. A hospital discharge summary, dated 02/19/14, documented the resident was discharged from the hospital with improved metabolic [DIAGNOSES REDACTED]; improved dehydration; sepsis, urinary tract infection, positive for E. coli; resolved acute kidney injury due to dehydration; [DIAGNOSES REDACTED] due to oral intake and severe progressive dementia. The facility's February 2014 Infection Control Log contained no documentation of the resident's UTI and sepsis. On 04/14/14 at 9:30 a.m., the DON was asked if the infection should have been included on the infection control log. The DON stated, Yes.
F 0456 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep all essential equipment working safely.** Based on observation and staff interview, it was determined the facility failed to ensure wheelchairs were maintained in good repair for five (#2, 17, 18, 19 and #21) of 13 sampled residents who utilized wheelchairs. This had the potential to affect 36 residents, identified by the DON, who utilized wheelchairs. Findings: On 04/07/14 at 11:45 a.m., during the noon meal, the following observations were made. Resident #17's left wheelchair armrest was torn. Resident #2's left w/c armrest was torn. Resident #18's left w/c armrest was cracked and torn. Resident #19's right w/c armrest was cracked and torn.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0456 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 21) Resident #21's left w/c armrest was covered with duct tape. On 04/14/14 at 9:15 a.m., the ADM was interviewed and he reported the equipment would be repaired.
F 0502 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined the facility failed to ensure laboratory analysis were completed as ordered for three (#7, 5 and #3) of seven sampled residents who had physician ordered laboratory analysis be completed. This had the potential to affect all 65 residents who resided in the facility. Findings: 1. Resident #7 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. A care plan, dated 09/15/11, documented the resident was on a special diet for diabetes mellitus, as a problem. The goal was for the resident to maintain her glucose levels through the next review date. An intervention listed was for the staff to perform FSBS as ordered by the physician and to notify the physician of any abnormal results. A computerized physician's orders [REDACTED]. A quarterly assessment, dated 03/12/14, documented the resident was cognitively intact and demonstrated no moods or behaviors. The resident's medical record documented the last HGBA1C was completed in December 2013. The resident was to have the next HGBA1C in March 2014. There was no documentation the resident had the laboratory test completed in March. On 04/09/14 at 4:15 p.m., the DON was asked for the March HGBA1C. The DON reported she would check with the laboratory provider. At 5:00 p.m., the DON reported the facility had missed the March 2014 HGBA1C for the resident and the nurse was contacting the physician at this time for new orders. The DON reported the resident's HGBA1C should have been obtained as ordered by the physician. 2. Resident #5 had [DIAGNOSES REDACTED]. A care plan, initially dated 09/20/12, documented the resident had chronic [MEDICAL CONDITION]. An intervention listed was for the staff to obtain laboratory tests as ordered, monitor values and consult results with the physician. A significant change assessment, dated 12/06/13, documented the resident was moderately impaired with cognition and had minimal depression with no behaviors. The assessment documented the resident had an indwelling urinary catheter (suprapubic) and was frequently incontinent of bowel. A nurse's note, dated 01/20/14 at 10:44 p.m., documented, resident confused, asking where does she go to the bathroom and asking who she is. Dr. (name deleted) notified and new order for ua with c/s. A care plan, dated 02/17/14, documented the resident had a history of [REDACTED]. No laboratory test result could be located for the above physician ordered UA with C&S. On 04/11/14, the staff were asked if they could locate the above laboratory results. On 04/14/14, during the exit conference, the DON reported the laboratory report, if available, was supposed to be faxed to the facility. The DON reported the staff would fax the laboratory report, if available, to the surveyors. On 04/16/14 at 1:10 p.m., a telephone call was received from RN #2 and she reported the laboratory test had not been obtained as ordered. 3. Resident # 3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 11/18/10, documented the resident had impaired swallowing and a potential for fluid imbalance, as a problem. A goal was for the resident to be free of s/s of fluid imbalance/dehydration. One intervention listed was for the staff to obtain and monitor lab/diagnostic work as ordered, report results to the physician and follow up as indicated for monthly Pre-[MEDICATION NAME]. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact and was totally dependent on two persons assistance for transfer, bed mobility, dressing, hygiene and bathing. The resident was totally dependent of one person assistance for eating. The resident was always incontinent of bowel and bladder. The resident had functional limitation in ROM to the upper and lower extremities. The resident required a PEG tube for nutrition. A computerized physicians order, dated 03/31/14 with an original date of 12/28/05, documented, PRE-[MEDICATION NAME] Q MONTH. The clinical record contained no documentation a pre-[MEDICATION NAME] level had been completed for November 2013 or for February 2014. On 04/08/14 at 11:30 a.m., the DON was questioned in regard to the pre-[MEDICATION NAME] laboratory analysis. The DON reported she would look to see if she could find the laboratory analysis. At 12:00 noon, the DON reported she was unable to locate the pre-[MEDICATION NAME] laboratory analysis. The DON was then asked if the pre-[MEDICATION NAME] levels should have been completed. The DON stated, Yes.

F 0514 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep accurate, complete and organized clinical records on each resident that meet professional standards **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure resident medical records were readily available and documentation were consistently completed: a) On the MARs, TARs for eight (#2, #3, #4, #7, #8, #9, #10 and #13) of 25 sampled residents who required documentation on the MARs and TARs. This had the potential to affect all 65 residents who resided in the facility. b) For intakes and outputs for two (#2 and #1) of two sampled residents who required intake and outputs be documented. This had the potential to affect six residents, identified by the DON, who required intakes and outputs be documented. c) To have meal intake documentation readily available and accessible for one (#1) of nine sampled residents who required meal intake documentation. This had the potential to affect 63 residents, identified by the DON, who required meal intake documentation. d) To have signed telephone physician's orders [REDACTED].#9) of nine sampled residents who had order changes in the past three months. This had the potential to affect all 65 residents who resided in the facility. e) To document episodes of diarrhea in the clinical record, which resulted in hospitalization , for one (#9) of four residents who required hospitalization in the past three months. This had the potential to affect all 65 residents who resided in the facility and required documentation of changes in condition. Findings: 1. Resident #7 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. A care plan, dated 09/15/11, documented the resident was at risk for [MEDICAL CONDITION], MI or [MEDICAL CONDITION] related to hypertension, as a problem. The goal was for the resident not to have any new [MEDICAL CONDITION], MI or [MEDICAL CONDITION] through the next review date An intervention listed was for the staff to give antihypertensive medications as ordered by the physician. Another problem documented the resident was on a special diet for diabetes mellitus. The goal was for the resident to maintain her glucose levels through the next review date. An intervention listed was for the staff to perform FSBS as ordered by the physician and to notify the physician of any abnormal results. A computerized physician's orders [REDACTED]. Everyday: 1 TAB DAILY HOLD MEDICATION IF PULSE BELOW 60 AND NOTIFY CHARGE NURSE.UNSPECIFIED ESSENTIAL HYPERTENSION. A computerized physician's orders [REDACTED]. FSBS-twice daily Everyday: B/S BID. The resident's February 2014 TAR was reviewed. The TAR had 56 opportunities to document the resident's FSBS and 18 opportunities were blank. The resident's February 2014 MAR indicated [REDACTED]. Three opportunities were blank for the B/P and pulse and one opportunity had a documented B/P without a pulse documented. The resident's March 2014 TAR was reviewed. The TAR had 62 opportunities to document the resident's FSBS and 32 opportunities were blank. The resident's March 2014 MAR indicated [REDACTED]. Two opportunities were blank for the B/P and pulse. A quarterly assessment, dated 03/12/14, documented the resident was cognitively intact and demonstrated no moods or behaviors. The resident's April 2014 TAR was reviewed. The TAR had 18 opportunities to document the resident's FSBS and six opportunities were blank. The resident's April 2014 MAR indicated [REDACTED]. One opportunity was blank for the B/P and pulse. On 04/09/14 at 5:15 p.m., the DON was shown the resident's MARs and TARs. The DON reported there was no way to know if the staff had performed the FSBSs, B/Ps and pulses, as ordered by the physician. The DON reported if the items had not been documented then they were not done. The DON reported she would in-service the staff. 2. Resident #8 was admitted on [DATE] with numerous [DIAGNOSES REDACTED]. A computerized physician's orders [REDACTED]. An initial assessment, dated 03/17/14, documented the resident was severely impaired with cognition and demonstrated no moods or behaviors. A care plan, dated 03/26/14, documented the resident had a history of [REDACTED]. The goal was for the resident to be free of s/s [MEDICAL CONDITION] the next review date. An intervention listed was for the staff to give antihypertensive medications as ordered by the physician. Another intervention listed was for the staff to monitor/document/report to the physician any s/s of hypertension. The March 2014 MAR indicated [REDACTED]. There were six blanks. The April 2014 contained six areas to document the medication, Carvedilol, had been given. One of the areas was blank. On 04/14/14 at 9:15 a.m., the DON was interviewed regarding the missing documentation. The DON reported the staff should always document the medications had been given and she would in-service the staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**
NAME OF PROVIDER OF SUPPLIER **BALLARD NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **201 WEST 5TH STREET** **ADA, OK 74820**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0514

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 22)

3. Resident #2 had been admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. An initial assessment, dated 08/18/13, documented the resident required extensive assistance with two person assist for bed mobility, total assist with two person assist for transfers, did not ambulate, required extensive assistance with dressing and hygiene, required total assist with bathing, had limitation in range of motion bilaterally in the lower extremities, was incontinent of bowel and required an indwelling urinary catheter. The March 2014 TARS were reviewed. Gaps in charting were found for the following orders: Does the resident exhibit any side effects from their pain medication every shift, had 93 opportunities to be documented. Of the 93 opportunities, 34 were blank. Does the resident exhibit any signs of sedation every shift, had 93 opportunities to be documented. Of the 93 opportunities, 36 were blank. Foley catheter care every shift, had 93 opportunities to be documented. Of the 93 opportunities, 39 were blank. How does the resident rate their pain every shift, had 93 opportunities to be documented. Of the 93 opportunities, 29 were blank. Monitor that foot cushion is in place when in wheelchair, had 93 opportunities to be documented. Of the 93 opportunities, 44 were blank. Right and left heel treatment [MEDICATION NAME] every shift, had 93 opportunities to be documented. Of the 93 opportunities, 39 were blank. The April 2014 TARS were reviewed. Gaps in charting were found for the following orders: Cleanse coccyx every other day, had 3 opportunities to be documented. Of the 3 opportunities, 3 were blank. Vitamin A & D Topical daily, had 7 opportunities to be documented. Of the 7 opportunities, 3 were blank. Does the resident exhibit any side effects from their pain medication every shift, had 21 opportunities to be documented. Of the 21 opportunities, 6 were blank. Does the resident exhibit any signs of sedation every shift, had 21 opportunities to be documented. Of the 21 opportunities, 6 were blank. How does the resident rate their pain every shift, had 21 opportunities to be documented. Of the 21 opportunities, 5 were blank. Monitor that foot cushion is in place when in wheelchair, had 21 opportunities to be documented. Of the 21 opportunities, 7 were blank. Right and left heel treatment [MEDICATION NAME] every shift, had 21 opportunities to be documented. Of the 21 opportunities, 7 were blank. Foley catheter care every shift, had 21 opportunities to be documented. Of the 21 opportunities, 8 were blank. The April 2014 computerized urinary output records were reviewed for every shift. The record had 48 opportunities to be documented. Of the 48 opportunities, 33 were blank. No other urinary output records were available during the six day survey. On 04/14/14 at 9:35 a.m., the DON and the corporate nurse were notified of the lack of consistent documentation. The DON reported she was aware of the problem. 4. Resident #10 had been admitted to the facility on [DATE], with medical [DIAGNOSES REDACTED]. The April 2014 MARs and TARs were reviewed. Gaps in charting were found for
the following orders: [MEDICATION NAME] 5 mg daily had 7 opportunities for daily pulse to be documented. Of the 7 opportunities, 2 were blank. [MEDICATION NAME] 5 mg daily had 7 opportunities for the medication to be documented. Of the 7 opportunities, 1 was blank. Montelukast Sodium 10 mg daily had 7 opportunities for the medication to be documented. Of the 7 opportunities, 1 was blank. [MEDICATION NAME] 10 mg daily had 7 opportunities for the medication to be documented. Of the 7 opportunities, 1 was blank. [MEDICATION NAME] 400 mg daily had 14 opportunities for the medication to be documented. Of the 14 opportunities, 1 was blank. [MEDICATION NAME] Inhalation twice daily had 14 opportunities for the medication to be documented. Of the 14 opportunities, 1 was blank. [MEDICATION NAME] 500 mg HCL twice daily had 14 opportunities for the medication to be documented. Of the 14 opportunities, 1 was blank. [MEDICATION NAME] twice daily had 14 opportunities for the medication to be documented. Of the 14 opportunities, 1 was blank. Oxygen at 2 LPM continuous had 28 opportunities for the oxygen to be documented. Of the 28 opportunities, 25 were blank. Skin check weekly by Licensed Nurse had 1 opportunity to be documented. Of the 1 opportunity, 1 was blank. On 04/14/14 at 9:35 a.m., the DON and the corporate nurse were notified of the lack of consistent documentation. The DON reported she was aware of the problem.

5. Resident #4 had [DIAGNOSES REDACTED]. The resident's clinical record was reviewed. There were blank entries in documentation found. The March 2014 TAR had multiple blanks in the following areas: Changing the urinary drainage bag every two weeks: two of two opportunities were blank. Irrigate the SP (suprapubic) catheter daily: four blanks out of 28 opportunities. Exhibit any side effects for pain medication every shift: 35 blanks out of 81 opportunities. Signs of sedation every shift: 29 blanks out of 81 opportunities. Empty urinary drainage bag every shift: 26 blanks out of 81 opportunities. Resident rate of pain on a scale of 0-10: 33 blanks out of 81 opportunities. Thera-shield Topical TID daily: 37 blanks out of 81 opportunities. The days the resident was in the hospital during March was not included in the calculation of these blank entries. The March 2014 physician orders [REDACTED]. The resident's urinary output record was reviewed from 03/12/14 through 04/09/14. There were 34 blank entries out of 80 opportunities to record the suprapubic urinary catheter output. The April TAR (April 1-7) was reviewed with the following blanks in documentation: [MEDICATION NAME] apply to buttocks TID: 12 blanks out of 21 opportunities. Exhibit any side effects from pain medication: six blanks out of 21 opportunities. Exhibit any signs of sedation: six blanks out of 21 opportunities. Foley catheter care every shift: six blanks out of 21 opportunities. Resident rate of pain on scale of 1-10: six blanks out of 21 opportunities. The April 2014 MAR (April 1-7) had the following blanks: [MEDICATION NAME] 20 mg one tablet daily: one blank out of seven opportunities. [MEDICATION NAME] 10 mg one table daily: one blank out of seven opportunities. [MEDICATION NAME] AC 10 mg AC
BID: one blank out of 14 opportunities. On 04/09/14 at 10:20 a.m., the DON was shown blanks/gaps in documentation in the resident's clinical record. The DON reported the blanks on the MAR indicated [REDACTED]. The DON reported the records would be audited and the staff wound be in-serviced.

6. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. On 04/08/14, during the noon meal, the resident was observed to be fed by a staff member. At 3:20 p.m., the DON was asked for documentation of the resident's meal and fluid intake due to the surveyors not having access to the facility's intake records on the computer. On 04/09/14 at 9:00 a.m., MDS coordinator #2 reported she would have to copy and paste the fluid intake amounts and the computer system would only show the past 30 days of information. The facility was unable to produce the meal intake records for the resident for the time of the resident's weight loss. On 04/14/14 at 9:45 a.m., the ADM and the DON were notified the resident's clinical information was not accessible to the surveyors and the meal and fluid intake information was not available for review for beyond the last 30 days. The ADM made no comment. 7. Resident #9 was admitted on [DATE] for skilled services and had [DIAGNOSES REDACTED]. A nurse's note, dated 03/18/14 at 3:30 p.m., documented, .NO EPISODES OF DIARRHEA REPORTED ON THIS
SHIFT. No note prior to this documented the resident experienced diarrhea. A nurse's note, at 5:54 p.m., documented the resident was sent to the emergency room after he experienced facial drooping and low blood pressure. The hospital history and physical report, dated 03/19/14 documented, .HISTORY OF PRESENT ILLNESS:.He has been having loose bowel movements for
the last 2-3 days and also incontinence of the stools. They have been using diapers for the diarrhea with incontinence. The resident's clinical record contained no documentation the resident experienced episodes of diarrhea. A nurse's note, dated 03/27/14, documented, (Physician's name deleted) called back (received) new order to put risperdone on hold. The clinical record contained no physician's telephone order to hold the [MEDICATION NAME]. The March 2014 treatment sheet documented, skin check weekly on Friday Order Date 2/7/2014 3-11 EVENING SHIFT Every Fri. The treatment sheet contained no initials to indicate the resident's skin was assessed during the month of March. The computerized physician's orders [REDACTED]. The order start date was documented as 03/26/14. The clinical record contained no original physician's telephone order for the treatment to the resident's heels. On 04/14/14 at 9:30 a.m., the DON and the corporate nurse were asked if they expected the resident's clinical record to contain complete documentation of the resident's condition. The DON stated, Yes.

8. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. A TAR, dated February 2014, contained 10 blank areas in
which to document FSBS. A TAR, dated March 2014, contained 90 blank areas in which to document FSBS. A TAR, dated March 2014, contained 21 blank areas in which to document wound care for bilateral heels. A TAR, dated April 2014, contained 2 blank areas in which to document wound care for bilateral heels. A TAR, dated April 2014, contained 11 blank areas in which to document FSBS. An assessment, dated 04/07/14, documented the resident was cognitively intact. The resident was admitted to the facility with one stage II pressure ulcer and two unstageable pressure ulcers. On 04/14/14 at 9:30 a.m., The DON was questioned in regard to the blank areas in documentation. The DON was asked if she expected documentation to be completed when care was completed. The DON stated, Yes. 9. Resident # 3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A significant change assessment, dated 06/22/13, documented the resident was cognitively intact and was totally dependent on two persons assistance for transfer, bed mobility, dressing, hygiene and bathing. The resident was totally dependent of one person assistance for eating. The resident was always incontinent of bowel and bladder. The resident had functional limitation in ROM to the upper and lower extremities. The resident required a PEG tube for nutrition. The MARs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375263**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/14/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLARD NURSING CENTER	**201 WEST 5TH STREET ADA, OK 74820**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 23) and TARs, dated January 2014, contained: 13 blank areas in which to document a treatment to the inner left thigh wound. 13 blank areas in which to document a treatment to the peg tube site. 25 blank areas in which to document application of a skin protectant. Five blank areas in which to document to wash the resident's body with [MEDICATION NAME] body wash on shower days. 31 blank areas in which to document side effects from pain medication. 31 blank areas in which to document signs of sedation. 31 blank areas in which to document HOB elevated at all times. 31 blank areas in which to document resident's pain scale rate. 32 blank areas in which to document checking PEG tube placement. 14 blank areas in which to document set up change of enteral tube. Nine blank areas in which to document the administration of [MEDICATION NAME]. Nine blank areas in which to document the administration of Pro Pass powder. The MARs and TARs, dated February 2014, contained: 38 blank areas in which to document the barrier cream had been applied. 30 blank areas in which to document checking PEG tube placement. 13 blank areas in which to document set up change of enteral tube. Five blank areas in which to document the administration of [MEDICATION NAME]. Six blank areas in which to document the administration of Pro Pass powder. 16 blank areas in which to document a treatment to the inner left thigh wound. 20 blank areas in which to document a treatment to the peg tube site. Six blank areas in which to document to wash the resident's body with [MEDICATION NAME] body wash on shower days. 28 blank areas in which to document side effects from pain medication. 28 blank areas in which to document signs of sedation. 28 blank areas in which to document HOB elevated at all times. 28 blank areas in which to document residents pain scale rate. The MARs and TARs, dated March 2014, contained: Nine blank areas in which to document PEG tube feeding set up change. Five blank areas in which to document the administration of [MEDICATION NAME]. Five blank areas in which to document the administration of [MEDICATION NAME]. Five blank areas in which to document the administration of Pro Pass powder. 43 blank areas in which to document the barrier cream had been applied. 40 blank areas in which to document checking PEG tube placement. The MARs and TARs, dated April 2014, contained: 12 blank areas in which to document side effects from pain medication. 13 blank areas in which to document signs of sedation. 13 blank areas in which to document HOB elevated at all times. 13 blank areas in which to document residents pain scale rate. Four blank areas in which to document a treatment to the inner left thigh wound. Three blank areas in which to document a treatment to the PEG tube site. 12 blank areas in which to document the barrier cream had been applied. 12 blank areas in which to document checking PEG tube placement. One blank areas in which to document the administration of [MEDICATION NAME]. Two blank areas in which to document the administration of [MEDICATION NAME]. One blank areas in which to document the administration of Pro Pass powder. The intake report contained 13 blank areas in which to document Peg tube feeding and water flush intake from 03/26/14 through 04/07/14. On 04/14/14 at 9:30 a.m., the DON was questioned in regard to the documentation. The DON was asked if she expected documentation to be completed. The DON stated, Yes.
F 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, it was determined the facility failed to maintain an effective quality assurance and assessment (QAA) program to identify the following system failures: accident prevention and supervision, physician notification, assessing, monitoring and intervening for resident conditions, identification and treatment of [REDACTED]. This had the potential to effect all 65 residents who resided in the facility. Findings: 1. Based on record review, observation and staff interviews, it was determined the facility failed to: ensure one (#2) of six sampled residents was transferred properly, without injury and according to the care plan, which resulted in an immediate jeopardy situation; ensure one (#5) of two sampled residents, who required sit to stand lifts, was not lifted by a sit to stand lift when lethargic; ensure a wheelchair was in the locked position and two staff were in attendance before a transfer was completed for one (#8) of six sampled residents who required assistance with transfers and utilized wheelchairs. See F323. 2. Based on record review, observation and staff interviews, it was determined the facility failed to notify the physician: of diastolic blood pressure readings over 90 for one (#1) of nine sampled residents who required blood pressure monitoring; of low blood pressure readings for two (#5 and #9) of nine sampled residents who required blood pressure monitoring; of the increase in size of two pressure ulcers for one (#13) of four sampled residents who had pressure ulcers; of a pressure ulcer for one (#9) of four sampled residents who had pressure ulcers and of a FSBS less than 60 for one (#13) of three sampled residents, who required FSBSs be obtained. See F157. 3. Based on observation, record review and staff interview, the facility failed to: obtain blood pressure parameters in which to contact the physician for eight (#1, 2, 4, 5, 7, 8, 9 and #10) of eight sampled residents, who required physician ordered blood pressure readings to be taken; complete weekly skin assessments with monitoring for one (#4) of nine sampled residents who required weekly skin assessments be conducted; assess and monitor one (#10) of four sampled residents who had experienced and complained of itching; provide suprapubic urinary catheter irrigation correctly for one (#4) of one sampled resident, who required suprapubic catheter irrigation; obtain FSBS as ordered by the physician for two (#7 and #13) of two sampled residents, who required FSBSs; obtain blood pressure and pulse readings, as ordered, for one (#7) of two sampled residents, who required blood pressure and pulse readings be obtained. See F309. 4. Based on observation, record review and staff and resident interviews, it was determined the facility failed to: notify the physician and obtain new orders when two pressure ulcers increased in size and stage for one (#13) of four sampled residents, which resulted in harm to the resident; notify the physician or obtain orders for one pressure sore on the resident's buttock and failed to assess and monitor the pressure ulcers on the resident's heels for one (#9) of four sampled residents, which resulted in harm to the resident. See F314. 5. Based on record review, observation and interviews, it was determined the facility failed to ensure adequate hydration was provided to prevent a hospitalization for one (#1) of one sampled resident, who experienced dehydration and hospitalization , which resulted in harm. See 327. 6. Based on observation, record review and staff interview, it was determined the facility failed to: ensure contaminated gloves had not come in contact with clean items and the staff completed handwashing between resident care for one (#1) of nine sampled residents, who required infection control be maintained during care; track and trend a UTI on the infection control log for two (#1 and #4) of three sampled residents who experienced a UTI; ensure hand washing was conducted between exits and entrances into a resident's room; ensure contaminated items were not touched with bare hands for one (#4) of one sampled resident; ensure staff did not touch sandwiches with their bare hand while cutting them for two (#19 and #21) of two sampled residents; ensure staff did not touch ten medications with bare hands for one (#26) of ten sampled residents who were observed to receive medications during the medication pass; and ensure the staff did not reach into a clean wipe container with contaminated gloves during the provision of care for one (#8) of eight sampled residents who required incontinent care. See F441. On 04/14/14 at 10:00 a.m., the ADM was interviewed regarding the facility's quality assurance program. The surveyor asked what resident care issues had been addressed in the QA program. The administrator reported the facility had addressed infection control practices and incontinent care. The ADM reported every time the DON resigned a new DON would be hired. The ADM reported the new DON would identify infection control problems then they would start over again. The ADM stated, We started over three times. The ADM was asked if there were any other issues identified. The ADM reported there were some non-nursing issues identified. The surveyor asked the ADM if there were any other resident care items which had been identified. The ADM shook his head no.