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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375486	A. BUILDING ______ B. WING _____	**08/21/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND PARK MANOR	**1307 R D MILLER DRIVE** **OKMULGEE, OK 74447**

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 ensure the physician and family were informed of a newly identified pressure sore for one (#2) of two residents sampled for pressure sores. This had the potential to affect three residents per the DON with identified pressure sores. Findings: Resident #2 had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 07/29/14, an admission 'Nurse's Note', documented, .Redness noted under breast & ABD fold. 0 open areas/wounds noted upon assessment. On 07/29/14, a 'Skin Risk Analysis', documented, Contributing Diagnosis: [REDACTED]. Contributing Factors: Limited/Poor Mobility. Braden Scale Risk Score: 17-Low. Final Skin Risk Analysis Score: Low-17. On 07/30/14, a 'Daily Skilled Nurse's Note', documented the resident had a rash under her breast and abdomen on day and night shifts. A 14 days assessment, dated 08/12/14, documented the resident was cognitively intact, required limited assistance with bed mobility, dressing, hygiene and bathing, had an indwelling urinary catheter, was continent of bowel, was at risk for pressure sores, but did not have a pressure sore at the time of the assessment. On 08/19/14, a 'Daily Skilled Nurse's Note', documented the resident had a rash on her skin on the day and night shift. The August 2014, 'Treatment Sheet', documented, Skin Mgmt: Monitor Skin Integrity weekly on Tuesday, if any skin problems noted document in progress notes, every evening shift every Tue. The form documented the resident's skin had been assessed one time, on the 5th. On 08/19/14 at 10:00 a.m., CNA #1 and CNA #2 were observed providing indwelling urinary catheter care for the resident. The resident was observed to have a Stage II pressure sore on her left inner buttock. CNA #2 was asked how long the open area had been present on the resident's buttock. The CNA reported the area had been there since admission. On 08/19/14 at 8:00 p.m., a 'Daily Skilled Nurse's Note', documented, Rsd c/o groin & buttocks irritation, Dr. (Name deleted) notified new order. Apply [MEDICATION NAME] daily & prn for irritation of groin & buttock medication ordered tx sheet up dated. Family aware of new order. The nurses' note did not contain a skin assessment for the pressure sore. The note did not document the family or physician had been informed of the resident having a pressure sore on her left buttocks. On 08/20/14, a 'Daily Skilled Nurse's Note', documented the resident had a rash on her skin on the night shift. No other skin complications were documented. On 08/20/14, the 'Weekly Head to Toe Skin Reviews' were reviewed since the resident's admission. The forms were blank. On 08/20/14 at 12:00 p.m., LPN #1 was observed to provide a skin assessment for the resident. The LPN assessed the pressure sore on the resident's left inner buttock and reported it was a Stage II and measured 0.3 x 0.3 cm. On 08/21/14 at 2:30 p.m., LPN #1 was interviewed regarding the pressure sore she had staged and measured on the 20th. The LPN was asked if she had contacted the physician and family regarding the pressure sore. The LPN reported she had not called either, because the resident already had a physician's orders [REDACTED].
F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide housekeeping and maintenance services.** Based on observation and staff interview, it was determined the facility failed to: a. Ensure the metal bathroom door frame in room #7 was not rusted. This had the potential to affect 4 residents who shared the bathroom per the DON. b. Ensure the door frame in room #10 was not scuffed and dirty. This had the potential to affect 4 residents residing in the rooms sharing the bathroom per the DON. c. Ensure the sinks in rooms #12 and #23 were not rusted around the sink drain. This had the potential to affect 4 residents sharing the sinks in their rooms per the DON. d. Ensure the sink vanity top in room #11 did not have chipped paint and the sink vanity top in room #21 did not have an approximately 24 x 7 inch area of chipped paint. This had the potential to affect 4 residents sharing the sinks with the chipped paint on the counter tops the DON. e. Ensure the wall crevice, on the right side of the sink between the wall and sink vanity in room #21, was free of dirt. This had the potential to affect two residents sharing the vanity per the DON. f. Ensure the free standing bathroom sink in room #31 was securely attached to the wall. This had the potential to affect one resident in the room per the DON. Findings: On 08/20/14 at 10:00 a.m., an observation was made of the following: 1. The metal bathroom door frame in room #7 was observed to have visible rust. 2. The door frame in room #10 was scuffed and dirty. 3. The sinks in rooms #12 and #23 were rusted around the sink drain. 4. The sink vanity top in room #11 had chipped paint and the sink vanity top in room #21 had an area of approximately 24 x 7 inches of chipped paint. 5. The wall crevice, on the right side of the sink, between the wall and sink vanity in room #21, had an area of approximately 1/4 inch x 2 1/2 feet that was covered with dirt. 6. The free standing bathroom sink in room #31 was not securely attached to the wall. On 08/20/14 at 10:55 a.m., a walk through of the facility was conducted with the maintenance supervisor. The findings were revealed and he reported he would take care of the issues.
F 0283 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide proper discharge planning and communication, of the resident's health status and summary of the resident's stay.** **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 a discharge summary was completed after a discharge for one (#14) of six residents sampled for discharge summaries. This had the potential to affect all 62 residents residing in the facility per the 'Resident Census and Conditions of Residents' Report. Findings: The [DIAGNOSES REDACTED]. The admission assessment, dated 04/30/14, documented the resident was severely cognitively impaired and required assistance with all ADLs. The resident's care plan documented the resident required assistance for all ADLs. On 05/20/14, a physician's telephone order, documented, Hospice consult. The June 2014, physician's orders [REDACTED]. On 06/11/14, a physician's telephone order, documented, DC all tube feedings and flushes.comfort measures only. On 06/17/14, a nurses' note documented, Release body to (Name deleted) Funeral Home. There was no discharge summary in the medical record. On 08/19/14 at 11:45 a.m., the DON was interviewed and reported the facility staff typically filled out a discharge summary and send it to the physician for signature. She reported she would attempt to locate the discharge summary. On 08/21/14 at 9:15 a.m., the DON was interviewed and reported she had been unable to locate the discharge summary. She further reported the facility should have completed the discharge summary within 30 days of the resident's discharge.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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.

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) On [DATE], an Immediate Jeopardy situation was determined to exist in regard to the facility's failure to follow their Do Not Resuscitate Policy to initiate CPR when a resident was found to be without V/S and had a full code status. The facility failed to ensure all direct care staff had knowledge of the facility's procedure for identifying residents' CPR status. The facility failed to ensure the code status for each resident was properly identified on the residents' medical record alert page to correlate with the physicians' order. On [DATE] at 1:30 p.m., the Oklahoma State Department of Health was notified and the Immediate Jeopardy situation was verified. At 1:45 p.m., the Administrator, the DON and the RN consultant were informed of the IJ situation. On [DATE] at 5:00 p.m., a plan of removal was accepted. The plan of removal documented the following: Immediate Jeopardy Plan of Removal 1. All CPR/DNR orders were printed and verified with the residents records and their alert page in the front of the chart. 2. All resident rooms will be checked within the next 30 minutes to ensure all name cards on the head of the beds have been removed and placed securely on the inside of the closet door at eye level with the resident's name and appropriate sticker to match their physician's orders [REDACTED]. 3. The Advanced Directive Policy and Procedure will be updated to reflect the following: a. The person finding the resident without vital signs will call out to other staff that there is a Code Blue and then immediately begin chest compressions until a CPR certified person comes to continue CPR with full measures and the CPR emergency chart. b. The chart alert page will be marked with the appropriate DNR or Full Code/CPR stickers. These same stickers will be placed on a name card taped securely to the inside of the resident's closet door at eye level. These stickers will be updated each time a new advanced directive physician's orders [REDACTED]. c. When a change in advanced directive order is reviewed in daily QA meeting, the nurse manager will go and ensure the name card on the resident's closet door has been updated correctly to match the new order. 4. All staff present today will be in-serviced on the new Advanced Directive/DNR policy as noted by 3:30 pm. All other staff will be contacted to come in for an in-service on the DNR/CPR policy and procedure as noted above by 5 pm today. If they are unable to be reached due to illness, being out of town etc, they will be in-serviced immediately prior to coming back to work. 5. The SSD will also monthly review all advanced directive records and orders to ensure all match as a QA check. The facility provided an inservice training for all staff titled, CPR - FULL CODE VERSUS DNR, dated [DATE] and [DATE], with the last inservice ending on [DATE] at 10:30 a.m. The inservice documented the following: CPR AND DNR STICKERS WILL BE PLACED ON THE INSIDE OF EACH RESIDENT'S CLOSET WITH THEIR NAME ON THE CARD. THESE WILL MATCH THEIR physician's orders [REDACTED]. IF YOU FIND SOMEONE WITHOUT VITAL SIGNS AND THEY ARE A FULL CODE DO THE FOLLOWING: a. The person finding the resident without vital signs will call out to other staff that there is a CODE BLUE. b. Then immediately begin chest compressions until a CPR-certified person comes to continue CPR with full CPR measures and the CPR emergency cart. c. CPR cannot be stopped until a physician is notified and orders it to be stopped or emergency personnel arrive and obtain the okay to stop from their physician. The chart alert page will be marked with the appropriate DNR or Full Code/CPR stickers. These same stickers will be placed on a name card taped securely to the inside of the resident's closet door at eye level. These stickers will be updated each time a new advanced directive physician's orders [REDACTED]. When a change in advanced directive order is reviewed in daily QA meeting, the nurse manager will go and ensure the name card on the resident's closet door has been updated correctly to match the new order. The last direct care staff had been inserviced on [DATE] at 10:30 a.m. The IJ was removed as of [DATE] at 10:30 a.m., after all direct care staff had been inserviced. The deficiency remained at a level of actual harm that was not immediate jeopardy and was isolated. On [DATE], staff were interviewed regarding knowledge of issues addressed in the inservice. The staff were able to verbalize knowledge related to CPR status determination found on the residents' closet door, when finding an unresponsive full code resident and they were to call out a Code Blue, and then immediately start chest compressions. All resident rooms were observed to have the correct CPR status stickers attached to the inside of the closet doors. All the residents' medical records were checked to see if the alert page had the correct sticker to correlate with the physicians' order for code status, and they did. Based on record review, observation and staff interview, it was determined the facility failed to: a) Follow their policy and procedure and initiate CPR for a resident who had a full code status and had been found without vital signs for one (#15) of nine sampled residents who had a full code status. The resident expired without CPR being initiated. This had the potential to affect 38 residents who had full code status, per the facility's 'Order Listing Report'. b) Ensure a system was in place to enable staff to quickly identify a resident's code status so CPR would be initiated immediately if a resident was a full code. c) Ensure the resident's medical record contained, on the alert page, a sticker code which correlated with the resident's physician's orders [REDACTED].#7) of 19 sampled residents. These had the potential to affect all 62 residents. d) Ensure a resident who was admitted with an indwelling urinary catheter, and had no [DIAGNOSES REDACTED].#2) of two sampled residents who had indwelling urinary catheters. This had the potential to affect five other residents who had indwelling urinary catheters. Findings: POLICY: DO NOT RESUSCITATE POLICY STATEMENT: 1. It is the policy of this facility to initiate cardiopulmonary resuscitation (CPR) for residents who suffer unexpected [MEDICAL CONDITION] in this facility. CPR will continue until emergency personnel or a physcian direct the CPR measures to stop. 2. Any exception to this policy requires a signed Do Not Resuscitate (DNR) form by the resident or their legal representative for health care decisions. (Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Rights of the Terminally Ill or Persistently Guardianship and/Conservatorship Act). PROCEDURE: 1. The DON or his/her designee will note on the medical record and communicate to the attending physician a resident's decision for a DNR and that the DNR has been signed appropriately. 2. DNR orders shall be entered in the appropriate form and shall bear the signature of the attending physician. Verbal or telephone orders must be received by a licensed nurse and signed by the attending physician within State licensure requirements. 3. Each resident with a signed DNR form will be identified by a DNR sticker on their chart. 4. The DNR order will be placed on the resident's monthly physician orders, to be signed and reviewed monthly by the physician. 5. A DNR order shall not affect the level of otherwise indicated medical and nursing care the resident receives. All forms of supportive care and pain relief shall be administered as the resident's physician orders [REDACTED]. 6. If the resident is transferred to another health care setting, a copy of the DNR will be sent with the resident to be given to the other health care setting. Review Date [DATE] 1. Resident #15 was admitted to the facility on [DATE]. The resident expired on [DATE]. The resident's medical record, had a 'Full Code' sticker placed on the 'alert' page. Diagnoses for the resident included [MEDICAL CONDITION] and [MEDICAL CONDITION] in situ of prostate. A care plan, dated [DATE], documented, I am a full code as this is my medical choice, I do have a healthcare proxy. Ensure that my choice to be a full code is respected and honored by next review. Please follow my wishes to be a full code and follow protocol if the need was to arise. A quarterly assessment, dated [DATE], documented the resident had a severely impaired mental status, required extensive assistance of one person for bed mobility, dressing and toilet use, required total assistance of two plus persons for transfers, had ROM deficits on both sides of lower extremities, and was always incontinent of bowel and bladder. The [DATE], physician's orders [REDACTED]. The physician's progress note, dated [DATE], documented, Continue to do good. On [DATE] at 8:00 p.m., a nurse's note, documented, Rsd in his rm awake watching his TV. Rsd appears weak and lethargic. Rsd responds to stuff when spoken to.peri-care given. At 8:30 p.m., a nurse's note, documented, Rsd in bed c eyes closed. V/S 96.4 62 ,[DATE] 0 c/o pain, 0 s/sx distress, call light c in reach. At 9:30 p.m., a nurse's note, documented, CMA in rsd room. Rsd alert and CMA gave rsd a drink of water & then he took his medications without any problems. At 10:15 p.m., a nurse's note, documented, Staff enters rm. and comes and finds nurse. Nurse goes into rsd rm. - Rsd has 0 vital signs. At 10:25 p.m., a nurse's note, documented, Nurse notified Director of Nurses & Dr. (Name deleted). At 10:30 p.m., a nurse's note, documented, (Hospice name deleted) notified. Rsd emergency contact (Name deleted) notified. Dtr. request that we wait until she arrives @ facility to call the funeral home. Dtr coming from Tulsa, Okla. At 11:25 p.m., a nurse's note, documented, Hospice (Name deleted) here still waiting for family arrival. At 11:45 p.m., a nurse's note, documented, Dtr here @ facility in rm c rsd. At 12:05 a.m., a nurse's note, documented, Nurse placed call to (Name of Funeral Home deleted). Awaiting arrival of Funeral Home. On [DATE] at 10:40 a.m., the ADON informed the surveyor the resident had been admitted to hospice the day he died . The ADON was asked where the hospice paperwork was located. The ADON said she would call hospice to have them fax the paperwork. At 11:15 a.m., the hospice faxed a form labeled Hospice Admission Service Agreement, dated [DATE]. The form documented the resident wanted to avoid further hospitalization s and did not want CPR. The form said the resident was unable to sign due to being confused, so the healthcare proxy had signed the form. There was no signed DNR form. On [DATE] at 11:45 a.m., the ADON was asked what should the nursing home charge LPN have done when she found the resident without vital signs with a full code status? She stated, She should have initiated a full code. She said if the staff was CPR certified they should have started the CPR. On [DATE] at 12:00 p.m., LPN #3, who was the charge nurse the night the resident expired, was interviewed per telephone. She was asked what had happened the night the resident was found without vital signs. She said the CNAs had begun their rounds to

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She reported sometimes different sections of the chart say one thing and another area says something else pertaining to code status. LPN #3 was asked what she did after she had left the resident's room. She said she had called hospice, the DON and the resident's physician. She stated, I can't remember if I left the doctor a message or talked to him, but I think I left a message. She reported she talked to the physician sometime, but couldn't remember just what time it had been. On [DATE] at 12:15 p.m., CNA #4 was contacted per telephone. CNA #4 was the CNA who had found the resident unresponsive the night he had expired. CNA #4 was asked what had happened the night she had found the resident unresponsive? She replied she had been doing rounds with another CNA when they had found the resident unresponsive. The CNA stated, He wasn't breathing. The CNA reported she called out for LPN #3, who was the charge nurse. The CNA said LPN #3 checked the resident's pulse and stated, He's gone. The CNA was asked if the LPN had started CPR on the resident. The CNA said she didn't know, because she had not stayed in the resident's room. CNA #4 was asked what was the facility's policy if staff found a resident unresponsive and not breathing? She stated, Tell our immediate supervisor. CNA #4 said she herself was CPR certified and had a CPR certification card. On [DATE] at 12:40 p.m., the hospice representative, whose name was on the hospice agreement was called per telephone. The hospice employee was asked what was her title for the hospice agency. She said she was the business manager. She said she had been in the facility in the afternoon of [DATE] (Saturday), to get the paperwork started for the resident to be signed up for hospice services. She said the resident's healthcare proxy had been there to visit the resident at that time. She said the healthcare proxy signed the starting hospice paperwork. The hospice business manager was asked if she had signed the resident up for hospice services the day she was there on [DATE] (Saturday). She said hospice did not have other staff available on the weekends for new admits, so she had gone to start the initial paperwork. She said she would have the hospice social worker return the signed forms on Monday. The hospice business manager was asked if she had told the facility the resident was going on hospice services. She stated she had not talked with any facility staff that day. She said another hospice employee was to come in the next day (Sunday, [DATE]), but the resident had expired before then. On [DATE] at 1:00 p.m., the DON was interviewed. The DON was asked what LPN #3 had told her when she called her the night the resident had expired. The DON stated, She told me (Resident's Name deleted) had passed away. (CNA #4's Name deleted) found him. The DON said she asked her if hospice was there and the CNA told her they had been called. The DON was asked if anything had been mentioned regarding CPR. The DON stated, She didn't mention CPR. She should have started it. On [DATE] at 1:50 p.m., the DON and the ADM were interviewed. They were asked what the staff were taught to do if they found a resident unresponsive. The DON said they were to use the call light and notify the nurse. The DON was asked how did the staff know what code status the residents were. She said on the residents' walls were either green or red dots, signifying each residents' code. She was informed not all the rooms had stickers on the wall for a code. The ADM stated, Sometimes the residents peel the stickers off. 2. Resident #7 had been admitted to the facility on [DATE], with diagnosed including: [DIAGNOSES REDACTED]. A care plan, dated [DATE], documented, 'Problem: Advance Directive: DNR/Living Will.Interventions: Copy of Advance Directive will be in chart. Chart labeled with DNR and Living Will stickers.In case of [MEDICAL CONDITION], do not resuscitate. Notify physician and responsible party of death. A quarterly assessment, dated [DATE], documented the resident was cognitively intact, required limited assistance with bed mobility and transferring between surfaces, dressing and bathing and was not ambulatory. The [DATE], physician's orders [REDACTED]. The [DATE], treatment sheet documented, Advanced Directive DNR-Do Not Resuscitate On two of the pages of the treatment sheets the DNR had been marked out and hand written to say Full Code. The resident's medical record was reviewed. Inside the front cover of the record was an orange sticker that stated, DNR. On [DATE] at 3:00 p.m., the DON was asked if the resident's code status was full code or DNR. The DON reviewed the record and reported when the resident had been admitted to the facility the resident's spouse had requested the resident be a DNR. At 3:30 p.m., the DON reported she had placed a phone call to the spouse. The DON then reported the spouse reported he did not have any paperwork of the resident desiring to be a DNR or a Living Will. On [DATE] at 11:30 a.m., LPN #2 was asked how she determined the resident's code status. The LPN reported she would go to the treatment record or the resident's chart, which ever was closest at the time. The LPN then went to the treatment record and reported the resident was a full code. The LPN then went to the resident's medical record and it had the orange DNR sticker. The LPN was then asked what she would do if the resident coded with this situation. The LPN stated, I would be in a bad position. On [DATE] at 11:00 a.m., the resident's code status had been placed inside the resident's closet. The inside of the resident's closet was observed to say Full Code. The resident was then asked by the surveyor if anyone had talked with her about her code status. The resident reported the facility staff had and she desired to be a full code. 3. Resident #2 had been admitted to the facility on [DATE], with diagnosed including: [DIAGNOSES REDACTED]. On [DATE], an admitting nurses' note, documented, .Stroke affected (R) side. Wt bearing ad lib. Has Foley cath & uses bedside commode for BM. The [DATE], physician's orders [REDACTED]. Check Foley/SP cath & urine q shift.change 2 times monthly & prn. A 14 day assessment, dated [DATE], documented the resident was cognitively intact, required limited assistance with bed mobility, extensive assistance with transferring between surfaces, dressing, hygiene and bathing. The assessment identified the resident as having an indwelling urinary catheter and always being continent of bowel. A care plan, dated [DATE], documented, Problem: The resident has indwelling catheter.Approach: position catheter bag and tubing below the level of the bladder.Monitor/document for pain/discomfort due to catheter. On [DATE] at 10:00 a.m., CNA #1 and CNA #2 were observed providing indwelling catheter care for the resident. On [DATE] at 10:30 a.m., the DON was interviewed regarding the medical justification for the use of the indwelling urinary catheter. The DON reviewed the resident's medical record and reported she did not have a [DIAGNOSES REDACTED]. The DON also reported she would work on getting the catheter discontinued.
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 record reviews, observation, resident and staff interviews, it was determined the facility failed to ensure a resident's call light was answered in a timely manner for one (#12) of 13 residents sampled. This had the potential to affect all 62 residents who needed assistance per the DON. Findings: Resident #12 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The care plan, dated 04/18/14, documented, Risk for falls r/t gait/balance problems.Be sure call light is within reach and encourage the resident to use it for assistance as needed. Check frequently for needs, prompt response to all requests for assistance.Follow facility fall protocol. Placed on Falling Leaves Program. Incident reports, dated from 04/30/14 through 8/11/14, documented the resident had fallen six times. A physicians order, dated 05/09/14, documented, Falling Leaves Program - Every shift look in room frequently as passing by, to see that the resident is not attempting to rise or walk unassisted. A quarterly assessment, dated 06/22/14, documented the resident was cognitively intact, needed limited assistance with bed mobility and transfers and had two falls in the last three months. On 08/19/14 at 12:25 p.m., an observation was made of the resident lying on his side, crossways in his bed. His head near the edge of the bed and his feet hanging off the bed with his W/C next to his bed. The resident motioned for the surveyor to come into the room. He said he needed some help to get in his W/C. The resident's call light was out of reach, so the surveyor turned the call light on to get help for the resident. There were no aides visible, but there were two nurses at the nurses' desk at that time. At 12:29 p.m., the resident saw Housekeeper #2 across the hall and called out to her several times. The housekeeper did not respond. The surveyor then told the housekeeper the resident was calling for her. The housekeeper then went into the resident's room. The resident said he needed help to get up. The housekeeper said she could not move him. She told him his call light was on and someone would be there in a little while to help him. There were no aides visible, but there were two nurses at the nurses' desk at that time. At 12:36 p.m., LPN #2, who was monitoring the dining room, wheeled a resident from the dining room to his room on the same hall as resident #12. There were still no aides visible, but the

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F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) two nurses remained at the nurses' desk. At 12:38 p.m., LPN #2 went into the resident's room to answer his call light. The resident's call light went unanswered for 13 minutes. On 08/18/14 at 3:00 p.m., an unidentified alert and oriented resident was interviewed. The resident was asked the timelines of her call light being answered. The resident reported it took a long time to get call lights answered. The resident reported sometimes as long as 30 minutes. On 08/19/14 at 2:00 p.m., 11 residents were present for the group meeting. During the group meeting, the resident's were asked if their call lights were answered in a timely manner. They reported they were not happy with the time it took staff to answer the call lights. They said during the lunch meal was the worst time. On 08/20/14 at 12:20 p.m., the resident was asked if he ever used his call light and how quickly did the staff answer his light. He said he used his light, but he said it would take awhile at lunch time for staff to get there. He said it was worse in the evenings. He said it takes 20 to 30 minutes and sometimes even an hour to get help. On 08/21/14 at 1:25 p.m., LPN #1 was asked what happened if a resident's call light is on and there is not a CNA available to answer it. She said the nurses should go check on the resident. On 08/21/14 at 1:42 p.m., the DON was informed about the resident's call light not being answered. She said the nurses are supposed to check on the residents if the aides aren't available at that time to answer the light.
F 0313 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that residents receive proper treatment and assistive devices to maintain their vision and hearing.** **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 ensure a resident received an eye examination for one (#6) of five sampled residents whose records were reviewed for vision services. This had the potential to affect all 62 residents who may need an eye exam per the 'Resident Census and Conditions of Residents' report. Findings: Resident #6 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A 'Vision and Ocular Health Examination' report, dated 11/01/12, documented, .Assessment: (1) Nuclear sclerotic cats OD (2) Partial [DIAGNOSES REDACTED] OD, likely secondary [MEDICAL CONDITION] (3) Probable dry eye OD > OS, possibly secondary [MEDICAL CONDITION]/Physician Comments: (1) Monitor, Re-examine 12 months A physician's orders [REDACTED]. as needed for eye problems. A quarterly assessment, dated 06/25/14, documented the resident had adequate vision, severely impaired cognition and needed assistance with walking, dressing and hygiene. On 08/18/14 at 5:15 p.m., the resident was observed lying on his bed in his room. He was watching his TV which was located at the foot of his bed. The resident was asked if he had any eye problems. He said his vision was a little fuzzy at a distance. He said it had been awhile since he had an eye exam. On 08/19/14 at 11:15 a.m., the DON was asked if the resident had seen the eye doctor since his appt in 2012. She said she did not know, but would call the Dr.'s office for records. On 08/20/14 at 9:55 a.m., the DON reported she had called the eye Dr.'s office and the resident had not had an eye exam since the one in 2012. She said the Dr.'s office usually calls to schedule the appts, but had missed this resident.
F 0314 **Level of harm -** Minimal harm or potential for 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 record review, observation and staff interview, it was determined the facility failed to ensure the physician was informed of a newly identified pressure sore to obtain a treatment and ensure the pressure sore was properly assessed for one (#2) of two residents sampled for pressure sores. This had the potential to affect three residents per the DON with identified pressure sores. Findings: Resident #2 had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 07/29/14, an admission 'Nurse's Note', documented, .Redness noted under breast & ABD fold. 0 open areas/wounds noted upon assessment. On 07/29/14, a 'Skin Risk Analysis', documented, Contributing Diagnosis: [REDACTED]. Contributing Factors: Limited/Poor Mobility. Braden Scale Risk Score: 17-Low. Final Skin Risk Analysis Score: Low-17. On 07/30/14, a 'Daily Skilled Nurse's Note', documented the resident had a rash under her breast and abdomen on the day and night shifts. A 14 day assessment, dated 08/12/14, documented the resident was cognitively intact, required limited assistance with bed mobility, dressing, hygiene and bathing, had an indwelling urinary catheter, was continent of bowel, was at risk for pressure sores, but did not have a pressure sore at the time of the assessment. On 08/19/14, a 'Daily Skilled Nurse's Note', documented the resident had a rash on her skin on the day and night shift. The August 2014, 'Treatment Sheet', documented, Skin Mgmt: Monitor Skin Integrity weekly on Tuesday, if any skin problems noted document in progress notes, every evening shift every Tue. The form documented the resident's skin had been assessed one time, on the 5th. On 08/19/14 at 10:00 a.m., CNA #1 and CNA #2 were observed providing indwelling urinary catheter care for the resident. The resident was observed to have an open area on her left inner buttock. CNA #2 was asked how long the open area had been on the resident's buttock. The CNA reported the area had been there since admission. On 08/19/14 at 8:00 p.m., a 'Daily Skilled Nurse's Note', documented, Rsd c/o groin & buttocks irritation, Dr. (Name deleted) notified new order. Apply [MEDICATION NAME] daily & prn for irritation of groin & buttock medication ordered tx sheet up dated. Family aware of new order. The nurses' note did not contain a skin assessment for the pressure sore. The note did not document the family or physician had been informed of the resident having a pressure sore on her buttocks. On 08/19/14, a telephone physician's orders [REDACTED]. On 08/20/14, a 'Daily Skilled Nurse's Note', documented the resident had a rash on her skin on the night shift. No other skin complications were documented. On 08/20/14, the 'Weekly Head to Toe Skin Reviews' were reviewed since the resident's admission. The forms were blank. On 08/20/14 at 12:00 p.m., LPN #1 was observed to provide a skin assessment for the resident. The LPN assessed the pressure sore on the resident's left inner buttock and reported it was a Stage II and measured 0.3 x 0.3 cm. On 08/21/14 at 2:30 p.m., LPN #1 was interviewed regarding the pressure sore she had staged and measured on the 20th. The LPN was asked if she had contacted the physician and family regarding the pressure sore. The LPN reported she had not called either, because the resident already had a physician's orders [REDACTED].
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, observation and staff interviews, it was determined the facility failed to ensure restorative orders were performed for two (#3 and #11) of three samples residents with contractures. This had the potential to affect 22 residents identified by the DON who were to receive restorative services. Findings: 1. Resident #3 had [DIAGNOSES REDACTED]. A significant change assessment, dated 07/21/14, documented the resident was moderately cognitively intact, required extensive assistance with transfers, dressing, personal hygiene and bathing. The assessment also documented the resident had impairment on one side of the upper extremities and impairment on both sides of the lower extremities. A care plan, dated 08/11/14, documented, .CONTRACTURES: The resident has contractures of the left arm and hand. The 'August Physicians Orders' documented, .Restorative program-BLE EXERCISES ALL PLANES.3-5 times weekly every day shift.Restorative Program-PROM LUE TO INCREASE FLEXIBILITY WITH THE AFFECTED ARM/SHOULDER 3-5 times weekly every day shift.PROM RUE ONLY-ONLY 4 SETS X 10 REPS TO MAINTAIN STRENGTH & FLEXIBILITY.3-5 TIMES WEEKLY every day shift.TRANSFER ASSIST SCOOTER-RECLINER 3-5 times weekly every day shift.Apply Hand Roll to Left Hand every shift. The 'August Treatment Record' documented, .Restorative program-BLE EXERCISES ALL PLANES.1 SET X 20 REPS 3-5 times weekly every day shift.Restorative Program-PROM LUE TO INCREASE FLEXIBILITY WITH THE AFFECTED ARM/SHOULDER 3-5 times weekly every day shift.PROM RUE ONLY-ONLY 4 SETS X 10 REPS TO MAINTAIN STRENGTH & FLEXIBILITY.3-5 TIMES WEEKLY every day shift.TRANSFER ASSIST SCOOTER-RECLINER 3-5 times weekly every day shift.Apply Hand Roll to Left Hand every shift. 08/19/14, was the only day initialed on the August 2014, treatment record documenting the resident had received the ordered services. The facility's 'RESTORATIVE NURSING POLICY' documented, .The Restorative Aide will complete a Monthly Rehabilitative Nursing Report to DON monthly, noting any residents who are refusing care, no longer requiring care, and/or any problems with current residents receiving care for change in orders. The DON will review the report and make needed changes in the program, as indicated. On 08/19/14 at 12:25 p.m., the resident was observed sitting up in a recliner in her room. No handroll was observed in the resident's (L) hand. During the

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND PARK MANOR	**1307 R D MILLER DRIVE OKMULGEE, OK 74447**

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

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F 0318 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) four days of the survey, the resident was not observed to have a handroll in her (L) hand. On 08/19/14 at 3:10 p.m., RA #1 was interviewed about resident #3 receiving restorative exercises. The RA reported she was not working the resident's hall that day and she also worked as a CNA. She further reported she had worked resident #3's hall this month and either missed the residents restorative care or missed signing the treatment record. On 08/21/14 at 10:25 a.m., the DON was interviewed regarding the facility's restorative policy and procedure and that the resident had not been receiving restorative services as ordered. The DON reported the MDS coordinator talked with the RA's about the services provided. She stated, I don't look at the reports. The DON was also informed that during the four days of the survey, no hand rolls had been observed in the residents (L) hand. The DON reported she would investigate the matter. At 10:30 a.m., the DON reported she had talked with the resident. The DON reported she had been informed by the resident that sometimes the RA will place a hand roll in her (L) hand and others times a hand roll is not placed. The DON stated, I don't know. 2. Resident #11 had [DIAGNOSES REDACTED]. An annual assessment, dated 07/28/14, documented the resident was severely cognitively impaired, required extensive assistance with transfers, dressing, personal hygiene and bathing and had impairment on one side of upper and lower extremities. A care plan, dated 12/15/13, documented .I am at risk of falls due to left side [MEDICAL CONDITION] restorative orders are followed as ordered. The 'August Physicians Orders' documented .Restorative Program-PROM BLE EXERCISES X 2 SETS X 10 REPS 3-5 times weekly every day shift.Restorative Program-PROM BUE EXERCISES X 2 SETS X 10 REPS 3-5X'S WEEKLY every day shift. The 'August Treatment Record' documented .Restorative Program-PROM BLE EXERCISES X 2 SETS X 10 REPS 3-5 times weekly every day shift.Restorative Program-PROM BUE EXERCISES X 2 SETS X 10 REPS 3-5X'S WEEKLY every day shift. There were no days on the August 2014, Treatment Record which had been initialed to indicate the services had been provided. On 08/19/14 at 5:05 p.m., the resident was observed lying in her bed with eyes closed. Fluids at bedside and call light in reach. On 08/20/14 at 11:05 a.m., RA #2 was interviewed regarding the resident receiving restorative services. The RA reported the resident had a contracture to her (L) hand and is supposed to have restorative 3 x's a week. The RA reported she was working another hall but was planning to do restorative care with the resident that day. The RA reported she also worked as a CNA. On 08/21/14 at 10:25 a.m., the DON was interviewed regarding the facility's restorative policy and procedure and that the resident had not been receiving restorative services as ordered. The DON reported the MDS coordinator talked with the RA's about the services provided. She stated, I don't look at the reports.
F 0328 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **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) Ensure a physician's order for the use of [REDACTED]. b.) Ensure a water canister was utilized while O2 was being administered for one (#1) of two of residents sampled who received O2. c) Ensure O2 tubing was dated when initiated for one (#1) of two of residents sampled who received O2. This had the potential to affect 14 residents who received O2 per the DON. Findings: The facility's policy, 'Oxygen Therapy', dated 10/1/13, documented, Oxygen administration units (cannula, mask or neubulizer tubing) is to be changed at least twice per month and documented on the treatment record. All humidifiers are to be disposable and changed when indicated.Always have sufficient distilled water in the humidifier, to prevent a drying effect on the lungs and nasal passages.In an emergency, oxygen may be started without a doctor's order, then the physician can be called for further orders. Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 08/18/14 at 11:20 a.m., during the initial tour, the resident was observed sleeping in her bed. The resident was wearing a nasal cannula. The O2 machine was not running and there was no water canister connected to the machine. The tubing was not dated to ensure when the tubing was applied or changed. On 08/18/14 at 3:45 p.m., the resident was observed coming out of her bathroom pushing her wheeled walker. The resident then got into bed. The resident was breathing deeply with an opened mouth. The CNA covered the resident with a sheet and then left the room. The resident stated to the surveyor, I'm out of breath. I need my oxygen. The resident's call light was turned on. CNA #6 came into the room and the resident asked her to put her oxygen on. The CNA gave the O2 nasal cannula to the resident and turned her O2 machine on to a setting of 3 LPM. There was not a water canister attached to the machine. The CNA was asked if the resident uses her O2 very often. She said she didn't know, because it was the first time she had taken care of her. The medical record was reviewed for a physician's order for the O2. There was no order found. On 08/19/14 at 4:50 p.m., LPN #2 was asked if the resident had a physician's order for her oxygen. She looked and said there wasn't one. She said an order should have been obtained when the resident was admitted , because she had oxygen at that time. The LPN was asked how often the oxygen tubing was changed. She said it was supposed to be changed on the first and 15th of every month. She was asked how the CNAs know what setting to set the resident's O2 on. She said it is usually set on 2-3 liters unless the order says otherwise. She was then asked if the setting should be assumed or should the CNA check with the nurse first. She said the aide should check first. On 08/19/14 at 4:55 p.m., the ADON was informed of the resident receiving O2 without a physician's order. She said the order should have been obtained before being administered. She was asked if the resident's O2 machine should have a water canister attached to humidify the oxygen. She said it should have.
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **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 ensure resident specific behaviors were monitored with appropriate interventions and outcomes for the use of an antipsychotic medication for one (#7) of four sampled residents receiving antipsychotic medications. This had the potential to affect eight residents per the DON receiving antipsychotic medications. Findings: Resident #7 had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An undated care plan documented, Receiving antipsychotic medication, potential for adverse reactions- [MEDICATION NAME] monitor behaviors every shift & document in progress notes if noted. An 'Antipsychotic Use in Dementia Assessment', dated 05/09/14, documented, Reason for antipsychotic initiation: unknown, admitted on med. Resident states started a year ago while at (Name deleted geri-psych unit), no behaviors noted recommend additional clinical assessment. A quarterly assessment, dated 07/21/14, documented the resident was cognitively intact, did not have any mood or behavior symptoms. The assessment also documented the resident required limited assistance with bed mobility, dressing/bathing and was not ambulatory. An antipsychotic medication had been administered the past 7 days. The August 2014, physician's orders [REDACTED]. The physician's orders [REDACTED]. Document in progress notes if observed every shift. The treatment sheet for the above physician's orders [REDACTED]. On 08/18/14 at 5:30 p.m., the resident was observed sitting on the side of her bed, eating her dinner meal. On 08/19/14 at 3:30 p.m., the DON was interviewed. The DON was asked if the facility was monitoring the resident's behavior, what specific interventions the staff was to attempt if specific behaviors were exhibited and the results of the interventions utilized. The DON stated, This is all I have. We used to use sheets that documented behaviors better.
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 record review, observations and staff interviews, it was determined the facility failed to: a) Ensure the dishwasher machine chemicals and temperatures were checked daily for one of one dishwasher located in the dietary department. b) Ensure the temperatures for two of two freezers and two of two refrigerators were monitored and recorded daily. c) Ensure the oven door handle was not coated with a sticky, greasy substance for one of one oven in the dietary department. d) Ensure the ice machine located in the stock room was in good repair and free of a orange colored substance for one of two ice machines used in the dietary department. e) Ensure cross contamination did not occur during meal service while putting condiments onto sandwiches for one of two meals observed. These had the potential to affect all 62 residents identified by the DM as eating from the dietary department. Findings: On 08/18/14 at 9:15 a.m., an initial tour of the

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NAME OF PROVIDER OF SUPPLIER **HIGHLAND PARK MANOR**		STREET ADDRESS, CITY, STATE, ZIP **1307 R D MILLER DRIVE** **OKMULGEE, OK 74447**	

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F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) dietary department was conducted. The following were observed: 1. The dishwasher machine monitoring log was reviewed. The log was blank for August 16th and 17th. On 08/18/14 at 10:00 a.m., the DM was asked to check the dishwasher machine chemicals. The DM checked the machine and it measured 100%. 2. The refrigerator temperature logs were blank for August 16th and 17th, for two refrigerators located in the dietary department. A large walk-in freezer was located in the dry storage area. The temperature logs were observed blank for August 16th and 17th. On 08/19/14 at 10:45 a.m., the DM was interviewed regarding the temperature logs being blank for August 16th and 17th. The DM reported she checked the temperatures when she was in the facility, Mondays thru Fridays, but would take care of the problem for the other two days. 3. One stove/oven was located in the dietary department. The oven door handle was sticky and coated with a greasy substance. 4. An ice machine located in the dry storage area was observed to have a deflector shield that was half disconnected from the machine and contained an orange colored substance which could be removed with a paper towel. 5. On 08/18/14, the dinner meal was observed being served. The menu documented the residents' were to be served submarine sandwiches. The meal was served in a buffet style by the facility. During the observation, the nursing staff serving the sandwiches was observed to take un-gloved hands, lift the top slice of bread and squeeze mayonnaise or mustard onto the bread slices. The staff would then take the plates the sandwich was on and deliver the plates to the different residents occasionally handling different items on the tables and then go back doing the same procedure without washing their hands. On 08/20/14 at 2:00 p.m., the DM was interviewed regarding the sanitation issues in the dietary department. The DM reported she would take care of the problems.
F 0411 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide routine and 24-hour emergency dental care for each 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 ensure a resident received dental services for one (#6) of five sampled residents whose records were reviewed for dental services. This had the potential to affect all 62 residents who may need dental services per the 'Resident Census and Conditions of Residents' report. Findings: Resident #6 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An annual assessment, dated 03/13/14, documented the resident had severely impaired cognition, needed assistance with hygiene and had inflamed or bleeding gums or loose natural teeth. The care plan, dated 03/26/14, documented, .Check with me to see if I am having any problems with my teeth. Observe and report any signs of bleeding, broken teeth or swelling of gums. A social service progress note, dated 04/23/14, documented, Spoke with (Name of resident deleted)sister/POA today. She was asking again about dental. I explained to her his only route would be to sign up for D-Dent or take him to a dentist. On 08/18/14 at 5:15 p.m., the resident was observed lying on his bed in his room. The resident appeared to have a few missing teeth. The resident was asked if he had any problems with his teeth. He said his teeth hurt on the sides of his mouth sometimes. He said he had not seen a dentist since he has been at the facility. He said he had talked to someone about setting up an appointment, but didn't know when it was. On 08/19/14 at 11:15 a.m., the DON was asked if the resident had seen a dentist since he had been at the facility. She said she did not know but would find out. The DON reported the social worker was not working at that time due to family issues. On 08/20/14 at 9:55 a.m., the DON reported she had not found any records where the resident had seen the dentist.
F 0425 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 an antipsychotic medication was administered in the dosage as ordered for one (#13) of four residents sampled for antipsychotic medications. This had the potential to affect eight residents residing in the facility who were receiving antipsychotic medications per the 'Resident Census and Conditions of Residents Report'. The [DIAGNOSES REDACTED]. The admission assessment, dated 07/11/14, documented the resident was severely cognitively impaired and required assistance with all ADL's. The July 2014, monthly physician's orders [REDACTED]. On 08/04/14, physician telephone orders, were received documenting, Risperdal tablet 0.5 mg give one tablet by mouth every 12 hours for 14 administrations, Risperdal tablet 0.5 mg give one tablet by mouth one time a day for seven administrations, Risperdal tablet 0.25 mg give one tablet by mouth one time a day for seven days then dc. The resident's care plan, dated 08/04/14, documented, Decreasing Risperdal to d/c. A review of the August 2014, MARS documented Risperdal tablet 0.5 mg every 12 hours for 14 administrations had been administered, as ordered, from 08/05/14 through 08/11/14. The MAR indicated [REDACTED]. The Risperidal 0.5 mg 1 x day should not have been changed until 08/12/14. The MAR indicated [REDACTED]. The Risperdal 0.25 mg should not have been started until 08/18/14. On 08/20/14 at 8:30 a.m., the DON was interviewed and reported the staff had not administered the medication as ordered by the physician.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**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 ensure: a) A CNA changed dirty gloves before touching clean objects for one (#1) of four sampled residents observed during incontinent care. This had the potential to affect 36 residents occasionally or frequently incontinent of bladder and 11 residents occasionally or frequently incontinent of bowel per the 'Resident Census and Conditions of Residents' report. b) A sign was posted on a resident's door to warn visitors to stop and speak to the nurse before entering the room for one (#1) of one sampled resident identified with[DIAGNOSES REDACTED]. This had the potential to affect all 62 residents per the DON. c) The infection control program included the tracking and trending of micro-organisms, the dates the infections had resolved and a monthly evaluation of the residents' infections and interventions/corrective actions implemented to reduce the infections. This had the potential to affect all 62 residents residing in the facility per the 'Resident Census and Conditions of Residents' report. Findings: The facility's policy on infection control documented, .It is the policy of this facility to establish and maintain an infection control program, which will provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.Each infection will be monitored on the monthly infection control report form along with a copy of their C&S for review of appropriate antibiotic usage, ect.Infection Control Coordinator.duties include:.Conducts surveillance of infections. Evaluates lab reports.Compiles and analyzes surveillance of infections. Monitoring resident care practice with regard to infection control practices.Performs statistical analysis of infections.Gathers information on each infection and develops the monthly surveillance reports.During the course of providing care for a resident, change gloves after having contact with infective material that may contain high concentrations of microorganisms, wound drainage.Attach the appropriate isolation door signs to the outside of the resident's room door. 1. Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The care plan, dated 08/13/14, documented, The resident has [DIAGNOSES REDACTED]icile.Ensure isolation precautions are posted and all visitors see charge nurse before entering room. On 08/18/14 at 11:20 a.m., during the initial tour, the resident was observed sleeping in her bed. A small two drawer cabinet was observed outside the resident's door. The cabinet contained gowns, gloves and red biohazard bags. There was a trashcan and cardboard box with red biohazard bags in them. There was not a sign on the resident's door to inform visitors that isolation precautions were in place. On 08/18/14 at 3:45 p.m., an observation was made of CNA #1 assisting the resident with pericare. The resident came out of her bathroom and stood beside her bed. The resident voiced that she wanted to do her own pericare. The CNA took the used brief, which was wet with urine, and with both hands folded the brief and put it in the biohazard trash. She then gave the resident two wet cloths with peri-wash on them, one at a time. The resident cleaned her peri-area with each one and gave them back to the CNA. The CNA each time would take the soiled cloths and deposit them into the biohazard red bag for laundry. The CNA then gave the resident, with the same hand, a clean wet cloth to rinse. The resident used the cloth and gave it back to the CNA. The CNA gave the resident a clean, dry wash cloth to dry. The resident returned the cloth to the CNA and she put it in the laundry box. The CNA then picked up a clean brief and assisted the resident with putting it on. The resident then got in bed and the CNA pulled the sheet up over the resident's body. The CNA then pulled the privacy curtain back, took her gloves off and then washed her hands. The CNA did not change her gloves after touching the soiled items and before touching the clean items. On 08/19/14 at 9:30 a.m., LPN #2 was asked how visitors knew when a resident was under isolation precautions. She said they see the sign on the door and talk to a nurse. On 08/19/14 at 9:33 a.m., the DON was informed about the resident's room not having a sign to inform visitors to speak with the nurse before entering the resident's room. She said a sign should have been posted on the resident's door when the resident first arrived from the hospital. On 08/20/14 at 4:20 p.m., the DON was informed of the cross-contamination observed during the personal care. She said the CNA

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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 -** Many	(continued... from page 6) should have changed her gloves after touching the soiled brief and cloths. 2. The infection control program was reviewed. The monthly surveillance did not include the micro-organisms involved in the infections, including lab and C&S reports and the dates the infections were resolved. The surveillance did not include a monthly analysis and documentation of interventions or corrected actions, such as inservices given to resolve the spread of infection. On 08/21/14 at 11:15 a.m., the Infection Control Coordinator/ADON was asked how she monitored which microorganisms were present in the facility. She said she looked at the labs, but she just hadn't been identifying the organism nor tracking and trending them. She was asked why she wasn't identifying the date the infection was resolved for each resident. She said she just assumed it was resolved when the antibiotics were finished. She was asked if she did monthly evaluations on the infections in the facility and include the corrective actions which were implemented. She said she did not do monthly evaluations, but did conduct inservices concerning infection control. She said she had not documented or included them with her infection control monitoring.
F 0490 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, it was determined the facility administration failed to identify a system failure which resulted in the facility's failure to: a) Follow their policy and procedure and initiate CPR for a resident who had a full code status and had been found without vital signs for one (#15) of nine sampled residents who had a full code status. The resident expired without CPR being initiated. b) Ensure a system was in place to enable staff to quickly identify a resident's code status so CPR would be initiated immediately if a resident was a full code. c) Ensure the resident's medical record contained, on the alert page, a sticker code which correlated with the resident's physician's orders [REDACTED].#7) of 19 sampled residents. This had the potential to affect all 62 residents. This resulted in an Immediate Jeopardy situation. Please refer to F309.
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, observation and staff interview, it was determined the facility failed to ensure physician ordered laboratory tests were obtained for one (#7) of 13 sampled residents. This had the potential to affect 31 residents with laboratory tests ordered in July 2014, per the DON. Findings: Resident #7 had been admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 05/16/14, a care plan documented, Focus: [DIAGNOSES REDACTED]. Monitor/document for side effects and effectiveness.Fasting Serum Blood Sugar as ordered by doctor. On 05/19/14, a care plan documented, Focus: [DIAGNOSES REDACTED]. On 07/21/14, a quarterly assessment, documented the resident was cognitively intact, did not have any mood or behavior symptoms, required limited assistance with bed mobility, dressing and bathing. The August 2014, physician's orders [REDACTED]. On 08/18/14 at 5:30 p.m., the resident was observed sitting on the side of her bed eating her dinner meal. On 08/19/14, the resident's medical record was reviewed. The record did not contain laboratory reports for the July 2014, TSH or A1C. On 08/19/14 at 12:30 p.m., the medical records clerk was asked if the laboratory test had been obtained. The clerk reported she would call the laboratory and check on the results. At 2:30 p.m., the medical records clerk reported neither the TSH nor the A1C had been obtained.
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 all residents' medical records were complete and accurate for three (#1, 6 and #15) of 15 sampled residents. This had the potential to affect all 62 residents residing in the facility per the DON. Findings: 1. The medical record for resident #15 was a closed record. The resident had expired on [DATE], on the evening shift. While reviewing the resident's closed medical record the TAR was also reviewed for care services. It was observed LPN #3 had initialed the [DATE], TAR, on the 10th, (night shift) that she had checked for proper placement of the resident's relief cushion in his W/C, checked his concave mattress the same night on the same shift, ensured his foot board halo was in proper position, offered him fluids, applied [MEDICATION NAME] skin protectant to his buttocks, performed ROM, repositioned the resident, and floated his heels. The initials were for the same LPN who had been working on [DATE], on the evening shift, the night the resident had passed away before midnight. On [DATE] at 10:30 a.m., the DON was shown the TAR where the LPN had initialed the night of the 10th care she had provided care for the resident. The DON was informed that the 10th was the night after the 9th, when the resident had expired. She was asked if the staff were pre-initialing services before the services were provided. The DON said she did not know. 2. Resident #6 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A quarterly assessment, dated [DATE], documented the resident was severely cognitively impaired, needed limited assistance with ADLs and had impairments on one side of his body. A physician's orders [REDACTED]. with SBA - Follow with wheel chair.AROM/PROM BLE exercises X 1 set X's 20 reps.BUE - grooming w/deodorant, might need cues, hand over hand instructions to understand how it works.Complete X 5 sit to stand from bed w/SBA, ,[DATE] times a weekly every day shift. The 'Restorative Nursing Care' documentation records were reviewed. There was no documentation the resident had received restorative services since [DATE]. On [DATE] at 5:15 p.m., the resident was observed moving himself from a lying position to a sitting position in his bed. He was asked if the staff worked with his range of motion and walking at least three times a week. He said the aides did help him. On [DATE] at 11:55 a.m., the DON was shown the blank pages for restorative documentation. She said the aides should be documenting the restorative services. They have been told to document. On [DATE] at 5:15 p.m., CNA #2 was asked if she provided restorative services for the resident. She said she had worked with the resident. She was asked why she had not documented the services. She said she just got busy and forgot to do it. On [DATE] at 5:35 p.m., CNA #1 was asked if she provided restorative services for the resident. She said she had worked with the resident with his exercises except for the walking portion. She said the resident preferred to walk late in the evenings. She was asked why she had not documented the services. She said she didn't know but should have. On [DATE] at 6:00 p.m., CNA #3 was asked if she provided restorative services for the resident. She said she had assisted the resident with walking. She was asked if she should have documented the services. She said she should have documented that he walked. 3. Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. The care plan, dated [DATE], documented the resident had [MEDICAL CONDITION] and to monitor for symptoms of blood in the stool. The care plan documented the resident needed the assistance of one person for toileting and bathing. The 'CNA Assignment Sheet' ADL forms, dated from [DATE] to [DATE], did not document the resident's BMs or baths. The resident's name was not documented on the forms except for [DATE] and [DATE]. On [DATE] at 3:45 p.m., the resident was observed coming out of her bathroom. The resident was asked if she had been having BMs. She said she had. At 5:46 p.m., the resident was asked if she had a bath since she had been in the facility. She said she has had a bedbath. On [DATE] at 5:15 p.m., CNA #2 was shown the CNA ADL forms with no documentation for the resident. She was asked if the resident has had BMs and baths since she was admitted . She said the resident has had BMs. She said the resident had not had any diarrhea and often takes herself to the restroom, before alerting us. She said the resident had received bedbaths because of being in isolation. She was asked why she had not documented the events. She said she just got busy and forgot to do it. On [DATE] at 4:20 p.m., the DON was shown the CNA ADL forms with no documentation for the resident. She was asked how the nurses know if the resident had been having BMs and baths. She said the CNAs are supposed to document it. She said sometimes the nurses have to ask the CNAs about the residents.