STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375398	A. BUILDING _____ B. WING _____	10/24/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BINGER NURSING HOME	516 NORTH BROADWAY BINGER, OK 73009

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 -** Immediate jeopardy **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** On 10/23/14, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to notify the physician when a change in treatment was necessary; to obtain physician' orders for continued care of the resident's wound; and to notify the physician when the resident's condition began to deteriorate due to lack of necessary care for one (#5) of two sampled residents with pressure ulcers. At 3:30 p.m., the existence of the IJ was verified with the Oklahoma State Department of Health (OSDH). At 3:42 p.m., the administrator, director of nursing (DON), regional DON and quality assurance (QA) nurse were notified of the existence of the IJ. At 5:35 p.m., an acceptable written plan of removal was received. The facility's plan for removal, dated 10/23/2014, documented, Binger Nursing Center 10/23/14. 1. The doctor for the identified resident (#5) will be notified regarding the current wound assessment. He has been notified on 10-23-14 at 1630. 2. A wound care consult will be scheduled for the identified resident. The wound care consultant will be here for evaluation tonight (10-23-14). Occurred at 1730. 3. Nursing staff (licensed staff) will be educated on the requirements for physician notification of changes in wounds on 10-23-14 by midnight. Those employees not able to be educated by this time will not be allowed to return to work until education is complete. 4. Nursing staff will be educated regarding the regulatory requirements for wound identification, assessment, treatment and reporting changes to the physician on 10-23-14 by 12 midnight. Those employees not able to be educated by this time will not be allowed to return to work until the education is complete. 5. The DON will monitor wounds weekly for compliance for a period of no less than 90 days. 6. New/readmissions will be reviewed to ensure continued compliance for a period of no less than 90 days. 7. Physician notification will be reviewed in the daily clinical meeting on an ongoing basis. 8. If unable to obtain orders from the PCP (primary care physician) the medical director will be notified for further instructions. 9. The wound care policy and procedure will be reviewed and updated by 10-24-14 at 12 noon. 10. The results of the audits and monitoring will be presented to the facility QA committee monthly for a period of no less than 90 days. 11. Any identified non-compliance will result in one on one education and progressive disciplinary action. On 10/24/14, three direct care staff members (LPN #1 at 11:45 a.m., LPN #3 at 3:06 p.m. and LPN #4 at 3:13 p.m.) were interviewed. All stated they had been inserviced and were able to verbalize the requirements on physician notification of changes in wounds and regulatory requirements for wound identification, assessment and treatment. The IJ was removed on 10/24/14 at 12:00 midnight, when all direct care staff had been inserviced. The deficient practice remained at a pattern, actual harm that was not an immediate jeopardy. Based on observation, record review and interview, it was determined the facility failed to ensure the physician was notified of the change of a resident's skin status for one (#5) of two sampled residents with pressure ulcers and failed to: ~ obtain clarification of a physician's orders [REDACTED].; ~ obtain post hospital orders which included wound care and ~ notify the physician of a change in status of a resident's knee wound after assessment (a hard white protruding object). The Census and Conditions report, dated 10/23/14, identified three residents with pressure ulcers. Forty-six residents resided in the facility. Findings: The policy, Change in a Resident's Condition or Status, last reviewed/revised on 04/26/11, documented, . Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's condition and/or status. Policy Interpretation and Implementation 1. The Nurse Supervisor will notify the resident's attending physician when. b. There is a significant change in the resident's physical, mental, or psychosocial status. c. There is a need to alter the resident's treatment significantly. f. Deemed necessary or appropriate in the best interest of the resident. The policy, Physician Services, last reviewed/revised on 04/12/12, documented, .Policy Interpretation and Implementation .The resident's attending physician participates in the resident's assessment and care planning, monitoring changes in resident's medical status, and providing consultation or treatment when called by the facility. Resident #5 had [DIAGNOSES REDACTED]. Prior surgeries included a total right knee replacement. The resident assessment, dated 06/25/14, documented the resident was at risk for the development of pressure ulcers. The assessment documented she had a Stage II pressure ulcer on that date, but did not indicated where the pressure ulcer was located. The medical record documented the resident had a pressure ulcer being treated at that time on both her right ankle and right heel. An incident report, dated 09/04/14, documented the resident had a fall which involved the resident's right knee. It was documented there were no apparent injuries or redness noted. A nurse's note, dated 09/05/14 at 10:18 a.m., documented the resident complained of pain. She had a large bruise on her right knee and had swelling to her right knee through her upper thigh. Ice was applied for swelling and new orders were received to x-ray the right knee and lower leg. A nurse's note, dated 09/05/14 at 1:49 p.m., documented the resident complained of knee pain. The x-ray tech (technician) was at the facility at 1:00 p.m. to x-ray the right knee and lower leg. The x-ray tech gave a preliminary report of the right knee being broken. The physician was notified and new orders were received to send the resident to the emergency room . A nurse's note, dated 09/05/14 at 9:51 p.m., documented the resident returned to the facility with new orders to do neurovascular checks every four hours for 48 hours. The notes documented the hard splint to her right leg was intact. A physician's orders [REDACTED]. A nurse's note, dated 09/09/14 at 12:40 p.m., documented the registered nurse (RN) took off the ace wrap to assess the resident's right leg. The nurse documented there were no blisters noted to the right leg; yellowish/purplish discolorations were noted to the right knee area. A significant change assessment, dated 09/15/14, documented the resident's cognition was severely impaired, she did not ambulate and was totally dependent on staff for transfers, dressing, hygiene and bathing. The resident had one fall with major injury and was at risk of developing pressure ulcers. A care plan, initiated on 09/16/14, documented, .Focus (Resident) has a history of falls and is at risk for falls due to cognitive status, and decline mobility 9-5-14 had a fall with a fracture. Goals.(Resident) will attempt to resume usual activities without further incident after fracture heels (sic) through the review date. Interventions.Had a fall with fracture, sent to the hospital, returned later in the evening with a splint on RLE (right lower extremity). 9-17-2014, she has an appt. (appointment) with (orthopedic surgeon) to determine further tx (treatment). A nurse's note, dated 09/17/14 at 12:32 p.m., documented the resident's PCP made rounds at 10:00 a.m. and there were no new orders. The PCP was aware of the resident going to see the orthopedic surgeon that day. A nurse's note, dated 09/17/14 at 4:20 p.m., documented the resident returned to the facility from the orthopedic surgeon's office and there were no new orders. The orthopedic surgeon's office visit note, dated 09/17/14, documented, .HISTORY OF PRESENT ILLNESS: (Resident) is an [AGE] year-old female who presented to the emergency roiagnom on ,[DATE]. She had been found with a mobile x-ray to have an acute [MEDICAL CONDITION] femur. She was splinted and sent home. The patient's family felt that she was not a surgical candidate, nor did the emergency room physician, but she was seen here for change of splint. PHYSICAL EXAMINATION. X-rays demonstrated a [MEDICAL CONDITION] femur with 100% offset. The total knee is in satisfactory position. These are x-rays taken in the office today AP (anterior/posterior) and lateral. The radiological impression is markedly displaced fracture,

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) periprosthetic femur. ADVISEMENT AND PLAN: The patient understands that the only option for any improvement would be surgery. The family has opted for non-surgical approach. Her splint was reapplied today. A new splint was applied anteriorly. We plan to speak with her daughter with regards to possible management. A nurse's note, dated 09/19/14 at 9:05 a.m., documented she was unable to assess under the resident's splint on her right leg due to no orders to take the splint off. A nurse's note, dated 09/24/14 at 9:56 a.m., documented she spoke with the orthopedic surgeon concerning getting the resident up in a reclining geri-chair and to see if they could take the ace wrap off to see the right heel. Orders were received to get the resident up in her geri-chair and to take the ace wrap off twice a week, check the heel, apply skin prep and foam pad, then rewrap. The PCP was notified. A nurse's note, dated 09/24/14 at 10:41 a.m., documented the licensed practical nurse (LPN) unwrapped the right leg from the knee down to the foot. There were no open areas. Skin prep was applied to the right ankle for redness. The right leg was rewrapped. A nurse's note, dated 10/08/14 at 3:02 p.m., documented, while doing residents treatment of [REDACTED]. resident's right ankle is red and is not open, skin prepped around area and applied foam dressing, re wrapped right leg with splint in place, faxed (PCP) in regards to this and (MDS nurse) LPN called wound care nurse and she is to come see resident on her next visit, changed order to assess right leg from twice a week to three times a week, also asked (PCP name) if we could increase pain meds, awaiting any new orders. A physician notification fax, dated 10/08/14 at 3:36 p.m., documented, . Situation: We have orders to take splint & wraps off 2 x weekly. Today when splint was took off she has a noted .7 cm x .8 cm open area on top of (R) (right) knee that has bloody drainage and is tunneling. We have contacted wound care nurse and she is coming to do a visit. Her (R) ankle is very red but not open. Applied a Solosite & foam dressing. She is in terrible pain when we get her up and when we do anything to her leg. She only has order for [MEDICATION NAME] 5/325 (1) PO (by mouth) q (every) 8 (hours) PRN and PRN Tylenol. Any new orders?. (physician's response, dated 10/09/14) C&S (culture and sensitivity) drainage if wound care nurse thinks its infected I'll give antibiotics before C&S return. A physician's telephone order, dated 10/08/14, documented to change order to three times weekly and to remove ace wraps and assess for pressure ulcers, cleanse area on right ankle with normal saline and four by four, apply skin prep, apply Solosite and cover with foam dressing three times weekly and cleanse area on right knee with normal saline, four by four and cover with foam dressing. A physician's telephone order, dated 10/08/14, documented for the wound care nurse to evaluate and treat, change heel and ankle assessment to three times weekly and place Solosite disk to right outside ankle on those days. No documentation was located in the nurses' notes or on the October 2014, treatment sheets of the wound treatments. A care plan, initiated on 10/09/14, documented, .Focus (Resident) has pressure ulcer development r/t (related to) Splint on right knee and ankle. Goals.(Resident) will have intact skin, free of redness, blisters or discoloration by/through review date. Interventions.Administer treatments as ordered and monitor for effectiveness. Follow treatments ordered by physician.Follow facility policies/protocols for the prevention/treatment of [REDACTED]. A nurse's note, dated 10/11/14 at 2:41 p.m., documented, .resident continues to be in pain at 8/10 to right knee. Tylenol 325mg two adm (administered) po. 130pm resident wound care adm to right knee per physician orders. Resident yelling in pain with routine pain med given at noon. Wound to right knee draining bloody yellow ting (sic) drainage. Reposition right knee and rewrapped. 150pm LPN notified (Name) daughter of resident being in constant pain even with routine pain med adm. Daughter agreed to send her to have surgery.new order received and noted to send to ER (emergency room) for eval (evaluation) at (Name) hospital. An emergency room report, dated 10/11/14, documented, .Musculoskeletal.Patient has what appears to be a decubitus to be (sic) medial anterior knee. Pressure to the medial thigh causes purulent drainage from the decubitus concerning for an abscess. Patient has a stage II decubitus to the right ankle/lateral malleolus with no drainage. A hospital history and physical report, dated 10/12/14, documented, .XXX[AGE] year-old female who sustained a distal femur fracture recently and was discharge to home with nursing home placement.She has come back with a wound over her right knee, worsening leg pain and a fever, along with a white blood cell count of 18,000. She is draining pus out of that wound over her knee which is a little concerning , because she has the obvious comminuted distal femur fracture and history of a total knee replacement, according to the medical record, with hardware in the knee. The patient is bedbound. She is nonambulatory, has a history of previous [MEDICAL CONDITION] A hospital physician's consult note, dated 10/13/14, documented, .seen in the office on September 17, 2014, and at that time had a [MEDICAL CONDITION] femur with 100% offset, but no significant displacement otherwise. No flexion deformity and no open wounds. The patient has been treated with just splinting since and presented to the emergency room again today.she was now found with an open wound with a white count of 18,000.They (family members) were contacted again today and (Physician) had told them the possibility that the only way she may have a chance for survival is with an AK (above knee) amputation for immediate mobilization.EXTREMITIES: Right lower extremity demonstrated a markedly deformed distal femur, but it is the proximal end of the fracture site. There is redness and drainage from this wound.CLINICAL IMPRESSION: Open fracture now with some drainage and white count of 18,000. A nurse's note, dated 10/13/14 at 1:21 p.m., documented the resident's daughter explained due to the severity of her mother's infection they were consulting with the orthopedic surgeon about leg amputation. The PCP was to be notified of any possible surgery. A nurse's note, dated 10/14/14 at 3:25 p.m., documented an aerobic culture of the right knee with critical [MEDICATION NAME]-Resistant [MEDICATION NAME] (VRE) was faxed to (hospital). A nurse's note, dated 10/15/14 at 7:49 a.m., documented the resident's daughter stated her mother would not be having surgery. The note documented the doctors at the hospital told her the mother would not make it through surgery. The daughter was told if her mother did have surgery and survived, her quality of life would not be good and it was suggested the resident go back to the nursing home and be placed on hospice. The note documented Hospice would be called after talking to the PCP. A nurse's note, dated 10/15/14 at 11:41 a.m., documented the PCP was informed of the resident's condition in the hospital and the request from the family. New orders were received for hospice to evaluate and treat when the resident returned to the facility. A hospital discharge summary, dated 10/16/14, documented, .FINAL Diagnoses: [REDACTED]. Hospital discharge orders, dated 10/16/14, documented, .Discharge to Nursing home with (Hospice) hospice to follow. Comfort Measures. Pt. (patient) is DNR (do not resuscitate). Give meds per med rec (reconciliation) sheet. Facility Physician to follow. Call for further orders (hand written) Diet as tolerated. The medication reconciliation sheet, dated 10/16/14, documented all medications were discontinued. There were no orders for wound care, splint care or care of the resident's fractured bones. A nursing admission screening/history assessment, effective date 10/16/14, documented the resident's right leg was fractured below the knee. She could bear weight on her right leg and had a wound on the front of her right knee measuring 2 cm x 2 cm x 1.7 cm at a stage III, which was caused by a screw rubbing her knee and a wound on her outer right ankle measuring 2 cm x 1 cm at a stage I caused by pressure. This was electronically signed on 10/18/14. A nurse's note, dated 10/16/14 at 12:30 p.m., documented, Resident back from hospital.new order received and noted. (Hospice) for comfort care and pain control.Right knee has open area 2 x 1.5. Pink around outer area, yellow brownish slough to top part of area, rest of open area red. Tunneling 1.7 in depth by 1.3. Clear bloody drainage. Has scab to the right of wound. No undermining. Cleansed with NSS (normal saline solution) 4x4, applied with gauze 4x4 cover with abd (abdominal) pad and tape. Re wrapped with ace wrap. No open areas to rest of skin. A physician's orders [REDACTED]. On 10/22/14 at 2:30 p.m., the MDS nurse was interviewed. She was asked if the ace wraps were taken off to assess the resident's leg between 09/09/14 and 09/24/14. She stated they did not take the wraps off. She stated they did not obtain an order to take the ace wraps off. At 3:55 p.m., the right knee wound was observed. The DON and the hospice nurse were performing the wound care. The resident was observed in bed with her right leg positioned on a hard splint from just slightly above the knee down to the foot. A pillow was positioned under the resident's lower right leg. The ace wrap had been removed and the indentation from the ace wrap could still be seen on the resident's skin from just above her knee to her toes. A foam pad was observed on the outside of the resident's right ankle. Both the DON and the hospice nurse positioned their hands under the resident's lower leg and slowly lifted the resident's leg, which caused the knee to assume a more flexed position. The resident yelled out in pain, Ohh, that hurts! As long as they held her leg the resident cried out in pain. A wound was observed on the top of her right knee. When the leg was lifted, a moderate amount of serosanguinous fluid ran out of the wound and down the inner side of the resident's knee. It measured 3cm wide by 3cm long. The DON inserted a cotton tipped swab into the wound and more serosanguinous fluid ran out. The wound had a tunneling depth which measured 3cm deep. The bed of the wound was dark beefy red with stings of yellow slough covering the lateral area of the wound. A white curved shaped object was protruding from the lower aspect of the wound approximately 1/2 inch. The DON tapped the white object several times with the cotton swab. The object made a tapping sound. The DON stated she thought the object was part of a bone. She was asked if the physician had been notified about the object. She just shrugged her shoulders. The DON was asked about the hard splint. She stated there was a top half to the splint that fit down over the bottom piece which made the splint more like a cast. She stated the top edge of the splint had been rubbing on the top of the knee and they had been concerned about the

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) development of a pressure ulcer on the knee. She was asked if they had contacted the physician about this concern. She stated she had taken over the DON position after the fracture and had not been told there was a resident with a fracture and a splint in the facility for over a week. She stated she had attempted to contact the orthopedic surgeon but he never returned her call. She stated she had called the PCP but he didn't want to give orders related to the splint and she had called the medical director but he didn't want to give orders on another physician's resident. She was asked if there was any documentation of the phone calls. She stated, No. The DON was asked about the removal of the ace wrap on 09/09/14, without physician's orders [REDACTED]. She stated there were no open areas but the right ankle was getting pink. She was asked about the nurse's note, dated 09/19/14, which documented they were unable to view the skin because they had no orders to remove the ace wrap and splint. The DON stated they still had not received orders to be able to remove the ace wrap and the splint at that time. She was asked about the knee wound, when it was found on 10/08/14. She stated the resident's knee wound was very small when she was admitted to the hospital and returned from the hospital stay with the large knee wound. She stated she thought the wound was possibly caused by a loose screw from the past knee replacement. The DON was asked if the physician had ordered a wound consult after the resident's return from the hospital. She stated, No. She was asked if the facility had talked with the physician about a wound consult. She stated, No. At 3:55 p.m., the regional DON was interviewed. She was asked if the resident was seen by the wound care nurse. She stated there was an order for [REDACTED]. She stated when the resident came back from the hospital she was on hospice. At 5:30 p.m., the medical director (MD) was interviewed. He was asked if he had been contacted by the facility in regard to the resident's leg. He stated he didn't remember being contacted by the facility. The MD stated he had never heard of the resident until that day. He was the physician for the hospice service who had assumed her care. He was asked if he would be managing her wound. He stated, No, just pain. The MD was asked if he, as the medical director, would give orders if the facility told him they were unable to get orders from a resident's PCP. He stated, Yes. That is my job. They just have to call me. On 10/23/14 at 9:30 a.m., the QA nurse was interviewed. She was asked if there were any treatment sheets for the order on 10/08/14, to cleanse the area on the right knee with normal saline, four by fours and cover with foam dressing. At 9:45 a.m., the QA nurse stated the 10/08/14, order to cleanse the knee didn't get transcribed to the treatment sheet, so the treatments didn't get done. At 12:55 p.m., LPN #2 was interviewed. She was asked about the resident's skin assessment that she had performed on 10/04/14. She was asked if there were any indications of the development of a pressure ulcer at that time. She stated there were no indications of a pressure ulcer. She stated she didn't think her wound was a pressure ulcer but thought the screw in her knee caused the wound. The LPN was asked if the resident's right leg should have been unwrapped and her skin assessed between the dates of 09/09/14 through 09/24/14. She stated she thought she told someone but couldn't remember. She stated the MDS nurse would have been the one to take the order and or call. At 1:35 p.m., the regional DON was interviewed. She was asked if there were any readmission orders [REDACTED]. She stated there were no readmission orders [REDACTED] At 2:00 p.m., the resident's PCP was interviewed. He was asked if he had been contacted by the facility to get clarification on the order to maintain the split to the resident's right leg continuously. He stated he would have to look at the resident's chart because he couldn't recall. The PCP stated if they would have called him in the clinic, it would have been documented. The PCP was asked if he had seen the resident's wound. He stated he had not seen the wound. He stated he wanted the orthopedic surgeon to make the decisions in regard to the wound and be involved. The PCP was asked if the facility had contacted him in regard to changing the dressing. He stated he did not recall any other requests for a different dressing change. The PCP was asked if the facility called him for a wound care consult. He stated the facility called him in regard to an open wound. He stated he told the facility to get a culture of the knee wound, before he started her on antibiotics. The PCP stated by the time they got the results she had been sent to the emergency room . He stated he has not been involved in the care of her leg since the resident came back from the hospital. The PCP stated he has not seen the resident since she's been back from the hospital.
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 clinical observation, record review and staff interview, it was determined the facility failed to update and revise care plans to reflect the residents' current status for one (#1) of twelve sampled residents whose records were reviewed for care plans. The Census and Conditions report, dated 10/23/14, identified 46 residents resided in the facility. Findings: The CAA (care area assessment) Summary for resident #1, dated 12/13/13, triggered for pressure ulcers and would be care planned. A physician's orders [REDACTED]. The care plan, dated 06/17/14, failed to address the resident's skin rash and treatments or isolation for scabies. A nurse's note, dated 10/15/14 at 11:35 a.m., documented, resident with increased itching and he has had a rash to back of his ankles for months that we are applying eurax cream daily, He does have areas betwenn (sic) his fingers this AM that appear to look like scabies. Faxed (primary care physician) to see if he wanted resident to be treated for [REDACTED]. A nurse's note, dated 10/15/14 at 12:31 p.m., documented, We were keeping resident in his roomdue (sic) to a rash that looks like scabies. explained to resident that he had a rash and we were taking precautions to prevent it being spread. On 10/20/14 at 8:56 a.m., a tour of hall 300 was conducted. A bedside table was observed outside of the room of resident #1. The table contained isolation equipment: gloves, gowns, masks and shoe covers. There was a biohazard container next to bedside table. The resident was standing in his room, talking with a staff member, who was standing outside of the room. On 10/22/2014 at 2:36 p.m., the minimum data set (MDS) nurse was asked if the rash on the ankles and isolation of resident #1 would be something that would be normally care planned. She stated, Yes, it should have been. I never put it in there, I missed it. She was asked if someone was put in isolation should that be put in the care plan. She stated, I didn't know he was in isolation, I was off three days, he was put in isolation while I was off. That should have been care planned.
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 interview, it was determined the facility failed to ensure a resident's skin was assessed and monitored for one (#1) of two sampled residents in isolation. The facility identified two residents in isolation for scabies. Findings: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The care plan, dated 06/17/14, failed to address the resident's skin rash and treatments. A skin observation tool, dated 09/02/14, documented, .no open areas noted to skin at this time, dry patches of skin to back of ankles, c/o (complained of) itching has eurax cream that is applied daily and he takes [MEDICATION NAME]. A skin observation tool, dated 09/09/14, documented, .no open areas noted to skin, dry skin and dry areas on back of ankles, eurax cream applied daily. The resident assessment, dated 09/12/14, documented the resident had moderately impaired cognition. He had severely impaired vision. He required limited assist with his ADLs (activities of daily living), which included walking in the corridor, locomotion on and off the unit, dressing, and hygiene. A skin observation tool, dated 09/16/14, documented, .Has dry rash areas to right back lower leg, and left lower leg. TMC ([MEDICATION NAME]) cream applied daily. Has sore to right shoulder from scratching. A skin observation tool, dated 09/23/14, documented, .Has numeras (sic) areas to hands, arms, torso, and legs from scratching. Dr (Name deleted) aware. Eurax cream daily. A skin observation tool, dated 09/30/14, documented, .Observations: Has red areas to body from scratching. Has Eruax (sic) cream daily. A skin observation tool, dated 10/7/2014, documented, .residednt (sic) has some bumps and that he scratches. he gets eurax cream daily. A skin observation tool, dated 10/14/14, documented, .no open areas noted, dry skin to back and dry patches of skin to back of both ankles that he scratches, doctor aware and he gets eurax 1% cream daily. A nurse's note, dated 10/15/14 at 11:35 a.m., documented, resident with increased itching and he has had a rash to back of his ankles for months that we are applying eurax cream daily, He does have areas betwenn (sic) his fingers this AM that appear to look like scabies. Faxed (primary care physician) to see if he wanted resident to be treated for [REDACTED]. A physician's orders [REDACTED].o. (by mouth) x (times) 1 days may repeat in 2 weeks, if symptoms persist. A nurse's note, dated 10/15/14 at 12:31 p.m., documented, We

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) were keeping resident in his roomdue (sic) to a rash that looks like scabies. explained to resident that he had a rash and we were taking precautions to prevent it being spread. A nurse's note, dated 10/15/14 at 1:12 p.m., documented, at 7am resident itching and scratching, he does have a rash to body and the doctor is aware. at 8am Benedryl was not effective he is still itching and scratching. A nurse's note, dated 10/15/14 at 10:34 p.m., documented, [MEDICATION NAME] was given this evening to treat for scabies. On 10/20/14 at 8:56 a.m., a tour of hall 300 was conducted. A bedside table was observed outside of the room of resident #1. The table contained isolation equipment: gloves, gowns, masks and shoe covers. There was a biohazard container next to bedside table. The resident was standing in his room, talking with a staff member, who was standing outside of the room. On 10/21/14 at 3:20 p.m., licensed practical nurse (LPN) #1 was asked to describe the rash on resident #1. She stated, It was on the ankles and more on the back, bumpy rash, no blisters on the back. But had them on the sides and head. She was asked what made her think it was scabies. She stated, They were starting between the fingers. She was asked if she documented what the rash looked like anywhere. She stated, I don't know, if so it was under the skin assessment. LPN #1 stated, He'd been scratching for months. He's had a rash on ankles for months, it was a dry rash. He had [MEDICATION NAME], those on the head were only there a couple of days. At 3:25 p.m., the regional DON was shown the nurses notes which asked the primary care physician if he wanted resident #1 put on contact isolation. She was asked if there was an order for [REDACTED]. On 10/22/14 at 2:30 p.m., the director of nursing (DON) was asked if the skin assessments should have been more descriptive. She stated, It does seem to be a little vague. If it were measurable it wasn't measured. It (the rash) should have had some type of measurement. At 2:49 p.m., the DON was asked about the descriptions of the skin in the nurses notes for resident #1. She stated, Yes it is lacking in description, it should have been more descriptive. It's similar to the skin assessments. No care plan for pruritis, scabies or isolation was located in the record. No documentation describing the skin after being placed in isolation and being treated for [REDACTED].
F 0314 **Level of harm** - Immediate jeopardy **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** On 10/23/14, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure assessment, monitoring, physician notification and treatment was obtained for pressure ulcers for one (#5) of two sampled residents with pressure ulcers. At 3:30 p.m., the existence of the IJ was verified with the Oklahoma State Department of Health (OSDH). At 3:42 p.m., the administrator, director of nursing (DON), regional DON and quality assurance (QA) nurse were notified of the existence of the IJ. At 5:35 p.m., an acceptable written plan of removal was received. The facility's plan for removal, dated 10/23/2014, documented, Binger Nursing Center 10/23/14. 1. The doctor for the identified resident (#5) will be notified regarding the current wound assessment. He has been notified on 10-23-14 at 1630. 2. A wound care consult will be scheduled for the identified resident. The wound care consultant will be here for evaluation tonight (10-23-14). Occurred at 1730. 3. Nursing staff (licensed staff) will be educated on the requirements for physician notification of changes in wounds on 10-23-14 by midnight. Those employees not able to be educated by this time will not be allowed to return to work until education is complete. 4. Nursing staff will be educated regarding the regulatory requirements for wound identification, assessment, treatment and reporting changes to the physician on 10-23-14 by 12 midnight. Those employees not able to be educated by this time will not be allowed to return to work until the education is complete. 5. The DON will monitor wounds weekly for compliance for a period of no less than 90 days. 6. New/readmissions will be reviewed to ensure continued compliance for a period of no less than 90 days. 7. Physician notification will be reviewed in the daily clinical meeting on an ongoing basis. 8. If unable to obtain orders from the PCP (primary care physician) the medical director will be notified for further instructions. 9. The wound care policy and procedure will be reviewed and updated by 10-24-14 at 12 noon. 10. The results of the audits and monitoring will be presented to the facility QA committee monthly for a period of no less than 90 days. 11. Any identified non-compliance will result in one on one education and progressive disciplinary action. On 10/24/14, three direct care staff members (LPN #1 at 11:45 a.m., LPN #3 at 3:06 p.m. and LPN #4 at 3:13 p.m.) were interviewed. All stated they had been inserviced and were able to verbalize the requirements on physician notification of changes in wounds and regulatory requirements for wound identification, assessment and treatment. The IJ was removed on 10/24/14 at 12:00 midnight, when all direct care staff had been inserviced. The deficient practice remained at a pattern, actual harm that was not an immediate jeopardy. Based on observation, record review and interview, it was determined the facility failed to ensure assessment and monitoring were performed and the physician was notified of changes; and to recieve treatment orders for pressure ulcers for one (#5) of two sampled residents with pressure ulcers. The facility failed to: ~ assess and monitor the skin of a resident identified at high risk for pressure ulcers, whose fractured leg was wrapped with an ace wrap in a hard splint for 14 days, ~ obtain clarification of a physician's orders [REDACTED]. ~ obtain post hospital orders in regard to wound care, ~ transcribe wound care orders to treatment sheets which resulted in no wound care being performed for three days and ~ notify the physician of a change in status of a resident's knee wound; the protrusion of a hard white object. The Census and Conditions report, dated 10/23/14, identified three residents with pressure ulcers. Forty-six residents resided in the facility. Findings: The policy, Change in a Resident's Condition or Status, last reviewed/revised on 04/26/11, documented, . Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's condition and/or status. Policy Interpretation and Implementation 1. The Nurse Supervisor will notify the resident's attending physician when. b. There is a significant change in the resident's physical, mental, or psychosocial status. c. There is a need to alter the resident's treatment significantly. f. Deemed necessary or appropriate in the best interest of the resident. The policy, Physician Services, last reviewed/revised on 04/12/12, documented, .Policy Interpretation and Implementation 1. The resident's attending physician participates in the resident's assessment and care planning, monitoring changes in resident's medical status, and providing consultation or treatment when called by the facility. The policy, Skin Care & Pressure Ulcer Management Program, provided by the regional DON on 10/23/14 at 5:39 p.m., documented, SKIN CARE & PRESSURE ULCER MANAGEMENT PROGRAM Standard This Skin Care & Pressure Ulcer Management Program describes the interdisciplinary approach to managing pressure ulcers, and uses the nursing process to ensure a comprehensive review. The program relies on evidence-based treatment protocols and standards of practice that focus on two aspects of care: 1. Prevention of pressure ulcer development by promoting healing and preventing infection when breakdown occurs. 2. Treatment that uses a standardized approach to promoting healing and preventing infection when skin breakdown occurs. Objectives Pressure ulcers are a serious concern especially in compromised residents. 1. Prevent pressure ulcers from developing in residents identified as being as risk. 2. Create care plans for residents who are at risk or have already developed pressure ulcers. 3. Identify newly acquired pressure ulcers. 4. Document the change of condition. 5. Provide standardized treatment and interventions that promote pressure ulcer healing and prevent infection. 6. Evaluate the effectiveness of interventions through the care-planning process and make changes, as necessary, to prevent development of additional pressure ulcers. 7. Provide staff education, training, and resources. SECTION 1: ASSESSMENT: IDENTIFYING RESIDENTS AT RISK OF SKIN BREAKDOWN. Time Frame: Before and during the admission process; daily, weekly, monthly and quarterly according to the MDS (minimum data set) assessment schedule; PRN (as needed). If the resident has a pressure ulcer or other wound at the time of admission, treatment begins promptly according to physician orders. SECTION 2: PLANNING, IMPLEMENTATION, AND EVALUATION: CARE PLANNING. Time Frame: Ongoing Developing an Individualized Skin Care Plan Based on the resident's assessment, the Interdisciplinary Team develops an individualized care plan to prevent or treat skin breakdown. Weekly Evaluation A licensed nurse performs head-to-toe skin check of the resident and documents the findings on the Treatment Administration Record (TAR). The licensed nurse documents using the following equations: * Y = skin intact * N = not intact If a licensed nurse documents N, she/he writes a note in the narrative note and wound sheet describing the area. If skin integrity is compromised, the process moves into the wound management phase. The physician and responsible party is notified, a progress note is completed and the care plan is updated with appropriate interventions. SECTION 3: THE Save Our Skin PROGRAM. Time Frame: Ongoing Identifying and Reporting Pressure Ulcers. If the licensed nurse determines that the identified area is a new skin issue, the nurse completes the investigation process described below. Investigation Process Any new skin issue is an incident which requires an investigation to determine the root cause. Follow these steps to investigate a skin issue: 1. Complete a Skin Risk Assessment. 2. Complete a Pain Evaluation form. 3. Complete a Pressure Ulcer Documentation Form to document the status of the pressure ulcer. 4. Notify the physician and responsible party and collaborate on a treatment order. 8. Update the care plan, as applicable. Evaluation Process When a pressure ulcer has been

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	375398	A. BUILDING _____ B. WING _____	10/24/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BINGER NURSING HOME	516 NORTH BROADWAY BINGER, OK 73009

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) identified, reported, and investigated, a licensed nurse completes a thorough evaluation to determine appropriate treatment interventions and updates the resident's plan of care. Resident #5 had [DIAGNOSES REDACTED]. Prior surgeries included a total right knee replacement. The resident assessment, dated 06/25/14, documented the resident was at risk for the development of pressure ulcers. The assessment documented she had a Stage II pressure ulcer on that date, but did not indicated where the pressure ulcer was located. The medical record documented the resident had a pressure ulcer being treated at that time on both her right ankle and right heel. An incident report, dated 09/04/14, documented the resident had a fall which involved the resident's right knee. It was documented there were no apparent injuries or redness noted. A nurse's note, dated 09/05/14 at 10:18 a.m., documented the resident complained of pain. She had a large bruise on her right knee and had swelling to her right knee through her upper thigh. Ice was applied for swelling and new orders were received to x-ray the right knee and lower leg. A nurse's note, dated 09/05/14 at 1:49 p.m., documented the resident complained of knee pain. The x-ray tech (technician) was at the facility at 1:00 p.m. to x-ray the right knee and lower leg. The x-ray tech gave a preliminary report of the right knee being broken. The physician was notified and new orders were received to send the resident to the emergency room . A nurse's note, dated 09/05/14 at 9:51 p.m., documented the resident returned to the facility with new orders to do neurovascular checks every four hours for 48 hours. The notes documented the hard splint to her right leg was intact. A physician's orders [REDACTED]. A nurse's note, dated 09/09/14 at 12:40 p.m., documented the registered nurse (RN) took off the ace wrap to assess the resident's right leg. The nurse documented there were no blisters noted to the right leg; yellowish/purplish discolorations were noted to the right knee area. A significant change assessment, dated 09/15/14, documented the resident's cognition was severely impaired, she did not ambulate and was totally dependent on staff for transfers, dressing, hygiene and bathing. The resident had one fall with major injury and was at risk of developing pressure ulcers. A care plan, initiated on 09/16/14, documented, .Focus (Resident) has a history of falls and is at risk for falls due to cognitive status, and decline mobility 9-5-14 had a fall with a fracture. Goals.(Resident) will attempt to resume usual activities without further incident after fracture heels (sic) through the review date. Interventions.Had a fall with fracture, sent to the hospital, returned later in the evening with a splint on RLE (right lower extremity). 9-17-2014, she has an appt. (appointment) with (orthopedic surgeon) to determine further tx (treatment). A nurse's note, dated 09/17/14 at 12:32 p.m., documented the resident's PCP made rounds at 10:00 a.m. and there were no new orders. The PCP was aware of the resident going to see the orthopedic surgeon that day. A nurse's note, dated 09/17/14 at 4:20 p.m., documented the resident returned to the facility from the orthopedic surgeon's office and there were no new orders. The orthopedic surgeon's office visit note, dated 09/17/14, documented, .HISTORY OF PRESENT ILLNESS: (Resident) is an [AGE] year-old female who presented to the emergency roiagnom on ,[DATE]. She had been found with a mobile x-ray to have an acute [MEDICAL CONDITION] femur. She was splinted and sent home. The patient's family felt that she was not a surgical candidate, nor did the emergency room physician, but she was seen here for change of splint. PHYSICAL EXAMINATION. X-rays demonstrated a [MEDICAL CONDITION] femur with 100% offset. The total knee is in satisfactory position. These are x-rays taken in the office today AP (anterior/posterior) and lateral. The radiological impression is markedly displaced fracture, periprosthetic femur. ADVISEMENT AND PLAN: The patient understands that the only option for any improvement would be surgery. The family has opted for non-surgical approach. Her splint was reapplied today. A new splint was applied anteriorly. We plan to speak with her daughter with regards to possible management. A nurse's note, dated 09/19/14 at 9:05 a.m., documented she was unable to assess under the resident's splint on her right leg due to no orders to take the splint off. A nurse's note, dated 09/24/14 at 9:56 a.m., documented she spoke with the orthopedic surgeon concerning getting the resident up in a reclining geri-chair and to see if they could take the ace wrap off to see the right heel. Orders were received to get the resident up in her geri-chair and to take the ace wrap off twice a week, check the heel, apply skin prep and foam pad, then rewrap. The PCP was notified. A nurse's note, dated 09/24/14 at 10:41 a.m., documented the licensed practical nurse (LPN) unwrapped the right leg from the knee down to the foot. There were no open areas. Skin prep was applied to the right ankle for redness. The right leg was rewrapped. A nurse's note, dated 10/08/14 at 3:02 p.m., documented, while doing residents treatment of [REDACTED]. resident's right ankle is red and is not open, skin prepped around area and applied foam dressing, re wrapped right leg with splint in place, faxed (PCP) in regards to this and (MDS nurse) LPN called wound care nurse and she is to come see resident on her next visit, changed order to assess right leg from twice a week to three times a week, also asked (PCP name) if we could increase pain meds, awaiting any new orders. A physician notification fax, dated 10/08/14 at 3:36 p.m., documented, . Situation: We have orders to take splint & wraps off 2 x weekly. Today when splint was took off she has a noted .7 cm x .8 cm open area on top of (R) (right) knee that has bloody drainage and is tunneling. We have contacted wound care nurse and she is coming to do a visit. Her (R) ankle is very red but not open. Applied a Solosite & foam dressing. She is in terrible pain when we get her up and when we do anything to her leg. She only has order for [MEDICATION NAME] 5/325 (1) PO (by mouth) q (every) 8 (hours) PRN and PRN Tylenol. Any new orders?. (physician's response, dated 10/09/14) C&S (culture and sensitivity) drainage if wound care nurse thinks its infected I'll give antibiotics before C&S return. A physician's telephone order, dated 10/08/14, documented to change order to three times weekly and to remove ace wraps and assess for pressure ulcers, cleanse area on right ankle with normal saline and four by four, apply skin prep, apply Solosite and cover with foam dressing three times weekly and cleanse area on right knee with normal saline, four by four and cover with foam dressing. A physician's telephone order, dated 10/08/14, documented for the wound care nurse to evaluate and treat, change heel and ankle assessment to three times weekly and place Solosite disk to right outside ankle on those days. No documentation was located in the nurses' notes or on the October 2014, treatment sheets of the wound treatments. A care plan, initiated on 10/09/14, documented, .Focus (Resident) has pressure ulcer development r/t (related to) Splint on right knee and ankle. Goals.(Resident) will have intact skin, free of redness, blisters or discoloration by/through review date. Interventions.Administer treatments as ordered and monitor for effectiveness. Follow treatments ordered by physician.Follow facility policies/protocols for the prevention/treatment of [REDACTED]. A nurse's note, dated 10/11/14 at 2:41 p.m., documented, .resident continues to be in pain at 8/10 to right knee. Tylenol 325mg two adm (administered) po. 130pm resident wound care adm to right knee per physician orders. Resident yelling in pain with routine pain med given at noon. Wound to right knee draining bloody yellow ting (sic) drainage. Reposition right knee and rewrapped. 150pm LPN notified (Name) daughter of resident being in constant pain even with routine pain med adm. Daughter agreed to send her to have surgery.new order received and noted to send to ER (emergency room) for eval (evaluation) at (Name) hospital. An emergency room report, dated 10/11/14, documented, .Musculoskeletal.Patient has what appears to be a decubitus to be (sic) medial anterior knee. Pressure to the medial thigh causes purulent drainage from the decubitus concerning for an abscess. Patient has a stage II decubitus to the right ankle/lateral malleolus with no drainage. A hospital history and physical report, dated 10/12/14, documented, .XXX[AGE] year-old female who sustained a distal femur fracture recently and was discharge to home with nursing home placement.She has come back with a wound over her right knee, worsening leg pain and a fever, along with a white blood cell count of 18,000. She is draining pus out of that wound over her knee which is a little concerning , because she has the obvious comminuted distal femur fracture and history of a total knee replacement, according to the medical record, with hardware in the knee. The patient is bedbound. She is nonambulatory, has a history of previous [MEDICAL CONDITION] A hospital physician's consult note, dated 10/13/14, documented, .seen in the office on September 17, 2014, and at that time had a [MEDICAL CONDITION] femur with 100% offset, but no significant displacement otherwise. No flexion deformity and no open wounds. The patient has been treated with just splinting since and presented to the emergency room again today.she was now found with an open wound with a white count of 18,000.They (family members) were contacted again today and (Physician) had told them the possibility that the only way she may have a chance for survival is with an AK (above knee) amputation for immediate mobilization.EXTREMITIES: Right lower extremity demonstrated a markedly deformed distal femur, but it is the proximal end of the fracture site. There is redness and drainage from this wound.CLINICAL IMPRESSION: Open fracture now with some drainage and white count of 18,000. A nurse's note, dated 10/13/14 at 1:21 p.m., documented the resident's daughter explained due to the severity of her mother's infection they were consulting with the orthopedic surgeon about leg amputation. The PCP was to be notified of any possible surgery. A nurse's note, dated 10/14/14 at 3:25 p.m., documented an aerobic culture of the right knee with critical [MEDICATION NAME]-Resistant [MEDICATION NAME] (VRE) was faxed to (hospital). A nurse's note, dated 10/15/14 at 7:49 a.m., documented the resident's daughter stated her mother would not be having surgery. The note documented the doctors at the hospital told her the mother would not make it through surgery. The daughter was told if her mother did have surgery and survived, her quality of life would not be good and it was suggested the resident go back to the nursing home and be placed on hospice. The note documented Hospice would be called after talking to the PCP. A nurse's note, dated 10/15/14 at 11:41 a.m., documented the PCP was informed of the

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F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 5) resident's condition in the hospital and the request from the family. New orders were received for hospice to evaluate and treat when the resident returned to the facility. A hospital discharge summary, dated 10/16/14, documented, .FINAL Diagnoses: [REDACTED]. Hospital discharge orders, dated 10/16/14, documented, .Discharge to Nursing home with (Hospice) hospice to follow. Comfort Measures. Pt. (patient) is DNR (do not resuscitate). Give meds per med rec (reconciliation) sheet. Facility Physician to follow. Call for further orders (hand written) Diet as tolerated. The medication reconciliation sheet, dated 10/16/14, documented all medications were discontinued. There were no orders for wound care, splint care or care of the resident's fractured bones. A nursing admission screening/history assessment, effective date 10/16/14, documented the resident's right leg was fractured below the knee. She could bear weight on her right leg and had a wound on the front of her right knee measuring 2 cm x 2 cm x 1.7 cm at a stage III, which was caused by a screw rubbing her knee and a wound on her outer right ankle measuring 2 cm x 1 cm at a stage I caused by pressure. This was electronically signed on 10/18/14. A nurse's note, dated 10/16/14 at 12:30 p.m., documented, Resident back from hospital.new order received and noted. (Hospice) for comfort care and pain control.Right knee has open area 2 x 1.5. Pink around outer area, yellow brownish slough to top part of area, rest of open area red. Tunneling 1.7 in depth by 1.3. Clear bloody drainage. Has scab to the right of wound. No undermining. Cleansed with NSS (normal saline solution) 4x4, applied with gauze 4x4 cover with abd (abdominal) pad and tape. Re wrapped with ace wrap. No open areas to rest of skin. A physician's orders [REDACTED]. On 10/22/14 at 2:30 p.m., the MDS nurse was interviewed. She was asked if the ace wraps were taken off to assess the resident's leg between 09/09/14 and 09/24/14. She stated they did not take the wraps off. She stated they did not obtain an order to take the ace wraps off. At 3:55 p.m., the right knee wound was observed. The DON and the hospice nurse were performing the wound care. The resident was observed in bed with her right leg positioned on a hard splint from just slightly above the knee down to the foot. A pillow was positioned under the resident's lower right leg. The ace wrap had been removed and the indentation from the ace wrap could still be seen on the resident's skin from just above her knee to her toes. A foam pad was observed on the outside of the resident's right ankle. Both the DON and the hospice nurse positioned their hands under the resident's lower leg and slowly lifted the resident's leg, which caused the knee to assume a more flexed position. The resident yelled out in pain, Ohh, that hurts! As long as they held her leg the resident cried out in pain. A wound was observed on the top of her right knee. When the leg was lifted, a moderate amount of serosanguinous fluid ran out of the wound and down the inner side of the resident's knee. It measured 3cm wide by 3cm long. The DON inserted a cotton tipped swab into the wound and more serosanguinous fluid ran out. The wound had a tunneling depth which measured 3cm deep. The bed of the wound was dark beefy red with stings of yellow slough covering the lateral area of the wound. A white curved shaped object was protruding from the lower aspect of the wound approximately 1/2 inch. The DON tapped the white object several times with the cotton swab. The object made a tapping sound. The DON stated she thought the object was part of a bone. She was asked if the physician had been notified about the object. She just shrugged her shoulders. The DON was asked about the hard splint. She stated there was a top half to the splint that fit down over the bottom piece which made the splint more like a cast. She stated the top edge of the splint had been rubbing on the top of the knee and they had been concerned about the development of a pressure ulcer on the knee. She was asked if they had contacted the physician about this concern. She stated she had taken over the DON position after the fracture and had not been told there was a resident with a fracture and a splint in the facility for over a week. She stated she had attempted to contact the orthopedic surgeon but he never returned her call. She stated she had called the PCP but he didn't want to give orders related to the splint and she had called the medical director but he didn't want to give orders on another physician's resident. She was asked if there was any documentation of the phone calls. She stated, No. The DON was asked about the removal of the ace wrap on 09/09/14, without physician's orders [REDACTED]. She stated there were no open areas but the right ankle was getting pink. She was asked about the nurse's note, dated 09/19/14, which documented they were unable to view the skin because they had no orders to remove the ace wrap and splint. The DON stated they still had not received orders to be able to remove the ace wrap and the splint at that time. She was asked about the knee wound, when it was found on 10/08/14. She stated the resident's knee wound was very small when she was admitted to the hospital and returned from the hospital stay with the large knee wound. She stated she thought the wound was possibly caused by a loose screw from the past knee replacement. The DON was asked if the physician had ordered a wound consult after the resident's return from the hospital. She stated, No. She was asked if the facility had talked with the physician about a wound consult. She stated, No. At 3:55 p.m., the regional DON was interviewed. She was asked if the resident was seen by the wound care nurse. She stated there was an order for [REDACTED]. She stated when the resident came back from the hospital she was on hospice. At 5:30 p.m., the medical director (MD) was interviewed. He was asked if he had been contacted by the facility in regard to the resident's leg. He stated he didn't remember being contacted by the facility. The MD stated he had never heard of the resident until that day. He was the physician for the hospice service who had assumed her care. He was asked if he would be managing her wound. He stated, No, just pain. The MD was asked if he, as the medical director, would give orders if the facility told him they were unable to get orders from a resident's PCP. He stated, Yes. That is my job. They just have to call me. On 10/23/14 at 9:30 a.m., the QA nurse was interviewed. She was asked if there were any treatment sheets for the order on 10/08/14, to cleanse the area on the right knee with normal saline, four by fours and cover with foam dressing. At 9:45 a.m., the QA nurse stated the 10/08/14, order to cleanse the knee didn't get transcribed to the treatment sheet, so the treatments didn't get done. At 12:55 p.m., LPN #2 was interviewed. She was asked about the resident's skin assessment that she had performed on 10/04/14. She was asked if there were any indications of the development of a pressure ulcer at that time. She stated there were no indications of a pressure ulcer. She stated she didn't think her wound was a pressure ulcer but thought the screw in her knee caused the wound. The LPN was asked if the resident's right leg should have been unwrapped and her skin assessed between the dates of 09/09/14 through 09/24/14. She stated she thought she told someone but couldn't remember. She stated the MDS nurse would have been the one to take the order and or call. At 1:35 p.m., the regional DON was interviewed. She was asked if there were any readmission orders [REDACTED]. She stated there were no readmission orders [REDACTED] At 2:00 p.m., the resident's PCP was interviewed. He was asked if he had been contacted by the facility to get clarification on the order to maintain the split to the resident's right leg continuously. He stated he would have to look at the resident's chart because he couldn't recall. The PCP stated if they would have called him in the clinic, it would have been documented. The PCP was asked if he had seen the resident's wound. He stated he had not seen the wound. He stated he wanted the orthopedic surgeon to make the decisions in regard to the wound and be involved. The PCP was asked if the facility had contacted him in regard to changing the dressing. He stated he did not recall any other requests for a different dressing change. The PCP was asked if the facility called him for a wound care consult. He stated the facility called him in regard to an open wound. He stated he told the facility to get a culture of the knee wound, before he started her on antibiotics. The PCP stated by the time they got the results she had been sent to the emergency room . He stated he has not been involved in the care of her leg since the resident came back from the hospital. The PCP stated he has not seen the resident since she's been back from the hospital.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** Based on observation and interview, it was determined the facility failed to ensure one of four clean work rooms were locked. The facility identified two residents who wandered. Findings: An inside environmental tour was conducted on 10/20/14 at 10:30 a.m. The door to the clean work room on Hall 100 had been left open. The drawers to the right of the sink contained four 7.5 ounce bottles of Bye, Bye Odor (a room deodorizer). The label on the deodorizer documented, Keep out of reach of children. On 10/22/14 at 1:22 p.m., the QA (quality assurance) nurse and the regional director of nursing (DON) were shown the bottles of room deodorizer. The QA nurse stated, They are usually kept in the supply closet. I don't know why they are in the clean work room. The regional DON stated, It's not supposed to be that way.
F 0387 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that doctors visit residents regularly, as required.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined the facility failed to ensure a resident was seen by their physician once every 30 days for the first 90 days after admission to the facility for one (#7) of 12 sampled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375398	A. BUILDING _____ B. WING _____	10/24/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BINGER NURSING HOME	516 NORTH BROADWAY BINGER, OK 73009

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 0387 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) residents whose clinical records were reviewed for physicians' visits. The facility identified 29 residents who are seen by physician #1. Findings: Resident #7 was admitted to the facility on [DATE]. Review of the clinical record documented the resident was seen by her physician in October 2013 and December 2013. There was no documentation to show the resident was seen by her physician during the month of November 2013. On 10/21/14 at 12:35 p.m., the director of nursing (DON) was asked to locate the November 2013 physician progress notes [REDACTED]. At 1:35 p.m., the minimum data set (MDS) nurse provided several physician progress notes [REDACTED]. There was no progress note for November 2013. At 1:45 p.m., the regional DON was informed a note for November 2013 was still missing. She stated she would call the physician's office herself. At 2:10 p.m., the regional DON stated, They are all there except November.
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, clinical record review and staff interviews, it was determined the facility failed to: ~ have polices and procedures in place to prevent the spread of infectious diseases and ~ have policies and procedures in place for the isolation of residents treated for [REDACTED].#1) of two sampled residents in isolation for treatment of [REDACTED]. The facility identified two residents in isolation for scabies. The Census and Conditions report, dated 10/23/14, identified 46 residents resided in the facility. Findings: The Centers for Disease Control and Prevention, Scabies Frequently Asked Questions, documented, .What is scabies? scabies is an infestation of the skin by the human itch mite. What is crusted (Norwegian) scabies? Crusted scabies is a severe form of scabies.Persons with crusted scabies are very contagious to other persons and can spread the infestation easily both by direct skin-to skin contact and by contamination of items such as their clothing, bedding, and furniture. What are the signs and symptoms of scabies infestation? The most common signs and symptoms of scabies are intense itching (pruritus), especially at night, and a pimple-like (papular) itchy rash. The itching and rash may affect much of the body or be limited to common sites such as the wrist, elbow, armpit, webbing between the fingers, nipple, penis, waist, belt-line, and buttocks. The rash also can include tiny blisters (vesicles) and scales. How is scabies infestation diagnosed ? [DIAGNOSES REDACTED]. Whenever possible, the [DIAGNOSES REDACTED]. This can be done by carefully removing a mite from the end of its burrow.or by obtaining skin scraping to examine under a microscope for mites.typically fewer than 10-15 mites can present on the entire body of an infested person who is otherwise healthy. However, persons with crusted scabies can be infested with thousands of mites and should be considered highly contagious. Can scabies be treated? Yes.Scabicides to treat human scabies are available only with a doctor's prescription; no over-the-counter (non-prescription) products have been tested and approved for humans. To determine when to [MEDICATION NAME] treatment should be given to reduce the risk of transmission, early consultation should be sought with a health care provider who understands: 1. the type of scabies (i.e. non-crusted vs crusted) to which a person has been exposed;. 4. whether the exposed person works in an environment where he/she would be likely to expose other people during the asymptomatic incubation period. For example, a nurse or caretaker who works in a nursing home or hospital often would be treated [MEDICATION NAME] to reduce the risk of further scabies transmission in the facility. A physician's orders [REDACTED]. WebMD, Eurax Topical, documented, Uses.to treat scabies. Side Effects Worsening skin irritation (such as itching, redness) may occur. If these effects persist or worsen, stop using this medication and tell your doctor or pharmacist promptly. A skin observation tool, dated 10/7/14, documented, .residednt (sic) has some bumps and that he scratches. he gets eurax cream daily. A skin observation tool, dated 10/14/14, documented, .no open areas noted, dry skin to back and dry patches of skin to back of both ankles that he scratches, doctor aware and he gets eurax 1% cream daily. A nurse's note, dated 10/15/14 at 11:35 a.m., documented, resident with increased itching and he has had a rash to back of his ankles for months that we are applying eurax cream daily, He does have areas betwenn (sic) his fingers this AM that appear to look like scabies. Faxed (primary care physician) to see if he wanted resident to be treated for [REDACTED]. A physician's orders [REDACTED].o. (by mouth) x (times) 1 days may repeat in 2 weeks, if symptoms persist. A nurse's note, dated 10/15/14 at 12:31 p.m., documented, We were keeping resident in his roomdue (sic) to a rash that looks like scabies. explained to resident that he had a rash and we were taking precautions to prevent it being spread. A nurse's note, dated 10/15/14 at 1:12 p.m., documented, at 7am resident itching and scratching, he does have a rash to body and the doctor is aware. at 8am Benedryl was not effective he is still itching and scratching. A nurse's note, dated 10/15/14 at 10:34 p.m., documented, [MEDICATION NAME] was given this evening to treat for scabies. On 10/20/14 at 8:56 a.m., a tour of hall 300 was conducted. A bedside table was observed outside of the room of resident #1. The table contained isolation equipment: gloves, gowns, masks and shoe covers. There was a biohazard container next to the bedside table. The resident was standing in his room, talking with a staff member, who was standing outside of the room. On 10/21/14 at 1:55 p.m., the director of nursing (DON), the regional DON and the quality assurance (QA) nurse were interviewed regarding the isolation of resident #1. They were asked if a skin scraping had been conducted to positively identify scabies. The QA nurse stated no skin scraping had been obtained. She stated the resident was constantly scratching. She stated both the resident's physician (the facility's medical director) and another physician looked at the resident. They were asked when the two physicians had looked at the resident. The DON stated it was the previous Wednesday (10/15/14). The DON was asked if there was any documentation that both physicians had looked at the resident. She stated, no. The QA nurse was asked if the facility had a written policy for the isolation of scabies. She stated, no. She stated nursing called the physician with a description of the resident's skin. She was asked how long the resident was to remain in isolation during the treatment. She stated possibly as long as two weeks. The DON stated she had asked the physician as of last Friday (10/17/14), when the resident could come out of isolation but did not have the conversation documented. She stated they were trying to err on the side of caution. They were asked if the facility had policies for other infectious diseases like Methicillin-resistant Staphylococcus aureus (MRSA). They stated, no. The regional DON nurse stated the facility needed a skin scraping and documentation for confirmation of scabies. At 3:25 p.m., the regional DON was shown the nurses notes which asked the primary care physician if he wanted resident #1 put on contact isolation. She was asked if there was an order for [REDACTED].#1. She stated, We don't have any order for isolation. On 10/22/14 at 8:35 a.m., the medication pass was completed with the certified medication aide (CMA) #1. She administered medications to resident #1. An isolation cart was observed outside his room and a biohazard barrel was observed against the wall at the back of the room. As she was placing a paper gown on, she stated she wasn't sure what she was suppose to wear for this isolation. She stated someone had told her a gown, gloves, mask and booties. Some one else had told her just a gown and gloves. She was asked what the facility policy for contact isolation was. She stated, Not sure. She also stated she didn't understand why they had to dress in the hall before entering the room, but had to undress at the back of the room where the biohazard barrel was located and possibly be recontaminated as they walked back through the room to exit the room.
F 0456 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep all essential equipment working safely.** Based on observation and interview, it was determined the facility failed to ensure the kitchen equipment was maintained in good working condition. The dietary manager (DM) identified 46 residents who received their meals from the kitchen. Findings: On 10/20/14 at 8:40 a.m., a tour of the kitchen was conducted. The following observations were made: ~ clear plastic used to line the white shelving in the dry storage room was chipped, cracked and in bad repair, ~ wood was bare and not sealed on the white shelving in the dry storage room, ~ the inside area of the cabinets in the food preparation/two compartment sink area had chipped paint, ~ Formica was missing off of the counter and there was a gap between the backsplash and counter in the food preparation/two compartment sink area, ~ Formica was missing off of the cereal cart, wood was not sealed, ~ Formica was missing off of the serve out window counter, the wood was not sealed and ~ the chemical storage cabinet located above the three compartment sink was not sealed, wood was bare, the door was bent and would not shut properly. At 12:55 p.m., a tour of the kitchen was conducted with the DM. She was in agreement the maintenance items should have been corrected.
F 0465 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**

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F 0465 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) Based on observation and interview, it was determined the facility failed to ensure the physical environment of the kitchen, shower rooms and outside area of the building were maintained in a safe and sanitary manner. The dietary manager identified 46 residents who received their meals from the kitchen. The Census and Conditions report, dated 10/23/14, identified 46 residents resided in the facility. Findings: The policy, Maintenance Service, documented, .The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.Maintaining the building in good repair and free from hazards.Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. Dietary: On 10/20/14 at 8:40 a.m., a tour of the kitchen was conducted. The following observations were made: ~ the wall near the two door reach-in cooler was not finished, the sheet rock was exposed, ~ the wall near the white chest freezer was not finished, the plaster was not sealed, ~ the wall below the three compartment sink had a large hole, ~ the ceiling was not finished in the dish wash area, the plaster was not sealed, ~ a baseboard tile was cracked near the fire suppression system, ~ the metal on the wall in the dish wash area was not secured to the wall, ~ the material was peeling off of the wall in the dish wash area and ~ a hole was in the wall below the dish machine. At 12:55 p.m., a tour of the kitchen was conducted with the DM. She was in agreement the maintenance items should have been corrected. Showers/Outside environment: On 10/20/14 at 11:15 a.m., an outside environmental tour was conducted. The following observations were made: ~ a hole was in the soffit on the southwest corner of the building, ~ a hole was in the soffit outside the break room on the southeast side of the building. The hole was filled with bird nest material. ~ from the northwest corner going east, the second and the fourth soffit boards had holes and gaps. On 10/21/14 at 11:30 a.m., the administrator (adm) was shown the outside of the building. When she observed the damaged soffit boards she stated, Yes, those need to be fixed. On 10/24/14 at 3:00 p.m., the following nonfunctioning showers were observed: ~ Halls 100 and 200 shared shower room both stalls were closed, ~ Halls 300 and 400 shared shower room, one stall worked, one did not. At 3:20 p.m., the adm was asked if the non- working showers needed to be repaired. She stated, Yes. The staff could shower the residents and help with meals much easier.
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 observation, record review and interview, it was determined the facility administration did not have a system in place to function effectively to be able to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings: 1. It was determined the facility failed to ensure assessment and monitoring were performed and the physician was notified of changes; and to recieve treatment orders for pressure ulcers for one (#5) of two sampled residents with pressure ulcers. The facility failed to: ~ assess and monitor the skin of a resident identified at high risk for pressure ulcers, whose fractured leg was wrapped with an ace wrap in a hard splint for 14 days, ~ obtain clarification of a physician's orders [REDACTED]. ~ obtain post hospital orders in regard to wound care, ~ transcribe wound care orders to treatment sheets which resulted in no wound care being performed for three days and ~ notify the physician of a change in status of a resident's knee wound; the protrusion of a hard white object. See F157 and F314. 2. It was determined the facility failed to: ~ have polices and procedures in place to prevent the spread of infectious diseases and ~ have policies and procedures in place for the isolation of residents treated for [REDACTED].#1) of two sampled residents in isolation for treatment of [REDACTED].
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 clinical record review and staff interviews, it was determined the facility failed to ensure: ~ physicians' progress notes were filed in the residents' clinical records for two (#3 and #7) of 12 sampled residents whose clinical records were reviewed for physicians' progress notes, ~ skin conditions were thoroughly described and documented on the weekly skin assessment sheets for one (#1) of 12 sampled residents whose clinical records were reviewed for completeness and accuracy, ~ orders were transcribed to the treatment administration records (TARs) for wound care orders for one (#5) of three sampled residents with wounds and ~ post hospital orders were obtained for one (#5) of three sampled residents who had hospital stays in the last two months. The Census and Conditions report, dated 10/23/14, identified 46 residents resided in the facility. Findings: 1. Resident #7 was admitted to the facility 10/03/13. Review of the clinical record documented progress notes for the months of October 2013, December 2013, February 2014, May 2014 and September 2014. On 10/21/14 at 12:35 p.m., the director of nursing (DON) was asked to locate physician progress notes [REDACTED]. At 1:35 p.m., the minimum data set (MDS) nurse provided several physician progress notes [REDACTED]. She stated, Found all but April. Dr. (Name deleted) only comes every two months not every month like Dr. (Name deleted). The faxed progress notes were reviewed. The only new note provided was for July 2014. At 1:45 p.m., the regional DON was informed there was still a gap in progress notes between February and May 2014. She stated she would call the physician's office herself. At 2:10 p.m., the regional DON stated, They are all there now except November. Surveyor: Cooper, Melissa 2. Resident #3 was readmitted to the facility 02/28/12. Review of the clinical record documented progress notes for the months of December 2013, February 2014, March 2014, April 2014 and September 2014. On 10/21/14 at 8:45 a.m., DON was asked to locate physician progress notes [REDACTED]. At 9:50 a.m., the regional DON was asked to locate physician progress notes [REDACTED]. She provided the June physician progress notes [REDACTED]. 3. Resident #5 was readmitted from the hospital on [DATE]. She had [DIAGNOSES REDACTED]. Prior surgeries included a total right knee replacement. A physician's telephone order, dated 10/08/14, documented to cleanse the area on the right knee with normal saline, four by fours and cover with foam dressing. No documentation was located in the nursing notes or on the October 2014 treatment sheets for the wound treatment. Hospital discharge orders, dated 10/16/14, documented, .Discharge to Nursing home with (hospice name deleted) hospice to follow. Comfort Measures. Pt. (patient) is DNR (do not resuscitate). Give meds (medications) per med rec (reconciliation) sheet. Facility Physician to follow. Call for further orders (hand written) Diet as tolerated. The medication reconciliation sheet documented all medications were discontinued, there were no orders for wound care, splint care or care of the resident's fractured bones. On 10/23/14 at 9:30 a.m., the quality assurance (QA) nurse was interviewed. She was asked if there were any treatment sheets for the order on 10/08/14 to cleanse the area on the right knee with normal saline, four by fours and cover with foam dressing. At 1:35 p.m., the regional DON was interviewed. She was asked if there were any readmission orders [REDACTED]. She stated there were no readmission orders [REDACTED]. 4. Resident #1 was admitted to the facility 11/30/12. Review of the clinical record documented skin assessment sheets for October 2014. A nurse's note, dated 10/15/14 at 11:35 a.m., documented, resident with increased itching and he has had a rash to back of his ankles for months that we are applying eurax cream daily, He does have areas betwenn (sic) his fingers this AM that appear to look like scabies. Faxed (primary care physician) to see if he wanted resident to be treated for [REDACTED]. A physician's orders [REDACTED].o. (by mouth) x (times) 1 days may repeat in 2 weeks, if symptoms persist. A nurse's note, dated 10/15/14 at 12:31 p.m., documented, We were keeping resident in his roomdue (sic) to a rash that looks like scabies. explained to resident that he had a rash and we were taking precautions to prevent it being spread. A nurse's note, dated 10/15/14 at 1:12 p.m., documented, at 7am resident itching and scratching, he does have a rash to body and the doctor is aware. at 8am [MEDICATION NAME] was not effective he is still itching and scratching. A nurse's note, dated 10/15/14 at 10:34 p.m., documented, [MEDICATION NAME] was given this evening to treat for scabies. On 10/22/14 at 2:30 p.m., the DON was asked if the skin assessments should have been more descriptive. She stated, It does seem to be a little vague. If it were measurable it wasn't measured. It (the rash)should have had some type of measurement. No documentation describing the skin after being placed in isolation and being treated for [REDACTED].