STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375117	A. BUILDING _____ B. WING _____	07/23/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAK HILL CARE CENTER	1100 WEST GEORGIA JONES, OK 73049

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 0221 **Level of harm -** Actual harm **Residents Affected -** Few	**Keep each resident free from physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of facility policies and procedures, it was determined the facility failed to ensure a resident was free from restraints without a medical reason for the use of the restraint. Mitten restraints were being held on the resident's wrist with the use of duct tape for one (#3) of three sampled residents reviewed for the use of restraints. Improper use of duct tape resulted in actual harm to the resident. This had the potential to affect three residents who utilized restraints as identified by the facility. Findings: A facility policy and procedure, titled Restraint, documented, Procedure 1. Document alternative measures to restraints that have been utilized and deemed unsuccessful. 2. Complete the Initial Restraint Assessment. 3. Obtain informed consent from the resident (if possible) for the use of the restraint. If the resident is mentally or physically incapable of signing the consent, then a legally responsible party may sign the consent form.Potential risks and benefits of restraint use should be explained to the resident/family. 6. The use/release of the restraint shall be documented every shift on the Restraint Release Record. 7. A Monthly Restraint Assessment will be completed to determine the continued need for the use of the restraint. 8. The use of the restraint must be documented in the resident's Care Plan. 9. Restraint reductions shall be attempted at least two (2) times per year. Resident #3 was admitted to the facility with [DIAGNOSES REDACTED]. A quarterly assessment, dated 05/02/14, documented, severe cognitive impairment for daily decision making skills. The resident was always incontinent of bowel and bladder. He required extensive assistance with transfers, dressing, hygiene, and bathing. A physician's telephone order, dated 11/20/12, documented, Attempt to use hand mitt for prevention of res (resident) picking at wounds on 6-2 off q (every) HS (hour of sleep) 10 pm. A nurse's note, dated 03/02/14, documented, Upon 1st rounds this morning the CNA (certified nursing assistant) (initials omitted) founds (sic) resident c (with) duck (sic) tape wrapped tightly around them. CNA reported to this nurse. This nurse gently removed duck (sic) tape and mittens. Pt (patient) was noted c (with) reddened bruises to B (both) wrist. Pt (patient) was assessed for further injury.appears calm and denies feeling afraid for his safety. Also we did not use mittens on pt (patient) (at) all yesterday (3/1/14). And we did not place mittens on resident prior to leaving last night. An incident report, dated 03/02/14, documented, .Pt (patient) noted c (with) mittens on both hands c (with) purple duck (sic) tape wrapped tightly around them. This nurse removed duck (sic) tape and mittens and noted red bruises on B (both) wrists. A document, dated 03/03/14, titled Report of Nursing Practice Incident, documented, .was reported to of hand mittens taped on with duck (sic) tape. Nurse (name omitted) was last nurse to of been responsible for resident (resident #3). Bruising to both wrist was found due to tightness of tape and use of mittens. A written statement by CNA #1, dated 03/04/14, documented, I did put the duct tape on (resident #3) (on Sat (Saturday) night/Sun (Sunday) MORN (morning) 3/1-3/2 on the 10-6 shift) to keep his mittens in place because he was digging in feces and smearing it on the wall (and) bed. He did this multiple times the night before and I did it to prevent it from reoccurring on this night. The nurse (name omitted) (and) she was aware that I had used duct tape instead of paper tape which had been used with prior incidents to keep on his mittens. A written statement by LPN #1, dated 03/05/14, documented, The CNA (certified nursing assistant) used tape to hold mittens on (resident #3), because he was able to remove them and he would not stop digging in his rectum. I assessed the tape and it was not tight around his wrists, it was moveable. On 07/21/14 at 12:24 p.m., the administrator was asked if he felt the use of duct tape to secure hand mitten restraints was acceptable. He stated, No. At 1:55 p.m., the director of nursing was asked if the use of duct tape to secure hand mittens was the proper application of a restraint. She stated, No, not at all. She stated the Velcro on the hand mittens was worn and not holding. She was then asked what would be a good intervention for hand mittens that had worn Velcro. She stated, Order new ones. She then stated she felt the benefits to utilizing duct tape to secure the hand mittens outweighed the negatives. At 4:00 p.m., the director of nursing was asked if there was documentation of assessments for the use of hand mitten restraints. She stated they did not think the use hand mittens was a restraint. There was no documentation of the hand mittens being monitored as restraints. On 07/23/14 at 12:23 p.m., the primary care physician was asked if use of duct tape to secure hand mittens in place was the proper use of a restraint. He stated, Nothing is to be used with duct tape on it. At 3:45 p.m., LPN #2 was asked if staff were to utilize duct tape and/or any other tape to secure mitten restraints. He stated, No. At 3:51 p.m., LPN #3 was asked if staff were to utilize duct tape and/or any other tape to secure mitten restraints. She stated, No, Velcro. On 07/23/14 at 3:55 p.m., the social services director was asked if staff were to utilize duct tape and/or tape to secure mitten restraints. He stated, No, not our policy. At 3:55 p.m., LPN #4 was asked if staff were to utilize duct tape and/or any other tape to secure mitten restraints. She stated, No.
F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of policies and procedures, it was determined the facility failed to report allegations of abuse to the nurse aide registry for one (#3) of three sampled residents reviewed for abuse. This had the potential to affect all 97 residents who resided in the facility. Findings: A facility policy, titled Abuse-Resident Rights, documented, .The facility shall report allegations of resident abuse, neglect, or misappropriation of the residents' property by certified or licensed personnel to the appropriate certifying body or licensing board. The Administrator and or Director of Nursing will be responsible for reporting to the appropriate state officials. Resident #3 was admitted to the facility with [DIAGNOSES REDACTED]. A quarterly assessment, dated 05/02/14, documented, severe cognitive impairment for daily decision making skills. The resident was always incontinent of bowel and bladder. He required extensive assistance with transfers, dressing, hygiene, and bathing. A physician's telephone order, dated 11/20/12, documented, Attempt to use hand mitt for prevention of res (resident) picking at wounds on 6-2 off q (every) HS (hour of sleep) 10 pm A nurse's note, dated 03/02/14, documented Upon 1st rounds this morning the CNA (certified nursing assistant) (initials omitted) founds (sic) resident c (with) duck (sic) tape wrapped tightly around them. CNA reported to this nurse. This nurse gently removed duck (sic) tape and mittens. Pt (patient) was noted c (with) reddened bruises to B (both) wrist. Pt (patient) was assessed for further injury.appears calm and denies feeling afraid for his safety. Also we did not use mittens on pt (patient) (at) all yesterday (3/1/14). And we did not place mittens on resident prior to leaving last night. An incident report, dated 03/02/14, documented, .Pt (patient) noted c (with) mittens on both hands c (with) purple duck (sic) tape wrapped tightly around them. This nurse removed duck (sic) tape and mittens and noted red bruises on B (both) wrists. A document, dated 03/03/14, titled Report of Nursing Practice Incident, documented, .was reported to of

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 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) hand mittens taped on with duck (sic) tape. Nurse (name omitted) was last nurse to of been responsible for resident (resident #3). Bruising to both wrist was found due to tightness of tape and use of mittens. A written statement by CNA #1, dated 03/04/14, documented, I did put the duct tape on (resident #3) (on Sat (Saturday) night/Sun (Sunday) MORN (morning) 3/1-3/2 on the 10-6 shift) to keep his mittens in place because he was digging in feces and smearing it on the wall (and) bed. He did this multiple times the night before and I did it to prevent it from reoccurring on this night. The nurse (name omitted) (and) she was aware that I had used duct tape instead of paper tape which had been used with prior incidents to keep on his mittens. A written statement by LPN #1, dated 03/05/14, documented, The CNA (certified nursing assistant) used tape to hold mittens on (resident #3), because he was able to remove them and he would not stop digging in his rectum. I assessed the tape and it was not tight around his wrists, it was moveable. On 07/21/14 at 12:24 p.m., the administrator was asked why there was no notification the nurse aide registry for an allegation of abuse done for CNA #1. He stated that the department of human services already sent the notification to the nurse aide registry during a previous investigation. He was then asked if the facility had reported the CNA to the nurse aide registry. He stated, No. He was then asked why she had not been reported to the nurse aide registry. He stated, Only thing I can think of is that she was new.
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of policies and procedures, it was determined the facility failed to follow policies and procedures for allegations of abuse for one (#3) of three sampled residents reviewed for abuse. This had the potential to affect all 97 residents who resided in the facility. Findings: A facility policy, titled Abuse-Resident Rights, documented, .The facility shall report allegations of resident abuse, neglect, or misappropriation of the residents' property by certified or licensed personnel to the appropriate certifying body or licensing board. The Administrator and or Director of Nursing will be responsible for reporting to the appropriate state officials. Resident #3 was admitted to the facility with [DIAGNOSES REDACTED]. A quarterly assessment, dated 05/02/14, documented, severe cognitive impairment for daily decision making skills. The resident was always incontinent of bowel and bladder. He required extensive assistance with transfers, dressing, hygiene, and bathing. A physician's telephone order, dated 11/20/12, documented, Attempt to use hand mitt for prevention of res (resident) picking at wounds on 6-2 off q (every) HS (hour of sleep) 10 pm A nurse's note, dated 03/02/14, documented Upon 1st rounds this morning the CNA (certified nursing assistant) (initials omitted) founds (sic) resident c (with) duck (sic) tape wrapped tightly around them. CNA reported to this nurse. This nurse gently removed duck (sic) tape and mittens. Pt (patient) was noted c (with) reddened bruises to B (both) wrist. Pt (patient) was assessed for further injury.appears calm and denies feeling afraid for his safety. Also we did not use mittens on pt (patient) (at) all yesterday (3/1/14). And we did not place mittens on resident prior to leaving last night. An incident report, dated 03/02/14, documented, .Pt (patient) noted c (with) mittens on both hands c (with) purple duck (sic) tape wrapped tightly around them. This nurse removed duck (sic) tape and mittens and noted red bruises on B (both) wrists. A document, dated 03/03/14, titled Report of Nursing Practice Incident, documented, .was reported to of hand mittens taped on with duck (sic) tape. Nurse (name omitted) was last nurse to of been responsible for resident (resident #3). Bruising to both wrist was found due to tightness of tape and use of mittens. A written statement by CNA #1, dated 03/04/14, documented, I did put the duct tape on (resident #3) (on Sat (Saturday) night/Sun (Sunday) MORN (morning) 3/1-3/2 on the 10-6 shift) to keep his mittens in place because he was digging in feces and smearing it on the wall (and) bed. He did this multiple times the night before and I did it to prevent it from reoccurring on this night. The nurse (name omitted) (and) she was aware that I had used duct tape instead of paper tape which had been used with prior incidents to keep on his mittens. A written statement by LPN #1, dated 03/05/14, documented, The CNA (certified nursing assistant) used tape to hold mittens on (resident #3), because he was able to remove them and he would not stop digging in his rectum. I assessed the tape and it was not tight around his wrists, it was moveable. On 07/21/14 at 12:24 p.m., the administrator was asked why there was no notification the nurse aide registry for an allegation of abuse done for CNA #1. He stated that the department of human services already sent the notification to the nurse aide registry during a previous investigation. He was then asked if the facility had reported the CNA to the nurse aide registry. He stated, No. He was then asked why she had not been reported to the nurse aide registry. He stated, Only thing I can think of is that she was new. At 1:55 p.m., the director of nurses was asked for the disciplinary action/consultations performed for staff involved in investigation of abuse. She stated she had counseled the staff and believed the paperwork was in their personal files. The personal files for LPN #1 and CNA #1 failed to contain any records of disciplinary action or consultation regarding the incident.