STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375316	A. BUILDING ______ B. WING _____	**03/13/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLINGTON HILLS LIVING & REHABILITATION CENTER	**SIXTH & WOODLAND EUFAULA, OK 74432**

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 0224 **Level of harm -** Actual harm **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to implement policies and procedures to prevent neglect for three (#3, #4, and #5) of five sampled residents reviewed for neglect. The facility neglected to respond to resident requests for provision of assistance with toileting. Resident #3 and #4 verbalized being left unattended in a urine soaked and feces soiled bed/chair for an extended period of time. a) During an interview resident #3 stated on two different occasions it had taken the staff so long to answer his call light he had to urinate on himself and finally have a bowel movement (BM) on himself and lay there in urine and feces until the call light was answered. The resident stated it made him feel like the lowest form of human dignity on earth to have to urinate and have a bowel movement on himself and then lie in urine and feces for six hours. The resident stated he did not treat his dogs that way. The resident stated he had cried himself to sleep. b) During an interview resident #4 stated the staff had shut the call light off a few minutes earlier. The resident stated her bottom was very sore from sitting in urine for 5 to 6 hours at a time. With tears in her eyes, the resident stated it went to hours and was very cold sitting in urine that long and no human should be treated that way. The resident stated her bottom was raw from sitting in urine. During observation of incontinent care for resident #4, an open stage II pressure sore was noted on the resident's left upper thigh and a stage I pressure sore was observed on the resident's right upper thigh. A nurse stated the wounds had not been noticed before. c) During an interview resident #5 stated two times he had a BM in the bed. The resident stated, That is embarrassing, have not done that since I was a kid. The resident stated he was left on the bedpan one hour and 45 minutes recently. During an observation resident #5 was assisted to turn. Discoloration was noted on the upper left leg and bottom buttock cheek (light purple, measuring approximately 5 x 10 cm). Multiple scratches with skin break were noted in the discolored area. A nurse observed the area and stated it looked like maybe it was caused by the bedpan. The facility identified nine residents who needed assistance with toileting and 25 incontinent residents as living in the facility. Findings: The facility policy and procedure for resident neglect documented neglect meant failure to provide goods and services necessary to avoid mental anguish. The facility policy and procedure for basic responsibility of call lights documented staff was to never make the resident feel like the staff was too busy to give assistance. The staffing policy provided by the facility documented the following: Census 46-52 day shift=7 staff, Census 53-59 day shift=8 staff, Census 60-66 day shift=9 staff, Census 46-55 afternoon shift =5 staff, Census 56-65 afternoon shift=6 staff, Census 1-42 evening shift=2 staff, Census 43-59 evening shift=3 staff, and Census 60-76 evening shift=4 staff. The facility provided a current list (as of 03/11/15) of 27 residents who were ventilator dependant. The facility provided a current list (as of 03/11/15) of four residents with facility acquired pressure ulcers. The facility provided a current list of nine residents (as of 03/11/15) who needed assistance with toileting. The facility provided a current list (as of 03/11/15) of 25 incontinent residents. 1. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A hospital discharge summary, dated 02/13/15, documented the resident had recurrent urinary tract infections (UTIs) due to pseudomonas, the urinary catheter was removed, and the resident was thought to have prostatis due to the recurrent UTI issue. The discharge summary documented however with all this he has been continent of urine. The certified nurse aide (CNA) care plan, dated 02/13/15, documented the resident was continent of bowel and bladder and used the urinal and bedpan. The admission assessment, dated 02/20/15, documented the resident was not impaired for daily decision making and required assistance with activities of daily living (ADLs). The assessment documented the resident was always continent of bowel and bladder. On 03/11/15 at 10:38 a.m., the respiratory therapist was interviewed regarding the new ventilators. The therapist stated the facility had changed over to the new ventilators about two weeks ago. The therapist stated the new ventilators were a little more sensitive and they alarmed more, especially when a resident talked or coughed. On 03/11/15 at 10:50 a.m., the resident was observed in bed with a tracheotomy in place and a ventilator in use. The resident was able to speak and hold conversation. The resident stated since the facility had changed to the new ventilators about two weeks ago the ventilator alarms went off constantly. The resident stated the CNAs were not able to answer call lights to help with with the urinal or bedpan because the ventilator alarms kept all the call lights going off all the time. The resident stated it was not uncommon to wait at least 30 minutes for someone to answer his call light. On 03/11/15 at 11:00 a.m., CNA #4 was interviewed regarding answering the call light for ventilator residents. The CNA stated the alarms on the new ventilators went off more, they were more sensitive. The CNA stated when the ventilator alarm went off the staff had to go see what the machine said and report to the nurse. On 03/11/15 at 11:10 a.m. CNA #1 was interviewed regarding answering call lights. The CNA stated the new ventilators alarmed constantly. The CNA stated some of the ventilator alarms were hooked into the call light system and made the call lights go off automatically. The CNA stated it was hard for the staff to get their work done because of the ventilator alarms/call lights. The CNA stated there was not enough staff to provide care to the residents. On 03/11/15 at 11:15 a.m., licensed practical nurse (LPN) #1 was asked if it took the staff longer to do routine bed checks for incontinent care and toileting of residents with the high volume of ventilator alarms/call lights going off in the past two weeks. The LPN stated sometimes incontinent care was late. On 03/11/15 at 3:50 p.m., CNA #3 was asked if incontinent care for the residents had been done less frequently in the last two weeks. The CNA stated it was a lot harder with the new ventilators alarming all the time and sometimes the residents had to wait for care. On 03/11/15 at 3:45 p.m., the resident was asked if the length of time it took for his call light to be answered had ever caused him to urinate or have a bowel movement (BM) on himself in the bed. The resident stated the facility never had enough staff and the problem had worsened when they got new ventilators two weeks ago. The resident stated on two different occasions it had taken the staff so long to answer his call light he had to urinate on himself and finally have a BM on himself and laid there in urine and feces until the call light was answered. The resident stated the first time it took staff two hours and the second time it took staff six hours to answer his call light. The resident stated it made him feel like the lowest form of human dignity on earth to have to urinate and have a bowel movement on himself and then lie in urine and feces for six hours. The resident stated he did not treat his dogs that way. The resident stated when the next shift came on duty they came in and asked him why his call light was on. The resident stated he told the staff he had turned the call light on six hours earlier because he needed to urinate. The resident told the staff he had urinated in his bed and finally had a bowel movement on himself and laid there crying for six hours. The resident stated he had cried himself to sleep. On 03/11/15 during a 13 minute time span from 3:40 p.m. until 3:53 p.m., eleven different call lights were observed to be on. The nurse aides were observed going from room to room at a fast pace. During this time ventilator alarms were never silent. On 03/11/15 at 4:00 p.m., the director of nurses (DON) was asked to stand in the hall and observe the staff answering call lights. The DON was informed an observation had been made minutes earlier of 11 call lights going off during a 13 minute time frame. The DON was told a

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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WELLINGTON HILLS LIVING & REHABILITATION CENTER	**SIXTH & WOODLAND EUFAULA, OK 74432**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) resident had complained it took 2 hours on one occasion and 6 hours on another occasion for the call light to be answered. The DON stated, The facility needed more staff. On 03/11/15 at 4:30 p.m., the administrator (ADM) was asked to stand in the hall and observe the staff answering call lights. The ADM was informed an observation had been made minutes earlier of 11 call lights going off during a 13 minute time frame. The ADM was asked if the facility had added any more staff to accommodate the change to the new, more sensitive alarming ventilators. The ADM stated according to the acuity and census of the facility there is staff sufficient to meet the residents' needs. The ADM stated the facility was unique in that it had not only ventilator residents but [MEDICAL TREATMENT] was performed in the facility as well. On 03/12/15 at 3:00 p.m., CNA #5 was interviewed. The CNA stated the call lights and ventilator alarms went off constantly with the new ventilators. The CNA stated the ventilator alarms were hooked into the call lights and when the alarm went off the staff had to go in and see if the resident was okay. The CNA stated this left call lights on for 30 more minutes due to staff having to go check the next alarm and light before care could be completed. The CNA stated part of the job duties for CNAs included getting 300 pound to 500 pound residents out of bed, and getting the [MEDICAL TREATMENT] residents up and taking them to and from the [MEDICAL TREATMENT] room on time. The CNA stated there was just not enough staff to provide care for all the residents. On 03/12/15 at 3:30 p.m., LPN #2 stated she thought the facility needed more help to provide care for the residents. The LPN stated the facility had a busy pace and there were a large number of staff who called in or just did not show up for work. On 03/12/15 at 4:30 p.m., the resident's family member was visiting. The family member stated he came in to visit the resident recently and found him crying and blaming himself due to an incident that had occurred when the resident was lying in urine and feces due to his call light not being answered for six hours. On 03/13/13 at 6:25 a.m., CNA #2 was asked the time frame for answering residents' call lights. The CNA stated the new ventilators alarmed constantly and they did not have enough help. The CNA stated it took longer to do bed checks for incontinent residents and answer call lights for the residents who were able to use a bedpan. The CNA stated the residents were wet longer and it was impossible for staff to get everything done. The CNA was asked if some of the residents were incontinent more due to the longer response time for call lights. The CNA stated some residents who were previously able to use the bedpan or urinal were incontinent. On 03/13/15 at 10:00 a.m., CNA #5 was asked if the resident had ever been incontinent of urine or BM. The CNA stated one time when the resident's call light was answered, the resident was upset and said he had cried himself to sleep waiting on his call light to be answered for 6 hours. The CNA stated the resident was wet with urine from both armpits to his knees and his whole back was covered with BM. The CNA stated she and another staff member took the resident to the shower and cleaned him up. 2. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 12/22/14, documented the resident had the urinary catheter removed on 12/29/14 and was incontinent of bowel and bladder and required extensive assist with incontinent care and toileting. The care plan stated the resident was at risk for skin breakdown due to her need for extensive assistance with care. The admission assessment, dated 12/29/14, documented the resident was not impaired for daily decision making and required assistance with ADLs. The assessment documented the resident had a [MEDICAL CONDITION], was on a ventilator, had a urinary catheter and was incontinent of bowel. On 03/13/15 at 6:00 a.m., the resident was observed in bed, awake, with a tracheotomy and ventilator in place. The resident had audible wheezes with each ventilation. The resident's mucous membranes were pink and the ventilator alarm was sounding. The resident's call light was not on. The resident stated the staff had shut the call light off a few minutes earlier. The resident stated her bottom was very sore from sitting in urine for 5 to 6 hours at a time. The resident stated she did not get her shower the day before and it was her regular shower day. The resident said she did not know why she did not get her shower and the staff always said they were too busy. The resident stated she sat in her chair in urine sometimes up to 5 or 6 hours because the aides all said, I'll be back in a second. With tears in her eyes, the resident stated it goes to hours and it is very cold sitting in urine that long and no human should be treated that way. The resident also stated she liked to be put back to bed at 5 p.m. The resident stated the staff said they were too busy to put her to bed in the evening. The resident stated one night it was 11:45 p.m. and last Saturday night (03/07/15) it was after midnight before they put her to bed. The resident stated her bottom was raw from sitting in urine. On 03/13/15 at 6:20 a.m., CNA #1, CNA #2 and LPN #3 were observed providing incontinent care to the resident. An open stage II pressure sore was noted on the resident's left upper thigh and a stage I pressure sore was observed on the resident's right upper thigh. These sores were located where the buttock meets the upper thigh. LPN #3 stated the wounds had not been noticed before. On 03/13/15 at 6:25 a.m., CNA #1 was asked why the resident did not get her shower the day before. The CNA stated the staff was busy answering call lights, there was just not enough help to get it all done. On 03/13/15 at 2:10 p.m., CNA #2 was asked if she ever worked the evening shift. CNA #2 stated she had worked all three shifts. The CNA was asked if the resident had ever been left in the chair after 5 p.m. The CNA stated sometimes the residents had to sit in the chair until the staff could get to them. On 03/13/15 at 3:00 p.m., LPN #2 stated she had just completed an assessment on the resident's skin and there were more sores on her coccyx. The LPN was asked what interventions were in place to prevent development of pressure sores. The LPN stated there was nothing on the care plan to prevent sores. 3. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 02/18/15, documented the bowel and bladder status would be evaluated and the resident placed on an appropriate toileting schedule. The admission assessment, dated 03/02/15, documented the resident was not impaired for daily decision making and required assistance with ADLS. The assessment documented the resident was continent of bowel and bladder and not at risk for skin breakdown. On 03/13/15 at 9:25 a.m., the resident was observed lying in bed and stated he was doing okay. The resident was asked if he had ever had an accident due to staff not answering the call light timely. The resident stated two times he had a BM in the bed. The resident stated, That is embarrassing, have not done that since I was a kid. The resident stated he was left on the bedpan one hour and 45 minutes recently. The resident was asked if staff gave a reason it took so long to answer the call light. The resident stated the staff just said they were short staffed. The resident was asked if he had any sores on his bottom. The resident stated the staff had said he had some scratches, but he could not reach back there and scratch himself. The resident stated he thought the scratches were from the bedpan being left under him too long. On 03/13/15 at 10:25 a.m., LPN #1 was asked if the resident had wounds. The LPN stated the only wound she was aware the resident had was on his stump. On 03/13/15 at 10:30 a.m., LPN #1 and LPN #2 assisted the resident to turn over to observe the sore place on the buttock. Discoloration was noted on the upper left leg and bottom buttock cheek (light purple, measuring approximately 5 x 10 cm). Multiple scratches with skin break were noted in the discolored area. LPN #2 observed the area and stated it looked like maybe it was caused by the bedpan. On 03/13/15 at 11:52 a.m., CNA #2 was asked if the resident had episodes of incontinence. The CNA stated she had cleaned the resident of BM once. The CNA was asked if the resident had stated why the episode of incontinence happened. The CNA stated, Maybe it was because the staff didn't get to him soon enough when his call light was on. The CNA stated the facility had been really short staffed lately and the residents were not getting the care they needed.
F 0241 **Level of harm -** Actual harm **Residents Affected -** Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to promote care for residents in a manner to maintain dignity for four (#1, #3, #4, and #5) of five sampled residents reviewed for dignity and respect. Resident #3 and #4 verbalized being left unattended in a urine soaked and feces soiled bed/chair for an extended period of time. a) During an interview resident #3 stated on two different occasions it had taken the staff so long to answer his call light he had to urinate on himself and finally have a bowel movement (BM) on himself and lay there in urine and feces until the call light was answered. The resident stated it made him feel like the lowest form of human dignity on earth to have to urinate and have a bowel movement on himself and then lie in urine and feces for six hours. The resident stated he did not treat his dogs that way. The resident stated he had cried himself to sleep. b) During an interview resident #5 stated two times he had a BM in the bed. The resident stated, That is embarrassing, have not done that since I was a kid. The resident stated he was left on the bedpan one hour and 45 minutes recently. During an observation resident #5 was assisted to turn. Discoloration was noted on the upper left leg and bottom buttock cheek (light purple, measuring approximately 5 x 10 cm). Multiple scratches with skin break were noted in the discolored area. A nurse observed the area and stated it looked like maybe it was caused by the bedpan. c) During an interview resident #4 stated the staff had shut the call light off a few minutes earlier. The resident stated her bottom was very sore from sitting in urine for 5 to 6 hours at a time. With tears in her eyes, the resident stated it went to hours and was very cold sitting in urine that long

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F 0241

Level of harm - Actual harm

Residents Affected - Some

(continued... from page 2)
and no human should be treated that way. The resident stated her bottom was raw from sitting in urine. During observation of incontinent care for resident #4, an open stage II pressure sore was noted on the resident's left upper thigh and a stage I pressure sore was observed on the resident's right upper thigh. A nurse stated the wounds had not been noticed before. d) Resident #1 waited 45 minutes to be cleaned up after being incontinent. The facility identified nine residents who required assistance with toileting and 25 incontinent residents. Findings: The facility policy and procedure for basic responsibility of call lights documented staff was to never make the resident feel like the staff was too busy to give assistance. The facility policy and procedure for promoting and maintaining resident dignity documented staff was to respond to requests for assistance in a timely manner. The staffing policy provided by the facility documented the following: Census 46-52 day shift=7 staff, Census 53-59 day shift=8 staff, Census 60-66 day shift=9 staff, Census 46-55 afternoon shift =5 staff, Census 56-65 afternoon shift=6 staff, Census 1-42 evening shift=2 staff, Census 43-59 evening shift=3 staff, and Census 60-76 evening shift=4 staff. The facility provided a current list (as of 03/11/15) of 27 residents who were ventilator dependant. The facility provided a current list of nine residents (as of 03/11/15) who needed assistance with toileting. The facility provided a current list (as of 03/11/15) of 25 incontinent residents. 1. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A hospital discharge summary, dated 02/13/15, documented the resident had recurrent urinary tract infections (UTIs) due to pseudomonas, the urinary catheter was removed, and the resident was thought to have prostatis due to the recurrent UTI issue. The discharge summary documented however with all this he has been continent of urine. The certified nurse aide (CNA) care plan, dated 02/13/15, documented the resident was continent of bowel and bladder and used the urinal and bedpan. The admission assessment, dated 02/20/15, documented the resident was not impaired for daily decision making and required assistance with activities of daily living (ADLs). The assessment documented the resident was always continent of bowel and bladder. On 03/11/15 at 10:38 a.m., the respiratory therapist was interviewed regarding the new ventilators. The therapist stated the facility had changed over to the new ventilators about two weeks ago. The therapist stated the new ventilators were a little more sensitive and they alarmed more, especially when a resident talked or coughed. On 03/11/15 at 10:50 a.m., the resident was observed in bed with a tracheotomy in place and a ventilator in use. The resident was able to speak and hold conversation. The resident stated since the facility had changed to the new ventilators about two weeks ago the ventilator alarms went off constantly. The resident stated the CNAs were not able to answer call lights to help with with the urinal or bedpan because the ventilator alarms kept all the call lights going off all the time. The resident stated it was not uncommon to wait at least 30 minutes for someone to answer his call light. On 03/11/15 at 11:00 a.m., CNA #4 was interviewed regarding answering the call light for ventilator residents. The CNA stated the alarms on the new ventilators went off more, they were more sensitive. The CNA stated when the ventilator alarm went off the staff had to go see what the machine said and report to the nurse. On 03/11/15 at 11:10 a.m. CNA #1 was interviewed regarding answering call lights. The CNA stated the new ventilators alarmed constantly. The CNA stated some of the ventilator alarms were hooked into the call light system and made the call lights go off automatically. The CNA stated it was hard for the staff to get their work done because of the ventilator alarms/call lights. The CNA stated there was not enough staff to provide care to the residents. On 03/11/15 at 11:15 a.m., licensed practical nurse (LPN) #1 was asked if it took the staff longer to do routine bed checks for incontinent care and toileting of residents with the high volume of ventilator alarms/call lights going off in the past two weeks. The LPN stated sometimes incontinent care was late. On 03/11/15 at 3:50 p.m., CNA #3 was asked if incontinent care for the residents had been done less frequently in the last two weeks. The CNA stated it was a lot harder with the new ventilators alarming all the time and sometimes the residents had to wait for care. On 03/11/15 at 3:45 p.m., the resident was asked if the length of time it took for his call light to be answered had ever caused him to urinate or have a bowel movement (BM) on himself in the bed. The resident stated the facility never had enough staff and the problem had worsened when they got new ventilators two weeks ago. The resident stated on two different occasions it had taken the staff so long to answer his call light he had to urinate on himself and finally have a BM on himself and laid there in urine and feces until the call light was answered. The resident stated the first time it took staff two hours and the second time it took staff six hours to answer his call light. The resident stated it made him feel like the lowest form of human dignity on earth to have to urinate and have a bowel movement on himself and then lie in urine and feces for six hours. The resident stated he did not treat his dogs that way. The resident stated when the next shift came on duty they came in and asked him why his call light was on. The resident stated he told the staff he had turned the call light on six hours earlier because he needed to urinate. The resident told the staff he had urinated in his bed and finally had a bowel movement on himself and laid there crying for six hours. The resident stated he had cried himself to sleep. On 03/11/15 during a 13 minute time span from 3:40 p.m. until 3:53 p.m., eleven different call lights were observed to be on. The nurse aides were observed going from room to room at a fast pace. During this time ventilator alarms were never silent. On 03/11/15 at 4:00 p.m., the director of nurses (DON) was asked to stand in the hall and observe the staff answering call lights. The DON was informed an observation had been made minutes earlier of 11 call lights going off during a 13 minute time frame. The DON was told a resident had complained it took 2 hours on one occasion and 6 hours on another occasion for the call light to be answered. The DON stated, The facility needed more staff. On 03/11/15 at 4:30 p.m., the administrator (ADM) was asked to stand in the hall and observe the staff answering call lights. The ADM was informed an observation had been made minutes earlier of 11 call lights going off during a 13 minute time frame. The ADM was asked if the facility had added any more staff to accommodate the change to the new, more sensitive alarming ventilators. The ADM stated according to the acuity and census of the facility there is staff sufficient to meet the residents' needs. The ADM stated the facility was unique in that it had not only ventilator residents but [MEDICAL TREATMENT] was performed in the facility as well. On 03/12/15 at 3:00 p.m., CNA #5 was interviewed. The CNA stated the call lights and ventilator alarms went off constantly with the new ventilators. The CNA stated the ventilator alarms were hooked into the call lights and when the alarm went off the staff had to go in and see if the resident was okay. The CNA stated this left call lights on for 30 more minutes due to staff having to go check the next alarm and light before care could be completed. The CNA stated part of the job duties for CNAs included getting 300 pound to 500 pound residents out of bed, and getting the [MEDICAL TREATMENT] residents up and taking them to and from the [MEDICAL TREATMENT] room on time. The CNA stated there was just not enough staff to provide care for all the residents. On 03/12/15 at 4:30 p.m., the resident's family member was visiting. The family member stated he came in to visit the resident recently and found him crying and blaming himself due to an incident that had occurred when the resident was lying in urine and feces due to his call light not being answered for six hours. On 03/13/13 at 6:25 a.m., CNA #2 was asked the time frame for answering residents' call lights. The CNA stated the new ventilators alarmed constantly and they did not have enough help. The CNA stated it took longer to do bed checks for incontinent residents and answer call lights for the residents who were able to use a bedpan. The CNA stated the residents were wet longer and it was impossible for staff to get everything done. The CNA was asked if some of the residents were incontinent more due to the longer response time for call lights. The CNA stated some residents who were previously able to use the bedpan or urinal were incontinent. On 03/13/15 at 10:00 a.m., CNA #5 was asked if the resident had ever been incontinent of urine or BM. The CNA stated one time when the resident's call light was answered, the resident was upset and said he had cried himself to sleep waiting on his call light to be answered for 6 hours. The CNA stated the resident was wet with urine from both armpits to his knees and his whole back was covered with BM. The CNA stated she and another staff member took the resident to the shower and cleaned him up. 2. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 12/22/14, documented the resident had the urinary catheter removed on 12/29/14 and was incontinent of bowel and bladder and required extensive assist with incontinent care and toileting. The care plan stated the resident was at risk for skin breakdown due to her need for extensive assistance with care. The admission assessment, dated 12/29/14, documented the resident was not impaired for daily decision making and required assistance with ADLs. The assessment documented the resident had a [MEDICAL CONDITION], was on a ventilator, had a urinary catheter and was incontinent of bowel. On 03/13/15 at 6:00 a.m., the resident was observed in bed, awake, with a tracheotomy and ventilator in place. The resident had audible wheezes with each ventilation. The resident's mucous membranes were pink and the ventilator alarm was sounding. The resident's call light was not on. The resident stated the staff had shut the call light off a few minutes earlier. The resident stated her bottom was very sore from sitting in urine for 5 to 6 hours at a time. The resident stated she did not get her shower yesterday and it was her regular shower day. The resident said she did not know why she did not get her shower and the staff always said they were too busy. The resident stated she sat in her chair in urine sometimes up to 5 or 6 hours because the aides all said I'll be back in a second. With tears in her eyes the resident stated it goes to hours and it is very cold sitting in urine that long and no human should be treated that way. The resident also stated she liked

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F 0241 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 3) to be put back to bed at 5 p.m. The resident stated the staff said they were too busy to put her to bed in the evening, one night it was 11:45 p.m. and Saturday night (03/07/15) it was after midnight before they put her to bed. The resident stated her bottom was raw from sitting in urine. On 03/13/15 at 6:20 a.m., CNA #1, CNA#2 and LPN #3 were observed providing incontinent care to the resident. An open stage II pressure sore was noted on the resident's left upper thigh and a stage I pressure sore was observed on the resident's right upper thigh. These sores were located where the buttock meets the upper thigh. LPN #3 stated the wounds had not been noticed before. On 03/13/15 at 6:25 a.m., CNA #1 was asked why the resident did not get her shower the day before. The CNA stated the staff was busy answering call lights, there was just not enough help to get it all done. On 03/13/15 at 2:10 p.m., CNA #2 was asked if she ever worked the evening shift. CNA #2 stated she had worked all three shifts. The CNA was asked if the resident had ever been left in the chair after 5 p.m. The CNA stated sometimes the residents had to sit in the chair until the staff could get to them. 3. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 02/18/15, documented the bowel and bladder status would be evaluated and the resident placed on an appropriate toileting schedule. The admission assessment, dated 03/02/15, documented the resident was not impaired for daily decision making and required assistance with ADLS. The assessment documented the resident was continent of bowel and bladder and not at risk for skin breakdown. On 03/13/15 at 9:25 a.m., the resident was observed lying in bed and stated he was doing okay. The resident was asked if he had ever had an accident due to staff not answering the call light timely. The resident stated two times he had a BM in the bed. The resident stated, That is embarrassing, have not done that since I was a kid. The resident stated he was left on the bedpan one hour and 45 minutes recently. The resident was asked if staff gave a reason it took so long to answer the call light. The resident stated the staff just said they were short staffed. The resident was asked if he had any sores on his bottom. The resident stated the staff had said he had some scratches, but he could not reach back there and scratch himself. The resident stated he thought the scratches were from the bedpan being left under him too long. On 03/13/15 at 11:52 a.m., CNA #2 was asked if the resident had episodes of incontinence. The CNA stated she had cleaned the resident of BM once. The CNA was asked if the resident had stated why the episode of incontinence happened. The CNA stated, Maybe it was because the staff didn't get to him soon enough when his call light was on. The CNA stated the facility had been really short staffed lately and the residents were not getting the care they needed. 4. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 01/21/15 documented a certified nurse aide care plan. A comprehensive care plan including problems, approaches or goals had not been developed. The admission assessment, dated 01/23/15, documented the resident was not impaired for daily decision making and required assistance with activities of daily living (ADLs). On 03/11/15 at 11:00 a.m., the resident was observed in bed, with a [MEDICAL CONDITION] and ventilator in use. The resident stated the care at the facility was not good. The resident stated she had to wait 45 minutes for someone to clean her up when she was incontinent. On 03/11/15 at 3:50 p.m., CNA #3 was asked if incontinent care for the residents had been done less frequently in the last two weeks. The CNA stated it was a lot harder with the new ventilators alarming all the time and sometimes the residents had to wait for care.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to fully develop care plans for five (#1, #2, #3, #4, and #5) of five sampled residents whose care plans were reviewed. The facility identified 52 residents lived in the facility. Findings: The facility policy and procedure for development of plans of care documented upon completion of the comprehensive assessment the interdisciplinary team would develop the plan of care for the resident. The facility policy and procedure for pressure risk assessment documented at risk residents needed to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. 1. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 01/21/15 was identified as a certified nurse aide care plan. The care plan included a one line list of instructions. The care plan did not include problems, approaches or goals. The admission assessment, dated 01/23/15, documented the resident was not impaired for daily decision making and required assistance with activities of daily living (ADLs). On 03/11/15 at 11:00 a.m., the resident was observed in bed, with a [MEDICAL CONDITION] and ventilator in use. On 03/13/15 at 11:05 a.m., Licensed practical nurse (LPN) #2 was asked who was responsible for the completion of care plans. The LPN stated she was the assistant director of nurses and helped with care plans. LPN #2 stated the completion of care plans was shared by three staff members. LPN #2 stated the facility knew they were behind on care plans and the resident's care plan had been updated last night. 2. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. No admission assessment had been documented. A certified nurse aide care plan, dated 02/19/15 did not include any documentation pertaining to the resident's ventilator or oxygen. On 03/11/15 at 11:00 a.m., the resident was observed in bed with a tracheotomy, ventilator and urinary catheter in place. On 03/12/15 at 4:20 p.m., licensed practical nurse (LPN) #2 stated she was one of the staff responsible for documenting care plans. The LPN stated the resident's care plan had not been completed. 3. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The certified nurse aide (CNA) care plan, dated 02/13/15, documented the resident was continent of bowel and bladder and used the urinal and bedpan. The care plan included a one line list of instructions, a new admit and an activity detail. The care plan did not include problems, approaches or goals specific to the residents care. The admission assessment, dated 02/20/15, documented the resident was not impaired for daily decision making and required assistance with activities of daily living (ADLs). The assessment documented the resident was always continent of bowel and bladder. On 03/11/15 at 4:45 p.m., the resident was observed in bed, a tracheotomy and ventilator were in use. The resident was able to speak and hold conversation. On 03/13/15 at 11:05 a.m., Licensed practical nurse (LPN) #2 was asked who was responsible for the completion of care plans. The LPN stated she was the assistant director of nurses and helped with care plans. LPN #2 stated the completion of care plans was shared by three staff members. LPN #2 stated the facility knew they were behind on care plans and the resident's care plan had been updated last night. 4. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 12/22/14, documented the resident had the urinary catheter removed on 12/29/14 and was incontinent of bowel and bladder and required extensive assist with incontinent care and toileting. The care plan stated the resident was at risk for skin breakdown due to her need for extensive assistance with care. The admission assessment, dated 12/29/14, documented the resident was not impaired for daily decision making and required assistance with ADLs. The assessment documented the resident had a [MEDICAL CONDITION], was on a ventilator, had a urinary catheter and was incontinent of bowel. On 03/13/15 at 6:00 a.m., the resident was observed in bed, awake, with a tracheotomy and ventilator in place. On 03/13/15 at 6:20 a.m., CNA #1, CNA#2 and LPN #3 were observed providing incontinent care to the resident. An open stage II pressure sore was noted on the resident's left upper thigh and a stage I pressure sore on resident's right upper thigh. These sores were located where the buttock meets the upper thigh. LPN#3 stated the wounds had not been noticed before. On 03/13/15 at 3:00 p.m., LPN #2 was asked what interventions were in place to prevent the development of pressure sores for the resident. The LPN stated there was nothing to prevent the development of pressure sores on the care plan. The LPN stated the preventative measures should have been included on the care plan because additional sores had been found on the resident's coccyx that morning when a more thorough skin assessment had been done. 5. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 02/18/15, documented the bowel and bladder status would be evaluated and the resident placed on an appropriate toileting schedule. The care plan included new admit to the nursing facility for the [DIAGNOSES REDACTED]. The care plan did not include specific interventions or goals. The admission assessment, dated 03/02/15, documented the resident was not impaired for daily decision making and required assistance with ADLS. The assessment documented the resident was continent of bowel and bladder and not at risk for skin breakdown. On 03/13/15 at 9:25 a.m., the resident was observed lying in bed and stated he was doing okay. The resident was asked if staff gave a reason it took so long to answer the call light. The resident stated the staff just said they were short staffed. The resident was asked if he had any sores on his bottom. The resident stated the staff had said he had some scratches, but he could not reach back there and scratch himself. The resident stated he thought the scratches were from the bedpan being left under him too long. On 03/13/15 at 10:25 a.m., LPN #1 was asked if the resident had wounds. The LPN stated the only wound she was aware the resident had was on his stump. On 03/13/15 at 10:30 a.m., LPN #1 and LPN #2 assisted the resident to turn over to observe the sore place on the resident's buttock. Discoloration was noted on the upper left leg and bottom buttock cheek (light purple, measuring approximately 5 x 10 cm).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375316**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/13/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLINGTON HILLS LIVING & REHABILITATION CENTER	**SIXTH & WOODLAND EUFAULA, OK 74432**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) Multiple scratches with skin break were noted in the discolored area. LPN #2 observed the area and stated it looked like maybe it was caused by the bedpan. On 03/13/15 at 3:00 p.m., LPN #2 was asked what interventions were in place to prevent the development of pressure sores for the resident. The LPN stated there was nothing to prevent the development of pressure sores on the care plan.
F 0312 **Level of harm -** Actual harm **Residents Affected -** Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to assist residents with grooming for three (#3, #4, and #5) of five sampled residents reviewed who needed extensive assistance with activities of daily living (ADLs) from the facility. a) During an interview resident #3 stated on two different occasions it had taken the staff so long to answer his call light he had to urinate on himself and finally have a bowel movement (BM) on himself and lay there in urine and feces until the call light was answered. The resident stated it made him feel like the lowest form of human dignity on earth to have to urinate and have a bowel movement on himself and then lie in urine and feces for six hours. The resident stated he did not treat his dogs that way. The resident stated he had cried himself to sleep. b) During an interview resident #4 stated the staff had shut the call light off a few minutes earlier. The resident stated her bottom was very sore from sitting in urine for 5 to 6 hours at a time. With tears in her eyes, the resident stated it went to hours and was very cold sitting in urine that long and no human should be treated that way. The resident stated her bottom was raw from sitting in urine. During observation of incontinent care for resident #4, an open stage II pressure sore was noted on the resident's left upper thigh and a stage I pressure sore was observed on the resident's right upper thigh. A nurse stated the wounds had not been noticed before. c) During an interview resident #5 stated two times he had a BM in the bed. The resident stated, That is embarrassing, have not done that since I was a kid. The resident stated he was left on the bedpan one hour and 45 minutes recently. During an observation resident #5 was assisted to turn. Discoloration was noted on the upper left leg and bottom buttock cheek (light purple, measuring approximately 5 x 10 cm). Multiple scratches with skin break were noted in the discolored area. A nurse observed the area and stated it looked like maybe it was caused by the bedpan. The facility identified nine residents who needed assistance with toileting and 25 incontinent residents as living in the facility. The facility identified nine residents who required assistance with toileting and 25 residents who were incontinent as living in the facility. Findings: The facility policy and procedure for basic responsibility of call lights documented staff was to never make the resident feel like the staff was too busy to give assistance. The staffing policy provided by the facility documented the following: Census 46-52 day shift=7 staff, Census 53-59 day shift=8 staff, Census 60-66 day shift=9 staff, Census 46-55 afternoon shift =5 staff, Census 56-65 afternoon shift=6 staff, Census 1-42 evening shift=2 staff, Census 43-59 evening shift=3 staff, and Census 60-76 evening shift=4 staff. The facility provided a current list (as of 03/11/15) of 27 residents that were ventilator dependant. The facility provided a current list (as of 03/11/15) of four residents with facility acquired pressure ulcers. The facility provided a current list of nine residents (as of 03/11/15) who needed assistance with toileting. The facility provided a current list (as of 03/11/15) of 25 incontinent residents. The facility policy and procedure for prevention of pressure ulcers documented staff was to reposition a resident in a chair at least every hour. The facility policy and procedure for prevention of pressure ulcers documented staff was to place residents on a minimum of a every 2 hour check and change program and provide personal hygiene care/bath. 1. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The certified nurse aide (CNA) care plan, dated 02/13/15, documented the resident was continent of bowel and bladder and used the urinal and bedpan. The admission assessment, dated 02/20/15, documented the resident was not impaired for daily decision making and required assistance with activities of daily living (ADLs). The assessment documented the resident was always continent of bowel and bladder. On 03/11/15 at 10:50 a.m., the resident was observed in bed with a tracheotomy in place and a ventilator in use. The resident was able to speak and hold conversation. The resident stated since the facility had changed to the new ventilators about two weeks ago the ventilator alarms went off constantly. The resident stated the CNAs were not able to answer call lights to help with the urinal or bedpan because the ventilator alarms kept all the call lights going off all the time. The resident stated it was not uncommon to wait at least 30 minutes for someone to answer his call light. On 03/11/15 at 11:10 a.m., CNA #1 was interviewed regarding answering call lights. The CNA stated the new ventilators alarmed constantly. The CNA stated some of the ventilator alarms were hooked into the call light system and made the call lights go off automatically. The CNA stated it was hard for the staff to get their work done because of the ventilator alarms/call lights. The CNA stated there was not enough staff to provide care to the residents. On 03/11/15 at 11:15 a.m., licensed practical nurse (LPN) #1 was asked if it took the staff longer to do routine bed checks for incontinent care and toileting of residents with the high volume of ventilator alarms/call lights going off in the past two weeks. The LPN stated sometimes incontinent care was late. On 03/11/15 at 3:50 p.m., CNA #3 was asked if incontinent care for the residents had been done less frequently in the last two weeks. The CNA stated it was a lot harder with the new ventilators alarming all the time and sometimes the residents had to wait for care. On 03/11/15 at 3:45 p.m., the resident was asked if the length of time it took for his call light to be answered had ever caused him to urinate or have a bowel movement (BM) on himself in the bed. The resident stated the facility never had enough staff and the problem had worsened when they got new ventilators two weeks ago. The resident stated on two different occasions it had taken the staff so long to answer his call light he had to urinate on himself and finally have a BM on himself and lay there in urine and feces until the call light was answered. The resident stated the first time it took staff two hours and the second time it took staff six hours to answer his call light. The resident stated it made him feel like the lowest form of human dignity on earth to have to urinate and have a bowel movement on himself and then lie in urine and feces for six hours. The resident stated he did not treat his dogs that way. The resident stated when the next shift came on duty they came in and asked him why his call light was on. The resident stated he told the staff he had turned the call light on six hours earlier because he needed to urinate. The resident told the staff he had urinated in his bed and finally had a bowel movement on himself and laid there crying for six hours. The resident stated he had cried himself to sleep. On 03/11/15 at 4:30 p.m., the administrator (ADM) was asked to stand in the hall and observe the staff answering call lights. The ADM was informed an observation had been made minutes earlier of 11 call lights going off during a 13 minute time frame. The ADM was asked if the facility had added any more staff to accommodate the change to the new, more sensitive alarming ventilators. The ADM stated according to the acuity and census of the facility, There is staff sufficient to meet the resident's needs. The ADM stated the facility was unique in that it had not only ventilator residents but [MEDICAL TREATMENT] was performed in the facility as well. On 03/12/15 at 3:00 p.m., CNA #5 was interviewed. The CNA stated the call lights and ventilator alarms went off constantly with the new ventilators. The CNA stated the ventilator alarms were hooked up into the call lights and when the alarm went off the staff had to go in and see if the resident was okay. The CNA stated this left call lights on for 30 more minutes due to staff having to go check the next alarm and light before care could be completed. The CNA stated part of the job duties for CNAs included getting 300 pound to 500 pound residents out of bed, and getting the [MEDICAL TREATMENT] residents up and taking them to and from the [MEDICAL TREATMENT] room on time. The CNA stated there was just not enough staff to provide care for all the residents. On 03/12/15 at 4:30 p.m., the resident's family member was visiting. The family member stated he came in to visit the resident recently and found him crying and blaming himself due to an incident that had occurred when the resident was lying in urine and feces due to his call light not being answered for six hours. On 03/13/15 at 6:25 a.m., CNA #2 was asked the time frame for answering residents' call lights. The CNA stated the new ventilators alarmed constantly and they did not have enough help. The CNA stated it took longer to do bed checks for incontinent residents and answer call lights for the residents who were able to use a bedpan. The CNA stated the residents were wet longer and it was impossible for staff to get everything done. The CNA was asked if some of the residents were incontinent more due to the longer response time for call lights. The CNA stated some residents who were previously able to use the bedpan or urinal were incontinent. On 03/13/15 at 10:00 a.m., CNA #5 was asked if the resident had ever been incontinent of urine or BM. The CNA stated one time when the resident's call light was answered, the resident was upset and said he had cried himself to sleep waiting on his call light to be answered for 6 hours. The CNA stated the resident was wet with urine from both armpits to his knees and his whole back was covered with BM. The CNA stated she and another staff member took the resident to the shower and cleaned him up. 2. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 12/22/14, documented the resident had the urinary catheter removed on 12/29/14, was incontinent of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375316**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/13/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLINGTON HILLS LIVING & REHABILITATION CENTER	**SIXTH & WOODLAND EUFAULA, OK 74432**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0312 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 5) bowel and bladder, and required extensive assist with incontinent care and toileting. The care plan stated the resident was at risk for skin breakdown due to her need for extensive assistance with care. The admission assessment, dated 12/29/14, documented the resident was not impaired for daily decision making and required assistance with ADLs. The assessment documented the resident had a [MEDICAL CONDITION], was on a ventilator, had a urinary catheter and was incontinent of bowel. On 03/13/15 at 6:00 a.m., the resident was observed in bed, awake, with a tracheotomy and ventilator in place. The resident had audible wheezes with each ventilation. The resident's mucous membranes were pink and the ventilator alarm was sounding. The resident's call light was not on. The resident stated the staff had shut the call light off a few minutes earlier. The resident stated her bottom was very sore from sitting in urine for 5 to 6 hours at a time. The resident stated she did not get her shower the day before and it was her regular shower day. The resident said she did not know why she did not get her shower and the staff always said they were too busy. The resident stated she sat in her chair in urine sometimes up to 5 or 6 hours because the aides all said, I'll be back in a second. With tears in her eyes, the resident stated it goes to hours and it is very cold sitting in urine that long and no human should be treated that way. The resident also stated she liked to be put back to bed at 5 p.m. The resident stated the staff said they were too busy to put her to bed in the evening. The resident stated one night it was 11:45 p.m. and Saturday night (03/07/15) it was after midnight before they put her to bed. The resident stated her bottom was raw from sitting in urine. On 03/13/15 at 6:20 a.m., CNA #1, CNA #2 and LPN #3 were observed providing incontinent care to the resident. An open stage II pressure sore was noted on the resident's left upper thigh and a stage I pressure sore on resident's right upper thigh. These sores were located where the buttock meets the upper thigh. LPN #3 stated she had not noticed the wounds before. On 03/13/15 at 6:25 a.m., CNA #1 was asked why the resident did not get her shower the day before. The CNA stated the staff was busy answering call lights, there was just not enough help to get it all done. On 03/13/15 at 2:10 p.m., CNA #2 was asked if she ever worked the evening shift. CNA #2 stated she had worked all three shifts. The CNA was asked if the resident had ever been left in the chair after 5 p.m. The CNA stated sometimes the residents had to sit in the chair until the staff could get to them. 3. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 02/18/15, documented the bowel and bladder status would be evaluated and the resident placed on an appropriate toileting schedule. The admission assessment, dated 03/02/15, documented the resident was not impaired for daily decision making and required assistance with ADLS. The assessment documented the resident was continent of bowel and bladder and not at risk for skin breakdown. On 03/13/15 at 9:25 a.m., the resident was observed lying in bed and stated he was doing okay. The resident was asked if he had ever had an accident due to staff not answering the call light timely. The resident stated two times he had a BM in the bed. The resident stated, That is embarrassing, have not done that since I was a kid. The resident stated he was left on the bedpan one hour and 45 minutes before. The resident was asked if staff gave a reason it took so long to answer the call light. The resident stated the staff just said they were short staffed. The resident was asked if he had any sores on his bottom. The resident stated the staff had said he had some scratches, but he could not reach back there and scratch himself. The resident stated he thought the scratches were from the bedpan being left under him too long. On 03/13/15 at 10:25 a.m., LPN #1 was asked if the resident had wounds. The LPN stated the only wound she was aware the resident had was on his stump. On 03/13/15 at 10:30 a.m., LPN #1 and LPN #2 assisted the resident to turn over to observe the sore place on the resident's buttock. Discoloration was noted on the upper left leg and bottom buttock cheek (light purple, measuring approximately 5 x 10 cm). Multiple scratches with skin break were noted in the discolored area. LPN #2 observed the area and stated it looked like maybe it was caused by the bedpan. On 03/13/15 at 11:52 a.m., CNA #2 was asked if the resident had episodes of incontinence. The CNA stated she had cleaned the resident of BM once. The CNA was asked if the resident had stated why the episode of incontinence happened. The CNA stated, Maybe it was because the staff didn't get to him soon enough when his call light was on. The CNA stated the facility had been really short staffed lately and the residents were not getting the care they needed.
F 0314 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to provide care and services to prevent the development of and/or promote healing of pressure sores for two (#4 and #5) of three sampled residents reviewed for pressure sores. The facility failed to: a) provide incontinent care and repositioning for resident #4 The facility documented 25 residents requiring assistance with incontinent care lived in the facility. b) provide assistance with a bedpan for resident #5 in a manner to prevent new pressure sores. The facility documented nine residents requiring assistance with toileting lived in the facility. Findings: The facility policy and procedure for prevention of pressure ulcers documented staff was to reposition a resident who was in a chair at least every hour. The facility policy and procedure for prevention of pressure ulcers documented staff was to place residents on a minimum of a every 2 hour check and change program and provide personal hygiene care/bath. 1. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 12/22/14, documented the resident had the urinary catheter removed on 12/29/14 and was incontinent of bowel and bladder and required extensive assist with incontinent care and toileting. The care plan stated the resident was at risk for skin breakdown due to her need for extensive assistance with care. The admission assessment, dated 12/29/14, documented the resident was not impaired for daily decision making and required assistance with ADLs. The assessment documented the resident had a [MEDICAL CONDITION], was on a ventilator, had a urinary catheter and was incontinent of bowel. On 03/13/15 at 6:00 a.m., the resident was observed in bed, awake, with a tracheotomy and ventilator in place. The resident had audible wheezes with each ventilation. The resident's mucous membranes were pink and the ventilator alarm was sounding. The resident's call light was not on. The resident stated the staff had shut the call light off a few minutes earlier. The resident stated her bottom was very sore from sitting in urine for 5 to 6 hours at a time. The resident stated she did not get her shower yesterday and it was her regular shower day. The resident said she did not know why she did not get her shower and the staff always said they were too busy. The resident stated she sat in her chair in urine sometimes up to 5 or 6 hours because the aides all said I'll be back in a second. With tears in her eyes the resident stated it goes to hours and it is very cold sitting in urine that long and no human should be treated that way. The resident also stated she liked to be put back to bed at 5 p.m. The resident stated the staff said they were too busy to put her to bed in the evening, one night it was 11:45 p.m. and Saturday night (03/07/15) it was after midnight before they put her to bed. The resident stated her bottom was raw from sitting in urine. On 03/13/15 at 6:20 a.m., CNA #1, CNA #2 and LPN #3 were observed providing incontinent care to the resident. An open stage II pressure sore was noted on the resident's left upper thigh and a stage I pressure sore was observed on the resident's right upper thigh. These sores were located where the buttock meets the upper thigh. LPN #3 stated the wounds had not been noticed before. On 03/13/15 at 6:25 a.m., CNA #1 was asked why the resident did not get her shower the day before. The CNA stated the staff was busy answering call lights, there was just not enough help to get it all done. On 03/13/15 at 2:10 p.m., CNA #2 was asked if she ever worked the evening shift. CNA #2 stated she had worked all three shifts. The CNA was asked if the resident had ever been left in the chair after 5 p.m. The CNA stated sometimes the residents had to sit in the chair until the staff could get to them. On 03/13/15 at 3:00 p.m., LPN #2 was asked what interventions were in place to prevent the development of pressure sores for the resident. The LPN stated there was nothing to prevent the development of pressure sores on the care plan. The LPN stated the preventative measures should have been included on the care plan because additional sores had been found on the resident's coccyx that morning when a more thorough skin assessment had been done. 2. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 02/18/15, documented the bowel and bladder status would be evaluated and the resident placed on an appropriate toileting schedule. The care plan did not document the resident was at risk for pressure sores. The admission assessment, dated 03/02/15, documented the resident was not impaired for daily decision making and required assistance with ADLS. The assessment documented the resident was continent of bowel and bladder and not at risk for skin breakdown. On 03/13/15 at 9:25 a.m., the resident was observed lying in bed and stated he was doing okay. The resident was asked if he had ever had an accident in the bed due to staff not answering the call light timely. The resident stated two times he had a BM in the bed. The resident stated That is embarrassing, have not done that since I was a kid. The resident stated he was left on the bedpan one hour and 45 minutes before. The resident was asked if staff gave a reason it took so long to answer the call light. The resident stated the staff just said they were short staffed. The resident was asked if he had any sores on his bottom. The resident stated the staff had said he had some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **375316**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/13/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLINGTON HILLS LIVING & REHABILITATION CENTER	**SIXTH & WOODLAND** **EUFAULA, OK 74432**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0314 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) scratches, but he could not reach back there and scratch himself. The resident stated he thought the scratches were from the bedpan being left under him too long. On 03/13/15 at 10:25 a.m., LPN #1 was asked if the resident had wounds. The LPN stated the only wound she was aware the resident had was on his stump. On 03/13/15 at 10:30 a.m., LPN #1 and LPN #2 assisted the resident to turn over to observe the sore place on the resident's buttock. Discoloration was noted on the upper left leg and bottom buttock cheek (light purple, measuring approximately 5 x 10 cm). Multiple scratches with skin break were noted in the discolored area. LPN #2 (the ADON) observed the area and stated it looked like maybe it was caused by the bedpan. On 03/13/15 at 11:52 a.m., CNA #2 was asked if the resident had episodes of incontinence. The CNA stated she had cleaned the resident of BM once. The CNA was asked if the resident had stated why the episode of incontinence happened. The CNA stated Maybe it was because the staff didn't get to him soon enough when his call light was on. The CNA stated the facility had been really short staffed lately and the residents were not getting the care they needed. On 03/13/15 at 3:00 p.m., LPN #2 was asked what interventions were in place to prevent the development of pressure sores for the resident. The LPN stated there was nothing to prevent the development of pressure sores on the care plan.
F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to provide sufficient nursing staff to maintain physical and mental well-being of each resident for five (#1, #2, #3, #4, and #5) of five sampled residents. The facility failed to: a) Implement policies and procedures to prevent neglect for residents #3, #4, and #5. Five sampled residents were reviewed for neglect. b) Promote care for residents in a manner to maintain dignity for residents #1, #3, #4, and #5. Five sampled residents were reviewed for dignity and respect. The facility failed to respond to resident requests for provision of assistance with toileting. Resident #3 and #4 verbalized being left unattended in a urine soaked and feces soiled bed/chair for an extended period of time. c) Assist residents with grooming for residents #3, #4, and #5. Five sampled residents were reviewed who needed extensive assistance with activities of daily living (ADLs) from the facility. d) Provide care and services to prevent the development of and/or promote healing of pressure sores for residents #4 and #5. Three sampled residents were reviewed for pressure sores. e) Maintain resident #1's tracheotomy care in a timely manner. The facility census was 53. Findings: The facility provided a current list (as of 03/11/15) of 27 residents that were ventilator dependant. The facility provided a current list (as of 03/11/15) of four residents with facility acquired pressure ulcers. The facility provided a current list of nine residents (as of 03/11/15) who needed assistance with toileting. The facility provided a current list (as of 03/11/15) of 25 incontinent residents. The facility policy and procedure for basic responsibility of call lights documented staff was to never make the resident feel like the staff was too busy to give assistance. The staffing policy provided by the facility documented the following: Census 46-52 day shift=7 staff, Census 53-59 day shift=8 staff, Census 60-66 day shift=9 staff, Census 46-55 afternoon shift =5 staff, Census 56-65 afternoon shift=6 staff, Census 1-42 evening shift=2 staff, Census 43-59 evening shift=3 staff, and Census 60-76 evening shift=4 staff. 1. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A hospital discharge summary, dated 02/13/15, documented the resident had recurrent urinary tract infections (UTIs) due to pseudomonas, the urinary catheter was removed, and the resident was thought to have prostatis due to the recurrent UTI issue. The discharge summary documented however with all this he has been continent of urine. The certified nurse aide (CNA) care plan, dated 02/13/15, documented the resident was continent of bowel and bladder and used the urinal and bedpan. The admission assessment, dated 02/20/15, documented the resident was not impaired for daily decision making and required assistance with activities of daily living (ADLs). The assessment documented the resident was always continent of bowel and bladder. A nurse note, dated 02/26/15, documented the resident refused to allow one of the ventilator alarms to be turned on during day hours due the alarm getting on the resident's nerves. On 03/11/15 at 10:38 a.m., the respiratory therapist was interviewed regarding the new ventilators. The therapist stated the facility had changed over to the new ventilators about two weeks ago. The therapist stated the new ventilators were a little more sensitive and they alarmed more, especially when a resident talked or coughed. On 03/11/15 at 10:50 a.m., the resident was observed in bed with a tracheotomy in place and a ventilator in use. The resident was able to speak and hold conversation. The resident stated since the facility had changed to the new ventilators about two weeks ago the ventilator alarms went off constantly. The resident stated the CNAs were not able to answer call lights to help with with the urinal or bedpan because the ventilator alarms kept all the call lights going off all the time. The resident stated it was not uncommon to wait at least 30 minutes for someone to answer his call light. On 03/11/15 at 11:00 a.m., CNA #4 was interviewed regarding answering the call light for ventilator residents. The CNA stated the alarms on the new ventilators went off more, they were more sensitive. The CNA stated when the ventilator alarm went off the staff had to go see what the machine said and report to the nurse. On 03/11/15 at 11:10 a.m. CNA #1 was interviewed regarding answering call lights. The CNA stated the new ventilators alarmed constantly. The CNA stated some of the ventilator alarms were hooked into the call light system and made the call lights go off automatically. The CNA stated it was hard for the staff to get their work done because of the ventilator alarms/call lights. The CNA stated there was not enough staff to provide care to the residents. On 03/11/15 at 11:15 a.m., licensed practical nurse (LPN) #1 was asked if it took the staff longer to do routine bed checks for incontinent care and toileting of residents with the high volume of ventilator alarms/call lights going off in the past two weeks. The LPN stated sometimes incontinent care was late. On 03/11/15 at 3:50 p.m., CNA #3 was asked if incontinent care for the residents had been done less frequently in the last two weeks. The CNA stated it was a lot harder with the new ventilators alarming all the time and sometimes the residents had to wait for care. On 03/11/15 at 3:45 p.m., the resident was asked if the length of time it took for his call light to be answered had ever caused him to urinate or have a bowel movement (BM) on himself in the bed. The resident stated the facility never had enough staff and the problem had worsened when they got new ventilators two weeks ago. The resident stated on two different occasions it had taken the staff so long to answer his call light he had to urinate on himself and finally have a BM on himself and lay there in urine and feces until the call light was answered. The resident stated the first time it took staff two hours and the second time it took staff six hours to answer his call light. The resident stated it made him feel like the lowest form of human dignity on earth to have to urinate and have a bowel movement on himself and then lie in urine and feces for six hours. The resident stated he did not treat his dogs that way. The resident stated when the next shift came on duty they came in and asked him why his call light was on. The resident stated he told the staff he had turned the call light on six hours earlier because he needed to urinate. The resident told the staff he had urinated in his bed and finally had a bowel movement on himself and laid there crying for six hours. The resident stated he had cried himself to sleep. On 03/11/15 during a 13 minute time span from 3:40 p.m. until 3:53 p.m., 11 different call lights were observed to be on. The nurse aides were observed going from room to room at a fast pace. During this time ventilator alarms were never silent. On 03/11/15 at 4:00 p.m., the director of nurses (DON) was asked to stand in the hall and observe the staff answering call lights. The DON was informed an observation had been made minutes earlier of 11 call lights going off during a 13 minute time frame. The DON was told a resident had complained it took 2 hours on one occasion and 6 hours on another occasion for the call light to be answered. The DON stated, The facility needed more staff. On 03/11/15 at 4:30 p.m., the administrator (ADM) was asked to stand in the hall and observe the staff answering call lights. The ADM was informed an observation had been made minutes earlier of 11 call lights going off during a 13 minute time frame. The ADM was asked if the facility had added any more staff to accommodate the change to the new, more sensitive alarming ventilators. The ADM stated according to the acuity and census of the facility there is staff sufficient to meet the resident's needs. The ADM stated the facility was unique in that it had not only ventilator residents but [MEDICAL TREATMENT] was performed in the facility as well. On 03/12/15 at 3:00 p.m., CNA #5 was interviewed. The CNA stated the call lights and ventilator alarms went off constantly with the new ventilators. The CNA stated the ventilator alarms were hooked into the call lights and when the alarm went off the staff had to go in and see if the resident was okay. The CNA stated this left call lights on for 30 more minutes due to staff having to go check the next alarm and light before care could be completed. The CNA stated part of the job duties for CNAs included getting 300 pound to 500 pound residents out of bed, and getting the [MEDICAL TREATMENT] residents up and taking them to and from the [MEDICAL TREATMENT] room on time. The CNA stated there was just not enough staff to provide care for all the residents. On 03/12/15 at 3:30 p.m., LPN #2 stated she thought the facility needed more help to provide care for the residents. The LPN stated the facility had a busy pace and there were a large number of staff who called in or just did not show up for work.

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F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 7) On 03/12/15 at 4:30 p.m., the resident's family member was visiting. The family member stated he came in to visit the resident recently and found him crying and blaming himself due to an incident that had occurred when the resident was lying in urine and feces due to his call light not being answered for six hours. On 03/13/13 at 6:25 a.m., CNA #2 was asked the time frame for answering residents' call lights. The CNA stated the new ventilators alarmed constantly and they did not have enough help. The CNA stated it took longer to do bed checks for incontinent residents and answer call lights for the residents who were able to use a bedpan. The CNA stated the residents were wet longer and it was impossible for staff to get everything done. The CNA was asked if some of the residents were incontinent more due to the longer response time for call lights. The CNA stated some residents who were previously able to use the bedpan or urinal were incontinent. On 03/13/15 at 10:00 a.m., CNA #5 was asked if the resident had ever been incontinent of urine or BM. The CNA stated one time when the resident's call light was answered the resident was upset and said he had cried himself to sleep waiting on his call light to be answered for 6 hours. The CNA stated the resident was wet with urine from both armpits to his knees and his whole back was covered with BM. The CNA stated she and another staff member took the resident to the shower and cleaned him up. 2. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 12/22/14, documented the resident had the urinary catheter removed on 12/29/14 and was incontinent of bowel and bladder and required extensive assist with incontinent care and toileting. The care plan stated the resident was at risk for skin breakdown due to her need for extensive assistance with care. The admission assessment, dated 12/29/14, documented the resident was not impaired for daily decision making and required assistance with ADLs. The assessment documented the resident had a [MEDICAL CONDITION], was on a ventilator, had a urinary catheter and was incontinent of bowel. On 03/13/15 at 6:00 a.m., the resident was observed in bed, awake, with a tracheotomy and ventilator in place. The resident had audible wheezes with each ventilation. The resident's mucous membranes were pink and the ventilator alarm was sounding. The resident's call light was not on. The resident stated the staff had shut the call light off a few minutes earlier. The resident stated her bottom was very sore from sitting in urine for 5 to 6 hours at a time. The resident stated she did not get her shower the day before and it was her regular shower day. The resident said she did not know why she did not get her shower and the staff always said they were too busy. The resident stated she sat in her chair in urine sometimes up to 5 or 6 hours because the aides all said, I'll be back in a second. With tears in her eyes, the resident stated it goes to hours and it is very cold sitting in urine that long and no human should be treated that way. The resident also stated she liked to be put back to bed at 5 p.m. The resident stated the staff said they were too busy to put her to bed in the evening, one night it was 11:45 p.m. and Saturday night (03/07/15) it was after midnight before they put her to bed. The resident stated her bottom was raw from sitting in urine. On 03/13/15 at 6:20 a.m., CNA #1, CNA#2 and LPN #3 were observed providing incontinent care to the resident. An open stage II pressure sore was noted on the resident's left upper thigh and a stage I pressure sore on resident's right upper thigh. These sores were located where the buttock meets the upper thigh. LPN#3 stated she had not noticed the wounds before. On 03/13/15 at 6:25 a.m., CNA #1 was asked why the resident did not get her shower the day before. The CNA stated the staff was busy answering call lights, there was just not enough help to get it all done. On 03/13/15 at 2:10 p.m. CNA #2 was asked if she ever worked the evening shift. CNA #2 stated she had worked all three shifts. The CNA was asked if the resident had ever been left in the chair after 5 p.m. The CNA stated sometimes the residents had to sit in the chair until the staff could get to them. On 03/13/15 at 3:00 p.m., LPN #2 stated she had assessed the resident's skin and there were more sores on her coccyx. The LPN was asked what interventions were in place to prevent development of pressure sores. The LPN stated there was nothing on the care plan to prevent sores. 3. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 02/18/15, documented the bowel and bladder status would be evaluated and the resident placed on an appropriate toileting schedule. The admission assessment, dated 03/02/15, documented the resident was not impaired for daily decision making and required assistance with ADLS. The assessment documented the resident was continent of bowel and bladder and not at risk for skin breakdown. On 03/13/15 at 9:25 a.m., the resident was observed lying in bed and stated he was doing okay. The resident was asked if he had ever had an accident due to staff not answering the call light timely. The resident stated two times he had a BM in the bed. The resident stated, That is embarrassing, have not done that since I was a kid. The resident stated he was left on the bedpan one hour and 45 minutes before. The resident was asked if staff gave a reason it took so long to answer the call light. The resident stated the staff just said they were short staffed. The resident was asked if he had any sores on his bottom. The resident stated the staff had said he had some scratches, but he could not reach back there and scratch himself. The resident stated he thought the scratches were from the bedpan being left under him too long. On 03/13/15 at 10:25 a.m., LPN #1 was asked if the resident had wounds. The LPN stated the only wound she was aware the resident had was on his stump. On 03/13/15 at 10:30 a.m., LPN #1 and LPN #2 assisted the resident to turn over to observe the sore place on the resident's buttock. Discoloration was noted on the upper left leg and bottom buttock cheek (light purple, measuring approximately 5 x 10 cm). Multiple scratches with skin break were noted in the discolored area. LPN #2 observed the area and stated it looked like maybe it was caused by the bedpan. On 03/13/15 at 11:52 a.m., CNA #2 was asked if the resident had episodes of incontinence. The CNA stated she had cleaned the resident of BM once. The CNA was asked if the resident had stated why the episode of incontinence happened. The CNA stated, Maybe it was because the staff didn't get to him soon enough when his call light was on. The CNA stated the facility had been really short staffed lately and the residents were not getting the care they needed. 4. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 01/21/15, was identified as a certified nurse aide care plan. The care plan included a one line list of instructions. The care plan did not include problems, approaches, or goals. The admission assessment, dated 01/23/15, documented the resident was not impaired for daily decision making and required assistance with activities of daily living (ADLs). On 03/11/15 at 11:00 a.m., the resident was observed in bed with a [MEDICAL CONDITION] and ventilator in use. The resident stated the care at the facility was not good. The resident stated she had to wait 45 minutes for someone to clean her up when she was incontinent. 5. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. No admission assessment had been documented. A certified nurse aide care plan, dated 02/19/15, did not include any documentation pertaining to the resident's ventilator or oxygen. On 03/11/15 at 11:00 a.m., the resident was observed in bed with a tracheotomy, ventilator and urinary catheter in place. The resident's call light was on. The resident's family member was standing at the door of the room looking down the hall. The resident's family member stated the resident's tracheotomy was dirty and she wanted it changed. The resident's family member stated she visited every day and it always took a while to get a nurse, sometimes 45 minutes. On 03/13/15 the facility provided a monthly census. The census for the month of March 2015 varied between 54 and 53. LPN #2 stated she was the staff member responsible for staffing the facility. LPN #2 provided the actual daily schedule sheets for March 2015. The LPN stated she checked the daily schedule sheets against the actual time cards to make sure the number of staff recorded was accurate. According to the monthly shift census for 03/08/15, the census was 54. The daily schedule sheets for 03/08/15 documented the total number of direct care staff present for the day shift was seven. This staffing level was below the facility policy. On 03/11/15 at 10:30 a.m. when surveyors entered the building, the number of direct care staff on duty was 12. The direct care staff on duty for the 2 p.m. to 10 p.m. was documented as nine. During the 2 p.m. to 10 p.m. time frame, observations were made and documented of the rapid pace the staff was working to answer the residents' call lights that had been triggered by the ventilator alarms.