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

PRINTED:7/30/2015 FORM APPROVED

			OMB NO. 0938-0391
DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	A. BUILDING	(X3) DATE SURVEY COMPLETED 03/13/2015
	375316		
NAME OF PROVIDER OF SUPPLIER		STREET ADDRESS, CITY, STA	ATE, ZIP

WELLINGTON HILLS LIVING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP 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.

OR LSC IDENTIFYING INFORMATION

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY)

F 0224

Level of harm - Actual

Residents Affected - Some

Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.

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 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=6 staff, Census 54-52 devening 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 four residents with facility acquired pressure ulcers. The facility provided a current list of nine residents (as of 03/11/15) who needed assist (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 wentilators 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 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.

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 375316 If continuation sheet Previous Versions Obsolete Page 1 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CLIA IDENNTIFICATION NUMBER	A. BUILDING	(X3) DATE SURVEY COMPLETED 03/13/2015
	375316		

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.

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

Level of harm - Actual

F 0224

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 president was okay. The CNA stated this left call lights on for 30 more minutes due to staff having to go. 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 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 for skin preakdown due to ner 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 nucous membranes were pink and the ventilator alarm was sounding. 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 chower day. The resident said she did not get her shower the day before and it was her regular chower day. 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 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 the bade ever had an accident due to staff not an 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 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. Provide care for residents in a way that keeps or builds each resident's dignity and

F 0241

Level of harm - Actual

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 dose that way. The resident stated he had cried himself to stay in particular sentent #5. 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. stated two times he had a bw in the bed. The resident stated, that is embartassing, have hot 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

FORM CMS-2567(02-99)

Event ID: YL1O11

Facility ID: 375316

If continuation sheet

	375316		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2015
			OMB NO. 0938-0391

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.

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

F 0241

Level of harm - Actual

Residents Affected - Some

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

(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 46-55 adhermoon shift—6 staff, Census 60-66 day shift—9 staff, Census 46-55 aftermoon shift—5 staff, Census 60-66 day shift—9 staff, Census 48-59 evening shift—3 staff, and Census 60-76 evening shift—4 staff. The facility provided a current list of nine residents (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. I. Resident #3 was admitted to the facility on IDATE with IDAGNOSES REDACTED J. A hospital discharge summary, dated 02/13/15, documented 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 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 start six nours to answer his call light. The resident stated it made nim feel like the lowest form of numan 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 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 as 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 as went off constantly with the new ventilators. of the facility there is staff sufficient to meet the residents' needs. The ADM stated the facility as 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 incontinent more due to the longer response time for call lights. The CNA stated some residents who were remontinent more due to the longer response time for call lights. The CNA stated some residents who were remontinent more due to the longer response time for call lights. The CNA stated some residents was uspest and said he had cried himself to sleep waiting on his call light to 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 adulble wheezes with each ventilation. The resident's mucous membranes were pink and the ventilator alarm was sounding. 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 sait 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 also stated she liked

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED:7/30/2015

CENTERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF CORRECTION	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING B. WING		03/13/2015
	375316		,	
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, STA	ATE, ZIP
WELLINGTON HILLS LIVI	NG & REHABILITATION CEN	TER	SIXTH & WOODLAND EUFAULA, OK 74432	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing hor	me or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		ENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0241	(continued from page 3) to be put back to bed at 5 p.m. Th	ne resident stated the staff said the	ey were too busy to put her to bed	in the evening, one
Level of harm - Actual harm	her bottom was raw from sitting incontinent care to the resident. A	in urine. On 03/13/15 at 6:20 a.m. an open stage II pressure sore was	midnight before they put her to be ., CNA #1, CNA#2 and LPN #3 w s noted on the resident's left upper	ere observed providing thigh and a stage I
Residents Affected - Some	thigh. LPN #3 stated the wounds did not get her shower the day be help to get it all done. On 03/13/1 had worked all three shifts. The C sometimes the residents had to si' facility on [DATE] with [DIAGN would	had not been noticed before. On fore. The CNA stated the staff we 5 at 2:10 p.m., CNA #2 was aske CNA was asked if the resident had in the chair until the staff could lOSES REDACTED]. The care p	ese sores were located where the bit of 3/13/15 at 6:25 a.m., CNA #1 was busy answering call lights, there are if she ever worked the evening ed ever been left in the chair after 5 get to them. 3. Resident #5 was adolan, dated 02/18/15, documented to	s asked why the resident was just not enough shift. CNA #2 stated she p.m. The CNA stated mitted to the he bowel and bladder status
	documented the resident was not documented the resident was con the resident was observed lying in due to staff not answering the cal stated, That is embarrassing, hav and 45 minutes recently. The resiresident stated the staff just said to resident stated the staff just said to resident stated the thought the scriber stated he thought the scriber was asked if the resident had stating the didn't get to him soon enoughately and the residents were not a [DIAGNOSES REDACTED]. The including problems, approaches coresident was not impaired for dai 03/11/15 at 11:00 a.m., the reside stated the care at the facility was when she was incontinent. On 03	impaired for daily decision makin timent of bowel and bladder and n a bed and stated he was doing okal light timely. The resident stated end to done that since I was a kid. dent was asked if staff gave a rea hey were short staffed. The reside he had some scratches, but he count atches were from the bedpan bein episodes of incontinence. The CN ed why the episode of incontinench when his call light was on. The getting the care they needed. 4. Recare plan, dated 01/21/15 docuor goals had not been developed. Ity decision making and required a ent was observed in bed, with a [N not good. The resident stated she 1/11/15 at 3:50 p.m., CNA #3 was eks. The CNA stated it was a lot I	hedule. The admission assessment ng and required assistance with Al at the two times he had a BM in the bed two times he had a BM in the bed some into the two times he had a BM in the bed some it took so long to answer the cent was asked if he had any sores of all onto reach back there and scratch gleft under him too long. On 03/1 A stated she had cleaned the resid ce happened. The CNA stated, Mae CNA stated the facility had been esident #1 was admitted to the facted that the state of the state	DLS. The assessment 03/13/15 at 9:25 a.m., and ever had an accident. The resident the bedpan one hour all light. The on his bottom. The n himself. The on his bottom. The n himself. The the start of BM once. The CNA ybe it was because the really short staffed ility on [DATE] with plan. A comprehensive care plan 10/23/15, documented the iving (ADLs). On tilator in use. The resident ne to clean her up esidents had been done
F 0279	Develop a complete care plan th actions that can be measured.	at meets all of a resident's need	ls, with timetables and	
Level of harm - Minimal	**NOTE- TERMS IN BRACKET		ROTECT CONFIDENTIALITY**	
harm or potential for actual harm	five (#1, #2, #3, #4, and #5) of five	ve sampled residents whose care p	ined the facility failed to fully dev plans were reviewed. The facility i	dentified 52
Residents Affected - Some	residents lived in the facility. Fin upon completion of the comprehe The facility policy and procedure have interventions implemented on [DATE] with [DIAGNOSES] care plan included a one line list admission assessment, dated 01/2 assistance with activities of daily [MEDICAL CONDITION] and v responsible for the completion of plans. LPN #2 stated the complet were behind on care plans and the facility on [DATE] with [DIAGN plan, dated 02/19/15 did not included the completion of the completion of the plant of the completion of plans. LPN #2 stated the completion of plans. LPN #3 stated the completion of plans. LPN #4 stated the completion of plans. LPN #4 stated the completion of plans. LPN #4 stated the completion of plans and the completi	dings: The facility policy and pro- nsive assessment the interdiscipl for pressure risk assessment doc- oromptly to attempt to prevent pro- REDACTED]. The care plan, dato of instructions. The care plan, dato of instructions. The care plan, dato distructions are plan diductions. The care plan diduction in use. On 03/13/15 at 1 care plans. The LPN stated she vion of care plans was shared by the restident's care plan had been up IOSES REDACTED]. No admiss de any documentation pertaining rved in bed with a tracheotomy, ve e (LPN) #2 stated she was one of n had not been completed. 3. Res ne certified nurse aide (CNA) care rinal and bedpan. The care plan i d not include problems, approac id/15, documented the resident we living (ADLs). The assessment de, the resident was observed in be rsation. On 03/13/15 at 11:05 a.n care plans. The LPN stated she ve ion of care plans was shared by the resident's care plan had been up IOSES REDACTED]. The care p d was incontinent of bowel and bi the resident was at risk for skin hent, dated 12/29/14, documented he assessment documented the residented the	procedure for development of plans of inary team would develop the plan umented at risk residents needed to essure ulcers. 1. Resident #1 was a ed 01/21/15 was identified as a cen to include problems, approaches as not impaired for daily decision 1:00 a.m., the resident was observed 11:05 a.m., Licensed practical nurs was the assistant director of nurses hree staff members. LPN #2 stated dated last night. 2. Resident #2 was ion assessment had been documer to the resident's ventilator or oxy wentilator and urinary catheter in p the staff responsible for documentident #3 was admitted to the facilic e plan, dated 02/13/15, documente included a one line list of instruction has not impaired for daily decision locumented the resident was alwayd, a tracheotomy and ventilator w. Licensed practical nurse (LPN) was the assistant director of nurses three staff members. LPN #2 stated dated last night. 4. Resident #4 walan, dated 12/22/14, documented the resident was alwayda, at tracheotomy and ventilator w. Licensed practical nurse (LPN) was the assistant director of nurses three staff members. LPN #2 stated dated last night. 4. Resident #4 walan, dated 12/22/14, documented the resident was not impaired for exident had a [MEDICAL CONDI' o a.m., the resident was observed i	of care documented of care for the resident. o be identified and dmitted to the facility tified nurse aide care plan. The or goals. The making and required din bed, with a et. LPN) #2 was asked who was and helped with care the facility knew they is admitted to the ted. A certified nurse aide care gen. On 03/11/15 at lace. On 03/12/15 at ting care plans. The ty on [DATE] with d the resident was continent of ons, a new admit and ts care. The making and required is continent of bowel and ere in use. The resident #2 was asked who was and helped with care the facility knew they is admitted to the he resident had the urinary st with incontinent care ensive assistance daily decision making and rION], was on a ventilator, had a first tife of the sident had the urinary st with incontinent care ensive assistance
	tracheotomy and ventilator in pla care to the resident. An open stag sore on resident's right upper thig wounds had not been noticed bef- the development of pressure sore sores on the care plan. The LPN's additional sores had been found of	ce. On 03/13/15 at 6:20 a.m., CN e II pressure sore was noted on th. These sores were located wher ore. On 03/13/15 at 3:00 p.m., LF s for the resident. The LPN stated stated the preventative measures son the resident's coccyx that morn	A #1, CNA#2 and LPN #3 were on the resident's left upper thigh and a rethe buttock meets the upper thigh and a rethe buttock meets the upper thigh and a was asked what intervention at there was nothing to prevent the should have been included on the ching when a more thorough skin as GNOSES REDACTED]. The care	bserved providing incontinent stage I pressure h. LPN#3 stated the s were in place to prevent development of pressure care plan because sessment had been done.

5. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, dated 02/18/13, 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).

Facility ID: 375316

FORM CMS-2567(02-99) Previous Versions Obsolete

CORRECTION	NUMBER 375316		03/13/2015
STATEMENT OF DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	A. BUILDING	(X3) DATE SURVEY COMPLETED 03/13/2015
			OMB NO. 0938-0391

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.

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

> 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

F 0279

Level of harm - Minimal harm or potential for actual

Residents Affected - Some

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 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 left 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 tourn 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 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 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 inventional residents. The facility prolicy and precedure for prevention of pressure ulsers decompanded staff was to 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 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 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 feeces 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 feeces for six hours. The resident stated he did not treat his does that way. The resident stated when the next shift came on duty they came in and asked him why his call light. 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 accompodate the change to the new more sensitive alarming ventilators. The ADM stated according to the 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 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 stated 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 urne of BM. The CNA stated one time when the resident's can light was answered, the resident was upset and said ne 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

FORM CMS-2567(02-99) Previous Versions Obsolete

AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER 375316	B. WING	03/13/2015
STATEMENT OF DEFICIENCIES		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
			OMB NO. 0938-0391

NAME OF PROVIDER OF SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP

WELLINGTON HILLS LIVING & REHABILITATION CENTER

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

SIXTH & WOODLAND EUFAULA, OK 74432

F 0312

Level of harm - Actual

(X4) ID PREFIX TAG

Residents Affected - Some

toolumed... from page 3) 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 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 the r worked the evening sint. CNA #2 stated she had worked at three sints. The CNA was asked in the restrict had even 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 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 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 because the control of the contr 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.

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY

F 0314

Level of harm - Minimal harm or potential for actual

Residents Affected - Some

Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed

*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 and repositioning for resident #4 The facility of documented 25 residents requiring assistance with nontinent 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 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. I. 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. 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 left upper thigh and a stage I pressure sore was observed on the resident's left upper thigh and a stage I pressure sore was observed on the resident's left upper thigh at the word of the resident's left upper thigh and a stage I pressure sore was observed on the resident's left upper thigh at 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 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

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YL1O11

Facility ID: 375316 If continuation sheet

Page 6 of 8

PRINTED:7/30/2015

WELLINGTON HILLS LIVING & REHABILITATION CENTER		SIXTH & WOODLAND EUFAULA, OK 74432		
NAME OF PROVIDER OF SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
	375316			
DEFICIENCIES AND PLAN OF CORRECTION	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING B. WING		03/13/2015
STATEMENT OF		(X2) MULTIPLE CONSTRUCT	ΓΙΟΝ	(X3) DATE SURVEY COMPLETED
CENTERS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-0391

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

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

F 0314

F 0353

Level of harm - Minimal harm or potential for actual

Residents Affected - Some

Level of harm - Minimal harm or potential for actual

Residents Affected - Many

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 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.

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

*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 four residents with facility acquired pressure ulcers. The facility provided a current list (as of 03/11/15) who needed assistance with toileting. 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 of nine residents (as of 03/11/15) who needed assistance with toileting. The facility provided a current list of nine residents 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 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 only impaired for daily decision making and required assistance with activities of daily living (ADLs). The assessment 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 resident stated the CNAs were not able to answer call lights to help with with the urnal 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 head for the steff to get their work their work of the ventilators alarms (call). 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 hed. The resident stated the facility never had enough staff and the problem had worsened when they got new 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 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 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 stated the ventration ratarians were nowced into the call rights and when the ataril were not the stair 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.

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 375316 If continuation sheet

PRINTED:7/30/2015 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION

DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING 03/13/2015 375316

STREET ADDRESS, CITY, STATE, ZIP

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

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

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

F 0353

Level of harm - Minimal harm or potential for actual

NAME OF PROVIDER OF SUPPLIER

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 belon. The CNA stated it took longer to do bed checks for incontinent residents and answer call lights for the 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 by 15/15 at 10:00 a.iii., CNA #3 was asked if the resident had ever been incontinent of thinle of 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, nim 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 Control of the care plan, 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 Control of the care plan, dated 12/22/14, documented the resident was not impaired for daily decision making and required assistance with ADLs. The assessment documented the resident had a [MEDICAL Control of the care plan, 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 control of the care plan, dated 12/29/14, documented the resident was not impaired for daily decision making and required assistance with ADLs. impaired for daily decision making and required assistance with ADLs. The assessment documented the resident had a [MED 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 stifting in urine that leage and no human chould be treated that way. The resident slot stated she liked to be not been the color of the property of the pr an said, 11 be back in a second. With tears in her eyes, the resident stated it goes to nours 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 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 cito the resident. An open stage II pressure sore was noted on the resident's left 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 the provident of the provident was a sked what interventions were in place to prevent development of the provident was a sked what interventions were in place to prevent development of the provident was a sked what interventions were in place to prevent development. 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 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 resident stated, that is embarrassing, have not done that since I was a kid. The resident stated ne 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 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 I 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 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 for the 2 p.m. to 10 p.m. was documented as nine. During 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.

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 375316 If continuation sheet Previous Versions Obsolete