PRINTED: 12/16/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	(X3) DA	TE SURVEY MPLETED
		375094	B. WING	- Property and the second seco		C <b>2/07/2015</b>
NAME OF P	ROVIDER OR SUPPLIER	J	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		7 TH 0.4	2425	SOUTH MEMORIAL		
MANORC	ARE HEALTH SERVICE	STULSA	TUL	SA, OK 74129		
(X4) ID		TATEMENT OF DEFICIENCIES	QI	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETION
F 000	INITIAL COMMENTS	8	F 000			1-15-16
						1
	A recertification surv	yey was conducted on				
}	11/30/15 through 12/	. •				
		7260 was investigated in				
	conjunction with the	survey.				
	. The following is a lief	t of abbroviations used				
	throughout this surve	t of abbreviations used by:				Ì
<b>[</b>	ADL- activity of daily	livina				
	ADON - assistant dir					}
	B [and] B- bowel and					
	BMI- body mass inde	ex	1			
1	BID- twice daily					
l	BTW- between					1
	BSC- bedside comm	ode				-
	C- with		]			
	CBC- complete blood	d count				!
1	CMP- complete meta	abolic profile	Ì			
	CNA - certified nurse	es aide				
	C/O- complaint of					
		tructive pulmonary disease	į į			į
	D/C- discontinue		ļ			
	DON- director of nun	sing	i			
	DX - diagnosis					j t
•	G- gram	<u>:</u>				)
	HS- at night/bed time KCAL- kilocalorie	±	}			
<b>}</b>	LBS- pounds				- 🖈	į
<u> </u>	LPN - licensed pract	ical nursa	}	·		
<u> </u>	MECH- mechanical	ion noise	1			!
ļ	MG- milligrams			DEC 24 2015		
	ML- milliter's			4 4 ZUI)		
	MOS- months				ş1 1	
1	NC - nasal cannula			-		
1	N/C - nasal cannula	1	i	•		-
i	NOV- November		9			ļ
1	NPO- nothing by mo	uth				
L		4			···	
LABORATORY	DIRECTOR'S OR PROVIDED	SUPPLIER REPRESENTATIVES SIGNATU	JRE	TIPLE		(X8) 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 discloseble 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	' '	SURVEY PLETED
			l	_		į	c
		375094	B. WING			12	/07/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	REET ADDRESS, CITY, STATE, ZIP CODE		
	,			24	125 SOUTH MEMORIAL		
MANORCA	ARE HEALTH SERVICES	-TULSA		T	ULSA, OK 74129		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 000	Continued From page	a 1	F	000			1-15-16
	N/S- normal saline		,	0001	The statements made on this plan of		
	O2 - oxygen				correction are not an admission to, nor		
		endoscopic gastrostomy			do they constitute an agreement with the	alleged	j
	PO- by mouth	,	}		deficiencies herein.		
	POC- plan of care		İ		Mr		Í
	PRN- as needed				To remain in compliance with all federa and state regulations the facility has take		
	PROT- protein		}		or will take, the actions set forth in the		
	Q- every		Ì		of corrections. The following plan of co		
	REC- recommended				constitutes the facility's		
	REWT- reweigh		Ì		allegation of compliance. All alleged defi	iciencies	
	RN- registered nurse SOB- shortness of br	eath			have been or will be corrected		
	SIG-significant	eaut	ì		by the date indicated		Ì
	STAT- immediately				F225		į
	TAB- tablet				1.22		ł
	UTI- urinary tract infe	ction			The facility will continue to ensure that all	new	
	VS- vital signs				employees receive reference checks prior t	o their hi	ire
	WT- weight				date.		
	X- times		}		David and Sala Calle Land		
	%- percent				Residents currently in the facility have the be effected.	potential	110
	#- number   2L- two liters				be encered.		ļ
E 225	483.13(c)(1)(ii)-(iii), (d	3/(2) (4)	_	225	Employees; C.N.A.#1, LPN #4, LPN #1, a	nd LPN	#2
SS=E				223	have received reference checks with prope	r	
30-6	ALLEGATIONS/INDI		)		documentation, and policies were followed		
					unsatisfactory findings exist based on thes	e checks.	
	The facility must not e	employ individuals who have			Human Resource Director will be re-educa	stad on	
	been found guilty of a	busing, neglecting, or			employee reference check policies and tim		f
		by a court of law; or have			reference checks.	CIIICOS C.	_
		into the State nurse aide	ļ				ļ
		buse, neglect, mistreatment			The Administrator and/or designee will co	mplete	
		propriation of their property;	ļ		random audits weekly for 60 days to		
		edge it has of actions by a			monitor for ongoing compliance.		į
	. •	in employee, which would service as a nurse aide or			Audit findings and trands will be seened	ta th a	
l		ne State nurse aide registry	ļ		Audit findings and trends will be reported QA Committee for oversight and direction		
1	or licensing authoritie				changes to the plan as needed.	101	
		· <del>-</del> ·			S		
					l		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION MUNICIPA		IPLE CONSTR	(X3) DATE SURVEY COMPLETED		
		375094	B. WING			1	C /07/2015
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	ES-TULSA		2425 SOU	DDRESS, CITY, STATE, ZIP CODE TH MEMORIAL DK 74129	1 12	0112013
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 225	involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and of the facility must have lations are thoroprevent further pote investigation is in part to the administrator representative and with State law (includent, and if the	sure that all alleged violations ent, neglect, or abuse, inknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the entification agency).  The evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F	125			1-15-16
	by: Based on staff inte was determined the reference checks w four (CNA #1, LPN five new employee potential to affect to in the facility. Findi  1. CNA #10 was hi employee file did no reference checks p	red on 09/20/15. The ot contain documentation of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
				_		,	c
		375094	B. WING			12/	07/2015
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-TULSA		2	TREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MEMORIAL ULSA, OK 74129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			(X5) COMPLETION DATE
F 241	checks prior to hire d  3. LPN #1 was hired file did not contain do checks prior to hire d  4. LPN #2 was hired file did not contain do checks prior to hire d  On 12/03/15 at 2:00 p director was asked if are checked prior to aware I needed to do 483.15(a) DIGNITY A INDIVIDUALITY  The facility must promanner and in an em	From page 3 contain documentation of reference to hire date.  was hired on 09/20/15. The employee contain documentation of reference to hire date.  was hired on 10/05/15. The employee contain documentation of reference to hire date.  So at 2:00 p.m., the human resources asked if new employees references ded to do them."  IGNITY AND RESPECT OF LITY  The facility will continue to promote the care for residents in a lin an environment that maintains or ach resident's dignity and respect in  The facility will continue to promote the care for residents in a manner and in an environment the maintains or enhances each resident's dignity are respect in full recognition of his or her individual.		did not contain documentation of reference ecks prior to hire date.  LPN #1 was hired on 09/20/15. The employee did not contain documentation of reference ecks prior to hire date.  LPN #2 was hired on 10/05/15. The employee did not contain documentation of reference ecks prior to hire date.  LPN #2 was hired on 10/05/15. The employee did not contain documentation of reference ecks prior to hire date.  12/03/15 at 2:00 p.m., the human resources ector was asked if new employees references echecked prior to hire. He stated, "I was not are I needed to do them."  3.15(a) DIGNITY AND RESPECT OF  DIVIDUALITY  F241  The facility will continue to promote the cresidents in a manner and in an environment maintains or enhances each resident's digression of his or her indicates the contained occurrence and in an environment that maintains or enhances each resident's digression of his or her indicates the contained occurrence and in an environment that maintains or enhances each resident's digression of his or her indicates the contained occurrence and in an environment that maintains or enhances each resident's digression of his or her indicates the contained occurrence and in an environment that maintains or enhances each resident's digression of his or her indicates the contained occurrence and in an environment that maintains or enhances each resident's digression of his or her indicates the contained occurrence and in an environment that maintains or enhances each resident's digression of his or her indicates the contained occurrence and in an environment that maintains or enhances each resident's digression of his or her indicates the contained occurrence and in an environment that maintains or enhances each resident's digression occurrence and in an environment that maintains or enhances each resident's digression occurrence and in an environment that maintains or enhances each resident's digression occurrence and in an environment that maintains or enhances each resident's digression occurrence and in an environment		ent that nity and lividuality	
	by: Based on observation interviews and review procedures, it was defensure a resident's in bag was covered for residents observed w catheters. This had residents identified b urinary catheters. Fin	etermined the facility failed to adwelling urinary catheter one (#18) of five sampled with indwelling urinary the potential to affect ten by the facility with indwelling			Residents residing in the facility with urin catheters have the potential to be affected practice.  Nursing staff have been re-educated on the cover the urinary catheter bag to ensure control provided in a manner to promote the digner resident.  The Director of Nursing and/or designed conduct random audits weekly for 60 day for ongoing compliance.  Audit findings and trends will be reported QA Committee for oversight and recommendations for changes to plan as a second catheter than the process of the provided commendations for changes to plan as a second catheter than the process of the provided catheter than the process of the	by this e need to are is ity of the will s to moni	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		375094	B. WING			Ì	C 07/2015
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	i-Tulsa		24	TREET ADDRESS, CITY, STATE, ZIP CODE 125 SOUTH MEMORIAL ULSA, OK 74129		
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F 241	Continued From page	<b>9</b> 4	F:	241			1-15-16
	Purpose: To recomm care hygiene for patie catheters.	nend the steps of catheter ents with indwelling					
	14. Check that tubin bag in catheter bag h	ng is off the floor - place in colder"					
	the facility, resident # room. The door to the	a.m., during a general tour of #18 was observed in her e room was open. Her was observed on the floor	•				
	At 9:49 a.m., CNA #2 urinary catheter bag s	de the window mowing.  Was asked how a resident's should be stored to maintain					
	On 12/03/15 at 3:10 pasked how urinary castored to maintain a r	p.m., the administrator was atheter bags should be resident's dignity. She					
	stated, "In a dignity b 483.15(f)(1) ACTIVIT INTERESTS/NEEDS	TES MEET	F	248	F 248		]
	of activities designed the comprehensive a	vide for an ongoing program I to meet, in accordance with Issessment, the interests and and psychosocial well-being			The facility will continue to ensure that eareceives Activities that meet their needs; be developing individualized activities care particular than the continue of the facility of the continue of the contin	oy olans.	
	This REQUIREMENT by:	T is not met as evidenced			Residents residing in the facility have the be affected by this practice.	potential	to

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	L		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		375094	B. WING			l	07/2015
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-TULSA		24	TREET ADDRESS, CITY, STATE, ZIP CODE 125 SOUTH MEMORIAL ULSA, OK 74129	,	
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F 248	Based on clinical recinterviews, it was detected an individual one (#12) of 12 samp an activities care plan affect all 71 residents Findings:  Resident #12 was add 10/27/15 with diagnostenosis of the right in muscle weakness, dy disease and hyperter.  An admission assess documented the residingaired in cognitive making. She required staff with transfers, discussion about her phone calls in private. She identified the folking of the resident in portant: take care belongings, family and discussion about her phone calls in private. She identified the folking of the resident. There activities care plan for the resident's asked if she was able plan for the resident.	ord review and staff ermined the facility failed to ized activities care plan for ided residents reviewed for in. This had the potential to who resided in the facility.  mitted to the facility on ses which included occlusion hiddle cerebral artery, sphagia, cerebrovascular sision.  ment, dated 11/03/15, lent was moderately skills for daily decision d extensive assistance from ressing, eating and bathing.  Dowing activities as very of her own personal d/or friends involvement in care and be able to make  Dowing activities as do things with groups of vorite activities.  I.m., the resident's care plan was no individualized	F	248	Activities Director will be re-educated on timely individualized activities care plans.  The Administrator or Director of Nursing designee will complete random audits we days to ensure ongoing compliance.  Audit findings and trends will be reported QA Committee for oversight and recommendations for changes to plan as recommendations.	and/or ekly for 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		277004	D MANIC				C
		375094	B. WING_			12/	07/2015
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	TIN CA			REET ADDRESS, CITY, STATE, ZIP CODE 15 SOUTH MEMORIAL		
MANGILOP				TU	LSA, OK 74129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 248	she was able to locate care plan for the reside find one. I'm sorry."  At 3:10 p.m., the adm does the facility ensure individualized activities "We make sure they what types of activities. She was then asked care plan is developed stated they should describe was notified the series.	vities director was asked if e an individualized activities dient. She stated, "No, I can't dinistrator was asked how re residents are provided an es program. She stated, have an assessment to see is they would enjoy."  If an individualized activity do for each resident. She evelop one for each resident.	F2	248			1-15-16
F 312 SS=D	"Ok." 483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives to maintain good nutrition and oral hygiene.  This REQUIREMENT		F3		F312  The facility will continue to ensure that who are unable to carry out activities of living receive necessary services to magood nutrition, grooming, and personal hygiene.  Resident #5 is being provided with time incontinent care.	of daily aintain al and or nely	al
	staff and resident into the facility failed to en provided in a timely n sampled residents of	n, clinical record review and erviews, it was determined asure incontinent care was manner for one (#5) of eight aserved for timely incontinent otential to affect 45 residents			Residents residing in the facility who to carry out activities of daily living for incontinent care have the potential to effected.	or	ole

OLLI I LLI	OT OUT MEDIONICE OF	MILDIOING GENTIONG			······································	CINIC III	7. 0000 000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
		375094	B. WING				C
		213034	D. WING	<del></del>		12	07/2015
NAME OF P	ROVIDER OR SUPPLIER			l s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	ARE HEALTH SERVICES	LTIII SA		24	425 SOUTH MEMORIAL		
HD411Q1(Q1				T	ULSA, OK 74129		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION		(X5)
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							1-15-16
F 312	Continued From page	<del>2</del> 7	F	312	Nursing staff will be re-educated on		, ,,
	identified by the facili	ty who were incontinent of			the proper procedural guidelines for the	mery	
	bowel and/or bladder	•			incontinent care for residents who req		
		· ·		1	assistance to carry out activities of da	ily living	<b>3</b> .
	Resident #5 was adm	nitted to the facility with					
	diagnoses which inch	uded congestive heart			The Director of Nursing and/or design		* 1
	failure, hypertension,	depressive disorder,			will conduct random audits/ observati		
	schizophrenia and Pa	arkinsons.			for 60 days to monitor for ongoing co	mplianc	e.
	A care plan, dated 05	i/10/11 and last updated			Audit findings and trends will be repo	orted	
		d, "FocusB [and] B			to the QA Committee for oversight ar		
	incontinence	a, oodoo [circi] o			recommendations to plan as needed.	ıu	:
	THOUSE THE PROPERTY OF THE PRO				recommendations to plan as needed.		1
	GoalWill have no co	omplications due to			 		
	incontinence						}
		Check for incontinence					
	frequently and provid		i				
	needed with 2 persor	assist"	İ				
	A quarterly assessme	ent, dated 10/19/15,		i			1
	documented the resid	dent was cognitively alert in					ĺ
		n making. She required					)
	,	from staff with transfers,	!				
· 		She was frequently	,				1
	incontinent of bowel a	and bladder.	1				
	On 11/30/15 at 10:47	a.m., CNA #2 and #3 were					
	ł	vided incontinent care for					
	the resident.						
					•		
	They knocked on the	resident's door and		,			
	announced themselve	es. They closed the door,					
		They washed their hands	1				
	and donned clean glo	oves.					1
	The resident was ass	sisted to a supine position in					1
		astened the resident's brief			<b>)</b>		
		n the resident's thighs. CNA					
		ri wipes. She then utilized					
	<u> </u>				1		I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	,	(X3) DATE SURVEY COMPLETED	
		375094	B. WING			C 12/07/2015	
	ROVIDER OR SUPPLIER	S-TULSA		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL TULSA, OK 74129			
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IU PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEDICIONCY)	SHOULD BE		
F 312	groin and labia major utilized a new wipe in the wipe in a front to consider the wipe in a front to consider the massister lying position. She to brief.  The brief was obsert from the front of the inside the brief was the resident's buttoo an approximately or length wet spot on the buttocks were obsert amount of dried feet crease.	the resident's left and right ora and labia minora. She with each pass. She moved	F3	12		1-15-16	
	utilized the wipes to rectal crease. She is back motion. She of pass. She wiped the crease 24 times. Si wipes. She utilized resident's left and right At 10:55 a.m., CNA brief was wet. She urine."  She was then asked the resident's buttoo stated, "It's urine."	cleanse the resident's midline moved the wipes in a front to obtained a new wipe with each the resident's midline rectal the then obtained clean periothe wipes to cleanse the ght buttocks.  #2 was asked if the resident's stated, "It's saturated with the wet spot was under the clean the ght buttocks.  when the resident was last thence. She stated, "When we					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		375094	B. WING			Ì	0
		0.0004				121	07/2015
NAME OF P	ROVIDER OR SUPPLIER			ទ	TREET ADDRESS, CITY, STATE, ZIP CODE		
			2425 SOUTH MEMORIAL		125 SOUTH MEMORIAL		i
MANORCA	ARE HEALTH SERVICES	-TULSA		T	ULSA, OK 74129		
			<del></del>	<u> </u>			<del>,</del>
(X4) ID		ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		DATE
TAG	ALGODII GILL GILL	EGG IDENTIT TING THE GIGIDATION	1,70	,	DEFICIENCY)	LJ 6	
		·	<del>-</del>				
F 312	Continued From page	2 Q		312			1-15-16
	Communa i form page		•	512			
	The maident of stand it	and the set of C:20 a man subseq	į				
		was about 8:30 a.m. when	ì				
ĺ	they got me up for br	eaktast					
		when was she got the					
	resident up for breakt	fast. She stated, "I got her	1				]
	up at 8:00 a.m."						
	CNA #3 was then ask	red if the resident had been					
	brought back to her re	oom at any time after					-
		d, "No, this is the first time."					
	Digantable with black	-,,					
	She was asked how	often incontinent residents					
		or incontinent episodes. She	İ				1
	stated, "Every two ho	ours,"					{
	Otali i i i i i i i i i i i i i i i i i i	::::::::::::::::::::::::::::::::::::::					
		if the resident was checked					
	timely. She stated, "I	No."					
		o.m., the administrator was	1				
	asked how often show	uld staff check residents for					
	incontinent episodes.	She stated, "Every two					
	hours or more if nece	ssary."	Ì				
	She was then notified	of the observation. She			•		' <b>{</b>
	stated, "Ok."				F 322 NG Treatment/Services-Restore	Fatino	
F 322	•	EATMENT/SERVICES -	F	322	Skilts	Carcing.	,
	RESTORE EATING		'	<b>UZZ</b>	No. of the Land		1
88=D	KESTOKE EXTING	SKILLS			The facility will continue to ensure reside	nt's	1
	Događ on the server	hanning apparement of a		İ	requiring a naso gastric tube receives appr		
		ehensive assessment of a			treatment and services.	opriace	i
	resident, the facility n	nust ensure that			The section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the se		
	443 8		1		Resident #1 is receiving the appropriate for	edina e	
		is been able to eat enough			physician order. Feeding solution is being		
		nce is not fed by naso gastric			appropriately.	5 Javeleu	
		ent's clinical condition	í		Resident #9 is receiving the appropriate p	an pita aa	***
	demonstrates that us	e of a naso gastric tube was	í			eg sitti ta	uv.
	unavoidable; and		1		Residents residing in the facility requiring	r g maco	
			1		gastric tube have the potential to be effect		
	]		1		Percent mor nave me horentist to be effect	cu.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY PLETED
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		375094	B. WNG			12/	07/2015
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-TULSA		2	TREET ADDRESS, CITY, STATE, ZIP CODE 426 SOUTH MEMORIAL ULSA, OK 74129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 322	(2) A resident who is gastrostomy tube recitreatment and service pneumonia, diarrhea, metabolic abnormaliti	fed by a naso-gastric or	F	322	Licensed staff will be re-educated on propolicies regarding naso gastric tubes.  The Director of Nursing and/or designee conduct random audits weekly for 60 day for ongoing compliance.  Audit findings and trends will be reported QA Committee for oversight and recommendations for changes to plan as n	will s to moni	
	by: Based on observation staff and resident inte policy and procedures facility failed to provid the needs of residents and #9) of two sample PEG tubes. This had	is not met as evidenced  n, clinical record review, rviews and review of facility s, it was determined the e care and services to meet s with PEG tubes for two (#1 ed residents reviewed with the potential to affect two r the facility who had PEG					
	(Pump) Feedings, don "ProcedureLabel of patient name and date tubing with patient na- time feeding is initiate  A facility policy titled, Care, documented: " procedure for enteral	syringe and plastic bag with eLabel container and me, date, formula, rate and d"  Enteral Tubes: Insertion SitePurpose: To describe the tube insertion site care. It by a licensed nurse					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		275004	B. WING			Ī	С
		375094	D. WING			12	07/2015
NAME OF P	ROVIDER OR SUPPLIER			ı	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORC	ARE HEALTH SERVICES	S-TULSA			2425 SOUTH MEMORIAL		
					TULSA, OK 74129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 322	Continued From pag	a 11	-	322		,	1-15-16
, UZZ	1		f.,	3Z.	2)		ì <b>i</b>
		s clinically indicated around					
	abdominal insertion s	rking outward in spiral	1				1
		riate cleansing solution (or					
							1 1
	skin with clean tap w	er physician order). Rinse					
	SVIII MITTI CICUTI IOD M	ac.					
	b Clean daily and a	s clinically indicated under					
	disc/bumper which m	-	l				
		Use skin integrity wound					ļ <b>i</b>
		g solution per physician	i				i l
	order). Rinse skin w		1				
		,	Ì				1
	Recommended Moni	itoring:					
	Insertion Site: Obs	serve for potential signs of	ļ				}
	infection or skin brea	kdown including fever,					
	redness, irritation, te	ndemess, swelling or					
	presence of drainage	e"					<u> </u>
	4 m-14-44						
		admitted to the facility on					
	11/4/15 with diagnos		1				ļ
		ase, left hemiparesis,			· a		
	dysarthria, and diabe	nes meillus type n.			4		
	Monthly physician's /	orders, dated December			1		
	2015, documented.	ordera, dated December					
	20 70, 4000111,011100,						
	"Diets11/04/15-N	PO [nothing by mouth]					
		sGlucerna 1.5 at 70 ml per	1				
		use until 1200 ml infused	1				{
	with auto flush 30 ml	water per hour"					
		output flow sheet, dated					1
	· ·	sumented 490 mL tube					
	feeding input on the	December 1, 11-7 shift.	}				
	0 40445 14055		ĺ				j
		a.m., the resident's feeding					
		A bottle of Jevity 1.5 was					]
	nung with approxima	tely 600 mL infused. The	Ì				) i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						l	С
		375094	B, WING			12	/07/2015
NAME OF P	ROVIDER OR SUPPLIER			,	EET ADDRESS, CITY, STATE, ZIP CODE		
MANORC	ARE HEALTH SERVICES	-TULSA			S SOUTH MEMORIAL		
	<del>, , , , , , , , , , , , , , , , , , , </del>			101	LSA, OK 74129		<del></del>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 322	rate was set at 70 mL set at 30 mL per hour 4863 mL fed and 199 containing the feeding. The tubing leading for resident's PEG tube v. LPN #2 was asked is pump. She stated the labeled. When asked showing four times the stated, "I don't the hung a new bottle."  She was unable to debeen hung. She stated.	attle was 1500 mL. The feed per hour and the flush was to the pump screen showed a mL flushed. The bottle g solution was not labeled. The solution to the was not labeled.  The pump screen showed the period of the flushed to the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of th	F	322			1-15-16
	was observed to have infused. LPN #2 was asked he the resident's feeding ordered by the physic	e of feeding tube solution approximately 800 mL  ow she would know when had reached 1200 mL as ian. She stated she would in the bottle had 300 mL left.					
	to ensure the residen amount of feeding. S initiated the feeding s On 12/01/15 at 2:15 p how staff should dete of enteral solution is a She stated the bottle	of this was an accurate way t received the correct the stated the person who hould have reset the pump.  o.m., the DON was asked rmine the ordered amount administered to a resident, and tubing should be should be reset when a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		375094	B. WING			C 12/07/2015	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES			2	TREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MEMORIAL TULSA, OK 74129	12	0172013
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 322	solution was an accurresident was being produced by the physic 2. Resident #9 was a 11/25/15 with diagnos myopathy, dysphagia Monthly physician ordwere reviewed. Then available for the gasti A treatment administr November 2015, doctassessment"  The assessment was The date was blank.  A nurse's note, dated "Admitted to facility alert and oriented, de assisted up to BSC, roew G-tube and was before, skin is intact, breakdown on heels if facility, no questions, There were no other during the month of Nocumented the residuant produced in the site dressing was characted.	if looking at a bottle of rate way to ensure the rovided tube feedings as sian. She stated, "No." admitted to the facility on sees which included and gastrostomy.  der's, dated November 2015, e was no treatment order ric feeding tube.  ration record, dated umented, "Admit skin  scheduled for 11/25/15.  11/25/15, documented, via w/c with sons present, nies any c/o pain at this time requires assist, she has a getting bolus feedings bottom slightly red, no noted, oriented to room and call light in reach"  nursing notes available lovember which dent's skin was intact or pegunged and/or peg care	F	322			1-15-16
	A nutrition assessment documented, "Res	nt, dated 11/25/15, is NPO. Peg tube placed					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE COMPI	
			D MANO				
wa	· · · · · · · · · · · · · · · · · · ·	375094	B. WING_			12/0	7/2015
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	3-TULSA		STREET ADDRESS, CITY, S 2425 SOUTH MEMORIAL TULSA, OK 74129	TATE, ZIP CODE		
	CURINADV CT	ATEMENT OF DEFICIENCIES			S PLAN OF CORRECTION		O/D
(X4) ID PREFIX TAG	(EACH DEFICIENC	ALEMENT OF DEPICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTED CROSS-REFERE	CTIVE ACTION SHOULD BE INCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 322	Continued From page	e 14	F3	22			1-15-16
,	while in the hospital						
	• • •	ders, dated December 2015, re was no treatment order ric feeding tube.					
	There were no notes	cember 2015 were reviewed. which documented the as assessed, cleaned or		A con-			
	On 12/02/15 at 10:00 a.m., the resident's gastric feeding site was observed. A dressing was in place. There was no date on the dressing. The resident was asked if the staff had cleaned the peg site and put a clean dressing on since she was admitted. The resident stated, "No, this is the same dressing I came in with."						
,		5 was observed as she r the resident's peg site. She rithout concems.					
, , , , ,	gastric feeding site is dressing is not chang	could happen if a resident's not assessed and the ged. She stated, "She could on, go septic, lots of things."	To compare the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s				
		when should the resident's I. She stated, "Definitely the				the day is the time of the second	•
	She further stated, "I assessed on admit."	know all skin should be					
	record and determine	e could review the resident's e when the resident's peg ed. She stated, "I can't find				and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375094	B. WING				C 07/2015
	ROVIDER OR SUPPLIÉR ARE HEALTH SERVICES	-TULSA		24	TREET ADDRESS, CITY, STATE, ZIP CODE 126 SOUTH MEMORIAL ULSA, OK 74129		01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 322	On 12/02/15 at 1:30 p.m., the DON was asked if she could review the resident's chart and locate an order for peg site care. She stated, "I do not see an order for the peg dressing dated prior to today."  On 12/03/15 at 3:15 p.m., the administrator was asked if the admitting nurse completes an assessment for peg sites and obtains an order for dressing changes. She stated, "That is what they should do."  She was then notified the resident's peg site was not assessed and the dressing had not been changed since prior to admission to the facility. She acknowledged the concerns.  483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE		F	322			1-15-16
F 325 SS=H			F		F 325	<u>_</u>	
	Based on a resident's comprehensive assessment, the facility must ensure that a resident -  (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  The facility will continue to ensure that residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and that the residents receive a therapeutic diet when there is a nutritional problem.  Resident #1 no longer resides in the facility Resident #4 is being provided assistance with meals and weights are being monitored appropriately.  Residents residing in the facility have the potential of the facility have the potential of the facility will continue to ensure that residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and that the residents receive a therapeutic diet when there is a nutritional problem.				is 1. Is		
	This REQUIREMENT is not met as evidenced by:  Based on observation, resident and staff interviews, and record review, it was determined the facility failed to implement interventions to aid				be affected.  Nursing staff will be re-educated on provassistance with meals and supplements as Licensed staff will be re-educated on the for obtaining, documenting and monitoring	appropri guideline	·S

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375094	B. WING		- TOTAL AND AND AND AND AND AND AND AND AND AND	ì	C /07/2015
	PROVIDER OR SUPPLIER  EARE HEALTH SERVICES	S-TULSA		24	STREET ADDRESS, CITY, STATE, ZIP CODE 425 SOUTH MEMORIAL ULSA, OK 74129	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	L	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16 in the prevention of severe weight loss for two (#1) and #4) of six sampled residents who were reviewed for weight loss. This resulted in actual harm for resident #4 who had a severe weight loss of 16.4 pounds (11.2%) in three months, 19.2 pounds (13.1%) in six months, and had developed a stage II pressure ulcer.  A facility policy titled, System for Obtaining Height and Weight, documented: "Weight is one of the most important points of objective data used in evaluating nutritional and clinical status, diet planning, calculating medication dosage as well as other clinical considerations for the patientWeighing may also be pertinent if there is a significant change in condition, food intake has declined and persisted (e.g., for more than a week), or there is other evidence of altered nutritional status"  A facility policy titled, Mealtime Observation, documented: "Positive interactions between staff and patient occurphysical assistance/guidance: feeds patient or guides patient to feed selfverbal instruction and prompting: 'pick up your spoon and take a bite.' 'swallow'"  1. Resident #4 was admitted to the facility on 03/29/13 with diagnoses which included hypertensive heart disease without heart failure, vitamin B12 deficiency, urinary tract infections, anemia, and gastroesophageal reflux.  A care pian, dated 04/01/13, documented, "Focus: ADL Self care deficit related to physical limitations"		F	325	The Director of Nursing and/or designee conduct random audits weekly for 60 days for ongoing compliance.  Audit findings and trends will be reported QA Committee for oversight and recommendations for changes to plan as recommendations.	s to moni I to the	1-15-16 itor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
		375094	B. WING	**************************************		C 12/07/2015
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-TULSA		STREET ADDRESS, CITY, STATE, ZIP C 2425 SOUTH MEMORIAL TULSA, OK 74129	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD B	T
F 325	meals"  A laboratory result, di "ALB [albumin] 3.3  A dietician progress r documented, "Sept month. Wt stable x 6 range. Diet Mech So last 15 meals. Recei meals and at HS. Or is on antibiotic therap areas reported. Labs POC"  A weights and vitals r documented, "Heig 20.65.0% change i 9/10/2015, 162.6 lbs, change [Comparison - 9.4%, -16.0 lbs]"  A significant change a documented the resid in cognitive skills for r required extensive as eating. He weighed 1	Provide assistance with atted 05/14/14, documented, (3.4 - 4.7)"  Note, dated 09/24/2015, wt 162.6#. Wt down 7# x 1 mos. BMI 22.1 - healthy wt fit, Enhanced. Eating 37% x ving nutritious treats btw in Remeron for appetite. Res by for UTI. No pressure is noted. Will monitor. Contact the port, dated 10/07/15, ht 72.0Current BMI:	F3		7)	1-15-16
	down 8.4# x 1 month month and 9.4% x 3 i range. Diet: Mech So last 15 [sic]. Receiving	note, dated 10/15/15, vt 154.2#. Rewt 152.6#. Wt . Sig wt loss of 5.2% x 1 mos. BMI: 20.7 - healthy wt oft, Enhanced. Eating 58% x ng nutritious treats btw n Remeron for appetite. No				

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		375094	B. WING				C
NAME OF PROVIDE	ER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL TULSA, OK 74129		121	07/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE
press sever monn Call protection A call protection A call significant external call significant external call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call for the call	eral UTIs lately. Faitor. Rec d/c nutritor. Rec d/c nutrition. Rec d/c nutrition. Rec d/c nutrition. Rec d/c nutrition. Rec d/c nutrition. Rec d/c nutritional sufficant weight loss ensive assist with rational sufficant weight loss  Inventions/Tasks: Active diet as ordered diet as ordered wide supplements active diet as ordered wide supplements active diet as ordered wide. Nov with. Sig wt loss of althy wt range. Ding 52% x last 15 robtw meals BID. Opressure areas repairtor. Nutritional in C"	ed. Labs noted. Has had fuids encouraged. Will itious treats. Rec add Two 0 (provides: 475 kcal, 20g 10/18/15, documented, status as evidenced by . Poor appetite. Now meals/intake  In further significant  Administer medications as did and notify physician of  as ordered"  ote, dated 11/12/15, wt. 152#. Wt down 2.2# x 1 10.4% x 3 mos. BMI: 20.6 et: Mech Soft, Enhanced. meals. Receiving Two Cal in Remeron for appetite. ported. No new labs. Will terventions in place. Cont	F	325			1-15-16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375094	B. WING			1	C
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL TULSA, OK 74129		1 12	07/2015
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	"ALB1.9 (3.6-5.1) On 11/30/15 at 8:30 a observed seated at the breakfast meal. He was observed feed eggs and drank a glasobserved during their on his pants. He was his fork with food on it.  No staff person was diassist the resident during their establishment of the resident during their establishment.  At 11:20 a.m., the resident during their establishment of their establishment of their establishment.  At 2:37 p.m., a cartor was observed on the Approximately 237 m cartor.  On 12/02/15 at 8:10 a observed seated at the breakfast meal.  CNA #4 was observed out the Approximately Signature of the seated at the breakfast meal.  CNA #4 was observed out the food. His hand was of trying to get the food	ated, 11/14/15, documented,"  a.m., the resident was the dining table for the dining table for the ding himself scrambled as of orange juice. He was meal to have dropped butter to observed to struggle to get to into his mouth.  Observed at the table to wring the meal.  Sident was observed in his seed. A Two Cal health shake win the carton. The shake bedside table. The carton call with approximately 237.  The of Two Cal health shake resident's bedside table. I were observed in the a.m., the resident was the dining table for the did to have placed a plate of	F	325			1-15-16

CLITTLE	O I ON WILDIOAILE G	MILDIONID OLI (MOLO		-		ONIO W	0. 0000-0001
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375094	B. WING	-		1 12	C 2/07/2015
NAME OF D	ROVIDER OR SUPPLIER	<u> </u>		ST.	REET ADDRESS, CITY, STATE, ZIP CODE		30112010
NAME OF M	KUVIDER OR BUPPLIER			ŀ			
MANORO	ARE HEALTH SERVICE	S.TIII SA		242	25 SOUTH MEMORIAL		
IIMIONO	AIL BEALIFOLIVIOL	0-10L0A		TU	LSA, OK 74129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	,	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	;	CY MUST BE PRECEDED BY FULL	PREF	x	(EACH CORRECTIVE ACTION SHOULD		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPE	STAIS	DATE
					DEFICIENCY) '		;
							1-15-16
F 325	Continued From pag	e 20	F	325			
				-			1
	CNA #5 was observe	ed to take the plate away and		1			1
		•		}			
	1	of cottage cheese and	- }	- 1			
		ard was applied to the plate.					
	• •	hes, handed the resident a	1	1			
	spoon and walked a	way.		+			
	,			i			
	The resident's hand	was shaking when he tried to	1				
	get the spoon to his	mouth. He then put the	1				
	, -	ked up the peaches with his	1				
		s then observed to have sat	Į,				
	down to help the res						İ
	GOMU TO Helb me les	ident with the meat.					
	On 12/02/15 of 0:00	am CNA#6 was saked					
	A.	a.m., CNA #6 was asked	-	}			
		th shakes provided to the					
	1	between breakfast and lunch	-				
	and one again after	lunch. She was asked if the		Ì			
	resident consumed a	all of the shakes. She stated					-
	yes.						
							}
	,	#5 was asked what the care					
	plan stated about fee	eding assistance for the	į.				
	resident. She stated	I he should be assisted with	ì	ł			
	his meals however, v	we let him do what he can for		}			,
	himself.						
	She was asked if she	e was aware he struggled					
	į ·	during breakfast. She stated	1 .	1			
	, —	roblems and sometimes he					
	· .	ANGUIS GITA SOUTERINGS HE		-			
	doesn't.		i	i			
	ALADAE - ONA	#4 was saked if the					
		#4 was asked if she was					
		t's difficulty with getting food	l	Ş			
		tated, "I didn't notice he	i	l			i
	needed help as I was	s busy passing out plates."	Ì	Ì			!
				ļ			
	At 10:50 a.m., the re	sident was observed lying in	}	}			
	bed with his eyes clo	osed. A full, opened carton of					
		e with straw was observed					
	,		1				1

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
	375094	B. WING		C 1 <b>2/07/2015</b>	
ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	3-TULSA	2425	SOUTH MEMORIAL	122072010	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	• • • • • • • • • • • • • • • • • • • •	Par a release	
on the bedside table. On 12/02/15 at 11:00 what would you do if struggling to get food meal. She stated she assist the resident.  She was asked what mean to you. She sta resident if needed, cle drinks.  A telephone physicial 2:20 p.m., documente c NS, pat dry, skin pr Tiod [sic] paste to ope  At 3:05 p.m., CNA #4 weigh the resident. To be 146.2#.  At 3:20 p.m., CNA #6 accepts the Two Call "Mostly he won't drint nurse and then try ag  At 3:55 p.m., RN #2 which caused him to extensive assistance did not know.  She was asked if she weight. She stated, "  She was asked how of	a.m., CNA #2 was asked you saw a resident into his mouth during a would wash her hands and does limited assistance ated she would feed the ean their mouth, and give n's order, dated 12/02/15 at ed, "Coccyx - clean wound ep to periwound and apply en area q shift"  and CNA #6 were asked to he weight was observed to was asked if the resident health shakes. She stated, at them. I tell the charge rain later."  was asked what occurred go from limited assistance to with meals. She stated she was aware he had lost 'Yes, he is on the list."	F 325		1-15-16	
At 4:15 p.m., the diet	ician was asked how she				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From page on the bedside table.  On 12/02/15 at 11:00 what would you do if struggling to get food meal. She stated she assist the resident.  She was asked what mean to you. She sta resident if needed, cle drinks.  A telephone physicial 2:20 p.m., documente c NS, pat dry, skin pr Tiod [sic] paste to ope  At 3:05 p.m., CNA #4 weigh the resident. To be 146.2#.  At 3:20 p.m., CNA #6 accepts the Two Call "Mostly he won't drint nurse and then try ag  At 3:55 p.m., RN #2 which caused him to extensive assistance did not know.  She was asked how of She was asked how of She stated she did not She was asked how of She stated she did not She was asked how of She stated she did not She stated she did not She stated she did not	CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375094  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21 on the bedside table.  On 12/02/15 at 11:00 a.m., CNA #2 was asked what would you do if you saw a resident struggling to get food into his mouth during a meal. She stated she would wash her hands and assist the resident.  She was asked what does limited assistance mean to you. She stated she would feed the resident if needed, clean their mouth, and give drinks.  A telephone physician's order, dated 12/02/15 at 2:20 p.m., documented, "Coccyx - clean wound c NS, pat dry, skin prep to periwound and apply Tiod [sic] paste to open area q shift"  At 3:05 p.m., CNA #4 and CNA #6 were asked to weigh the resident. The weight was observed to be 146.2#.  At 3:20 p.m., CNA #6 was asked if the resident accepts the Two Cal health shakes. She stated, "Mostly he won't drink them. I tell the charge nurse and then try again later."  At 3:55 p.m., RN #2 was asked what occurred which caused him to go from limited assistance to extensive assistance with meals. She stated she	DEPICIENCIES CORRECTION  (X1) PROVIDER/SUPPLIER AT A CHARGE HEALTH SERVICES-TULSA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21  on the bedside table.  Con 12/02/15 at 11:00 a.m., CNA #2 was asked what would you do if you saw a resident struggling to get food into his mouth during a meal. She stated she would wash her hands and assist the resident.  She was asked what does limited assistance mean to you. She stated she would feed the resident if needed, clean their mouth, and give drinks.  A telephone physician's order, dated 12/02/15 at 2:20 p.m., documented, "Coccyx - clean wound c NS, pat dry, skin prep to periwound and apply Tiod [sic] paste to open area q shift"  At 3:05 p.m., CNA #4 and CNA #6 were asked to weigh the resident. The weight was observed to be 146.2#.  At 3:20 p.m., CNA #6 was asked if the resident accepts the Two Cal health shakes. She stated, "Mostly he won't drink them. I tell the charge nurse and then try again later."  At 3:55 p.m., RN #2 was asked what occurred which caused him to go from limited assistance to extensive assistance with meals. She stated she did not know.  She was asked how often the dietician visits. She stated she did not know.	EXPERIORNOISES CONFIDENCES CONFIDENCES CONFIDENCES CONFIDENCES CONFIDENCES CONFIDENCES CONFIDENCES CONFIDENCES CONFIDENCES CONTINUED ON MUNICIPAL CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 242 SOUTH MEMORIAL TULSA, OK 74128  SUMMARY STATEMENT OF DEFICIENCIES GEAR DEFICIENCY MUST BE PRECEDED BY PULL RESULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 21 on the bedside table.  CO 12/02/15 at 11:00 a.m., CNA #2 was asked what would you do if you saw a resident struggling to get food into his mouth during a meal. She stated she would wash her hands and assist the resident.  She was asked what does limited assistance mean to you. She stated she would feed the resident if needed, clean their mouth, and give drinks.  A telephone physician's order, dated 12/02/15 at 2.20 p.m., documented, "". Coopy: clean wound c NS, pat dry, skin prep to periwound and apply Tiod [sic] paste to open area q shift"  At 3:20 p.m., CNA #4 and CNA #6 were asked to weigh the resident. The weight was observed to be 146.2#.  At 3:20 p.m., CNA #6 was asked if the resident accepts the Two Cal health shakes. She stated, "Mostly he won't drink them. I tell the charge nurse and then try again later."  At 3:55 p.m., RN #2 was asked what occurred which caused him to go from limited assistance to extensive assistance with meals. She stated she did not know.  She was asked fi she was aware he had lost weight. She stated, "Yos, he is on the list."  She was asked how often the dietician visits. She stated she did not know.	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		375094	B. WNG_			1	C 07/2015
1111E OF D	20, 10, 20, 20, 20, 20, 20, 20, 20, 20, 20, 2			-	DOCT ABORDO OTH CTATE TO CODE	1 12	0172015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MANORCA	ARE HEALTH SERVICES	S-TULSA		24	26 SOUTH MEMORIAL		
			1	T	JLSA, OK 74129		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	JD.	1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOULD B	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	- 1	CROSS-REFERENCED TO THE APPROPRIA	ATE.	DATE
					DEFICIENCY)		
				İ			1-15-16
F 325	Continued From page	e <b>2</b> 2	F 3	325		ļ	15/5/2
	determines if a reside	ent is getting the	ĺ	- {			
		recommended. She stated		ļ			
	she asks the nurses		ŀ				
	She was asked if she	had reviewed the laboratory		-		i	
		She stated she had not	į				
		eeded to discuss it further		- (		ı	
	with the physician. S		1				
		e moved to the assisted	ļ				
ı		adding additional protein to	1	- 1			
	his meals.	adding additional protest to	ļ	Į		I	
	IIIS (Heals.		l				
	On 12/03/15 at 0:30 s	a.m., physician #1 was		į			
		e of the resident's weight	}	ĺ			
		ad been the resident's	}	ľ		,	
			ĺ			1	j
	, , ,	in for many years and was				i	ĺ
	aware of the weight is		ļ	ĺ			
	_	t review occurred every six	ļ	}			ſ
'	weeks with the reside	ents on his service.	}	1		1	}
	He was asked if he w	vas aware of the December		1		1	
			ļ	}			
		2/02/15. He stated no, he	l	į			
		dent yet however, he would	ŀ				
	be reviewing labs and	d weights today.		Ì		:	
'	Lia vuon naivaul Milaa J	Albumin level listed on the	ĺ	}			
			}	İ		į	
		eport had been faxed to him		ļ			
		his physician's assistant				ŀ	
		g to the documentation on					
		He then stated he had not		1		1	
		found the decline in the	1	İ		ļ	
	· •	e further stated he would be					
;	addressing it today d	uring rounds.		ļ			
	ا الله الله مداحة الألواء	uniaht lang was granidakte	į	İ			
		veight loss was avoidable or		Ì		i	
		ted he was not surprised					
	_	due to his medical history					
		le further stated changes				ļ	
	could be made to imp	prove his care.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	ļ	375094	B, WING_		3	C	
		373094	D, 771110_	ATTENT ADDRESS CITY STATE TO CODE	1 12	/07/2015	
NAME OF PE	ROVIDER OR SUPPLIER		l	STREET ADDRESS, CITY, STATE, ZIP CODE			
MANORCA	ARE HEALTH SERVICES	-TULSA	- (	2425 SOUTH MEMORIAL			
				TULSA, OK 74129			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 325	Continued From page	÷23	F3	325		1-15-16	
	weight loss unavoidat other interventions where interventions where the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state of the complete state o	ase, left hemiparesis, tes mellitus type II. by the facility on 11/30/15, ding tube/potential for ing tube use itor tube feeding adequacy report any significant weight and responsible party status as evidenced by it loss/gain related to					
	Monthly physician's o	rders, dated December					
<u> </u>	2010, 0000000000000000000000000000000000						
<u> </u>	"Diets11/04/15-NF	O [nothing by mouth]					
(	Tube Feeding Orders	Glucerna 1.5 at 70 ml per					
	hour start at 4 pm inft	use until 1200 ml infused	İ			]	
	with auto flush 30 ml			{		1	
	Weight Order11/0 days (4 weeks)"	4/15-Weekly Weight for 28					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					·	(	C
		375094	B. WING			12/	07/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	ARE HEALTH SERVICES	LTIU SA		2	425 SOUTH MEMORIAL		
MANORO	ANE HEALIN SERVICES	FIGLOA		T	ULSA, OK 74129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325			F:	325			1-15-16
	A treatment administr				· •		
		umented, "Weekly weights					
	x4 weeks then monthly."						
	According to the treat	ment administration record	1				<b>i</b>
	According to the treatment administration record, weights were to be done by the day shift on 11/4/15, 11/11/15, 11/18/15, and 11/25/15.				; !	İ	
	)					l	
	The weights were rev	riewed on the treatment	-				
	record. The admission weight on 11/4/15 was		1			į	
	documented as 178.6	<mark>3.</mark>	}				
	The success for the success	inht dan mantation an					
	11/11/15 was blank.	ight documentation on				1	
	I I I I I I I I I Was Dialik.						
		ight documentation on als of an LPN, but no weight.					
	The space for the we 11/25/15 was blank.	ight documentation on					
	On 12/1/15 at 10:10 a	a.m., the administrator was					
		weights for the resident.					
	She stated the weight	ts should be documented on	İ		•		
		stration record. She then					
		the DON to provide the					,
	requested documents	ation to the surveyor.					
	At 10:15 a m the DC	ON reviewed the November	;				
		nistration record with the					
		ent administration record					
		eights recorded in the					
	spaces which were pr					İ	
			İ				1
		d the weights had been	1				
		ious day. She was then					
		ded the weights. The DON	}			:	
		/ note which documented, 178.4179.8177.6."			}		
	VVL VVECKIY 170.0	170.4178.0177.0.	<u>i</u>				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDE		CONSTRUCTION		E SURVEY IPLETED
		275004	B. WING				C
		375094	D. 11410			1:	2/07/2015
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
MANORC	ARE HEALTH SERVICE	AP UT.P		242	25 SOUTH MEMORIAL		
MANUNC	ANE NEALIN SERVICE	2-1 OT3V		TU	LSA, OK 74129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Ю		PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			COMPLETION DATE	
F 325	Continued From pag	e 25	F	325			1-15-16
	This was the only do	cumentation on the sticky		1			
		s corresponded to the four					
		the treatment administration		- }			
	- 0	ated she was unaware of					
	who had documented the weights, but would look			1			
	into it.						
	A+ 10:30 a m the a	dministrator approached this		- 1			1
		she was unhappy regarding		1			ļ
			1				
	the late documentation of weights on the resident, and there would be an internal investigation into the situation.			ŧ			
				1			5
		.m., the facility was asked to					ł
	the admission weigh	sing the same technique as t.					
	CNA#8 and CNA#9	were observed using the					!
	ľ	igh the resident. He was					
	l ' -	nd raised above his bed until					
		n contact with the bed. The		ļ			
	weight was observed	to be 154 pounds.	į	İ			
	At 3:30 p.m., the DO	N was asked if the weights					
		atment administration record					
	were accurate. She		1		,		1
	confidence in the ad	mission weight documented		- 1			ĺ
	on 11/04/15.						
	She was then asked	who had recorded the					
		y had been provided on		İ			ļ
		d, "I don't know. That's the					
	investigation we are	working on."					
	She was asked whic	h staff had initialed the	!	!			
		/15 but not recorded the	1	Ì			}
		LPN #4 had confirmed during		-			1
	the facility investigat	ion she had weighed the					ļ

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 '		E CONSTRUCTION		SURVEY PLETED
		375094	B. WING			i	C /07/2015
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-TULSA		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL TULSA, OK 74129	112	372013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 325	resident but did not k computer.  The DON was inform observed weight earl asked if the resident admission and 154 p be considered severe	ed about the resident's fer in the day. She was weighed 178.6 pounds at bounds on 12/2/15, would this e weight loss. She stated the doctor and notify the	F	325			/-15-1b
	as ordered by the phyprevented the resider She stated intervention implemented sooner.  At 3:40 p.m., LPN #4 weighed the resident she had weighed the	was asked if she had on 11/18/15. She stated resident and entered it into but must not have saved it					
	resident's weight that remember exactly bu	if she remembered the day. She stated she did not tit was in the "high 150's". Inst the admission weight on a 20 pound loss.					
	been documented. Sconsidered this a sign said yes. She was a physician regarding to She stated, "No. I she stated, "No. I she had been notified.	reight for 11/11/15 had not she was asked if she nificant weight loss. She sked if she notified the he significant weight loss. sould have but didn't."  stered dietician was asked if the by the facility regarding for the resident. She stated					

OFMILL	O I ON MEDICATIVE &	MICDIGNID OF LAIOFO				OIAID IAO: 0330-0381	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		375094	B. WNG			C 12/07/2015	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	3-TULSA	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL TULSA, OK 74129		DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI HE APPROPRIA	1	
F 328	instances of significa stated, "Yes." She was consider a weight los severe. She stated, On 12/03/15 at 11:35 interviewed regarding He was asked when by the facility about the stated 12/02/15.  He was then asked if determining if the calfor a resident who was PEG tube. He stated would be in later toda nutritional status.  483.25(k) TREATME NEEDS  The facility must ensproper treatment and special services: Injections; Parenteral and entered.	facility should contact her in not weight changes, and she was asked if she would as of 13.7% in one month "Yes."  is a.m., physician #2 was go the resident's weight loss, he had first been contacted he resident's weight loss. He weights were important in onic needs were being met as getting all nutrition via it, "Yes." He then stated he asy to assess the resident's NT/CARE FOR SPECIAL were that residents receive care for the following all fluids; omy, or ileostomy care;		The facility will continue to e receive proper treatment and care.  Resident # 18 has been revie order was obtained for oxyger Residents residing in the facil of oxygen have the potential t practice.  Licensed staff will be re-educ obtain a physician order for the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the	wed and a pl n. lity that requ to be affected sated on the use of oxy	piratory hysician ire the use d by this need to ygen.	
	This REQUIREMENT by:	is not met as evidenced		The Director of Nursing and/conduct random audits weekl for ongoing compliance.	or designee by for 60 day	will s to monitor	

F 328 Continued From page 28 Based on observation, clinical record review and staff interviews, it was determined the facility failed to obtain a physician's order prior to oxygen  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Audit findings and trends will be reported to the OA Committee for oversight and recommendations for changes to plan as needed.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	(X3) DATE SURVEY COMPLETED			
MANORCARE HEALTH SERVICES-TULSA  STREET ADDRESS, CITY, STATE, ZIP CODE  2425 SOUTH MEMORIAL  TULSA, OK 74129  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 328 Continued From page 28 Based on observation, clinical record review and staff interviews, it was determined the facility failed to obtain a physician's order prior to oxygen  STREET ADDRESS, CITY, STATE, ZIP CODE  2425 SOUTH MEMORIAL  TULSA, OK 74129  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DAT			375094	B. WING_		_	ł	
F 328 Continued From page 28 Based on observation, clinical record review and staff interviews, it was determined the facility failed to obtain a physician's order prior to oxygen  F 328 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO T					2425 SOUTH MEMORIAL	ATE, ZIP CODE	1 120	7772010
Based on observation, clinical record review and staff interviews, it was determined the facility failed to obtain a physician's order prior to oxygen	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA	1	(X5) COMPLETION DATE
administration for one (#18) of seven sampled residents reviewed for oxygen administration. This had the potential to affect 14 residents identified by the facility who utilized oxygen therapy. Findings:  Resident #18 was admitted to the facility on 11/06/15 with diagnoses which included fracture of left acetabulum and diabetes mellitus type two.  A care plan, dated 11/09/15, documented, "FocusHas/At risk for respiratory impairment related to SOB  GoalWill develop no infectionsMaintain patent airway  Intervention/TasksEncourage deep breathing exercises  Evaluate lung sounds and VS as needed. Report abnormalities to physician  Administer medications/treatments per physician orders  Administer oxygen as per physician order"  An admission assessment, dated 11/13/15, documented the resident was cognitively alert in skills for daily decision making. She required extensive assistance from staff with transfers, dressing and hygiene. She received oxygen therapy.  On 11/30/15 at 9:30 a.m., the resident's clinical	Based staff int failed to administ resident This had identified therapy Reside 11/06/1 of teft at A care "Foct related GoalV airway. Interver exercise Evaluat abnorm Administ orders. Administ An administration of the country skills for extensing therapy	d on observation terviews, it was to obtain a phy istration for on the potential ided by the facility. Findings:  ent #18 was and 15 with diagnoral acetabulum and plan, dated 15 with diagnoral plan, dated 16 with diagnoral plan, dated 17 with diagnoral plan, dated 18 with diagnoral plan, dated 19 with diagnoral plan, dated 19 with diagnoral plan, dated 19 with diagnoral with the ses  Will develop number the lung sound malities to physister medication ister oxygen as mission assessmented the residor daily decision is and hygiener and hygiener ye.	on, clinical record review and as determined the facility visician's order prior to oxygen e (#18) of seven sampled or oxygen administration. It to affect 14 residents ity who utilized oxygen dimitted to the facility on ses which included fracture in diabetes mellitus type two.  1/09/15, documented, it for respiratory impairment or infectionsMaintain patent incourage deep breathing  s and VS as needed. Report sician  Ins/treatments per physician order"  sment, dated 11/13/15, dent was cognitively alert in on making. She required afrom staff with transfers, e. She received oxygen	F 32	OA Committee for o	versight and		1-1516

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		375094	B. WING		C 12/07/2015	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-TULSA		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL TULSA, OK 74129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	At 9:40 a.m., the resident in her consal cannula on at the resident's record. She locate an order for the She stated, "She doe oxygen. I'll have to consider the stated, "She doe oxygen to admicate and/or treatment stated, "Exactly, I dor long she's been on it when she returned fron 11/06/15."  On 12/03/15 at 2:00 plong the resident had She stated, "Since shalways has it on."  At 3:10 p.m., the admission of the was then notified she was then notified she was aware of the	There was no physician inistration.  dent was observed seated in toom. She had oxygen via hree liters per minute.  was asked to review the se was asked if she could a resident's oxygen therapy. In the show an order for all her doctor."  show she determines how inister and what types of its should be provided. She not know. I'm not sure how. I know she had oxygen on toom her doctors appointment.  D.M., LPN #3 was asked how received oxygen therapy. Its was admitted. She inistrator was asked if staff cian's order prior to oxygen stated, "Yes."	F 32		1-15-16	
	PALATABLE/PREFE  Each resident receive food prepared by me	RITIVE VALUE/APPEAR, R TEMP es and the facility provides thods that conserve nutritive bearance; and food that is	F 36	The facility will continue to ensure that ear receives and the facility provides food premethods that conserve nutritive value, fla appearance; and food that is palatable, atta at the proper temperature.	uch resident pared by vor, and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED
		375094	B. WING		C 12/07/2015
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	12/0//2013
			1 :	2425 SOUTH MEMORIAL	
MANORC	ARE HEALTH SERVICES	-TULSA		TULSA, OK 74129	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
			ĺ	-	1-15-16
F 364	Continued From page		F 364	Food is currently being served which is c	
palatable, attractive, and at the proper nutritive value, flavor, and appearance; and if					
	temperature.			palatable, attractive, and at the proper ten current residents residing in the facility.	iperature to
	This REQUIREMENT	is not met as evidenced		Residents residing in the facility have the be affected.	potential to
	1 * '	n, staff interview, and review		0.1.81	•
	of facility policy and p		1	Cook #1 was educated on proper pureed	consistency;
		y failed to ensure pureed		palatability. Dietary staff will be re-educated on prope	er muraad
		for three (the noon meal on		consistency; palatability.	i hareen
	· · · · · · · · · · · · · · · · · · ·	meal on 12/02/15 and the		, parametri,	
		15), of three pureed meals		The Administrator, Food Service Director	and/or
sampled for palatability. This had the potential to			designee will conduct random audits wee	kly for 60	
		dentified by the facility with		days to monitor for ongoing compliance.	
	physician orders for p	oureed diets. Findings:	}		
	A distant policy titled	Food Testing, documented:		Audit findings and trends will be reported	to the
	"The cook tastes e	Food Tasting, documented:	1	QA Committee for oversight and recommendations for changes to plan as re	andad
		occur during preparation to		recommendations for changes to plan as t	ecacu
		easoning and to allow time			
	for correction if need				
	Consistency of Madis	ad Cando Thiskspee and			
		ed FoodsThickener and needed to achieve the			j l
		cy, which is similar to	-		
		drier foods, or pudding for	Í	1	i i
	foods with a higher m				
	On 11/30/15 at 10:50	a.m., cook #1 was observed			
:		pureed meal for the noon	1	1	
		aced cooked chicken and	· l	and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	}
ì	broth into the food pro		}		
		served to have measured			
		nstant food thickener to the			ļ <b>,</b>
		processed the food multiple	{		į
	times to reach the de	sired consistency.			
		placed into a steam table			
	bin. The pureed mea	t was tasted by this surveyor	1	1	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/16/2015 FORM APPROVED

CENTER	S FUR WEDICARE &	MEDICAID SERVICES		-		ONID IN	<i>).</i> 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	1	PLETED
		375094	B. WING_			1	C 07/2015
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
	1		1	242	25 SOUTH MEMORIAL		
MANORCA	ARE HEALTH SERVICES	S-TULSA	l		ILSA, OK 74129		
	····						
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION	-	(X5) COMPLETION
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX	•	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
IAG	ALOGE (I DIC)	and in the list of the list of	IAG		DEFICIENCY)		
				+		·	
E 004		- 04					1-15-16
F 364			F3	64			
		eat tasted under seasoned	Ì				
	and bland. Cook #1	was observed to add a					
'	minimal amount of se	easoning to chicken. She		Ì			]
	was not observed to	have retasted the chicken					
	puree.		1				
	ľ			ĺ			į
	At 10:58 a.m., cook #	f1 was observed to puree	r	1			r r
		d the dressing to equal five					
		processor. She was					
		ded 1/2 cup of chicken broth					İ
		the dressing until the desired					
		rveyors tasted pureed		1			
		er seasoned and bland.	1				:
	Cressing. It was unu	er seasoned and biarid.	1				
	44 42:00 p.m. cook 4	f1 was observed to be	1	1			
	1		1	{			
		al which consisted of roast					
		nbread dressing, seasoned	1				
		read, and apple cobbler.					
	i ne gravy was in a p	an beside the steam table.					
	18ishum, through the	neel contine the array was					:
		neal service, the gravy was					
;		red thick and gelatinous.	i				
	· ·	for temperature. It was 104	Ì				
Ì		Cook #1 was asked what					
		e gravy should be when					
	served. She stated,	145."		1			
		stated, "It should be 165					
		but 145 to serve. Put it					
		The gravy was reheated to			ì		
		eit prior to continuing the					
	meal service.			Į			
		-	1				
		a.m., a puree diet tray was					
		then. The tray contained					
		y, hot cereal, and peaches.		l			
	Five surveyors tasted	the puree diet tray and all	1	1			]
		ted sweet and unidentifiable					
	and the texture was p	astelike. The temperature		}			
	·	<u> </u>	<del></del>				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		375094	B. WING		C 12/07/2015	
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	S-TULSA		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL TULSA, OK 74129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	` 1 1	
F 364	of the pureed biscuit Fahrenheit.  At 12:00 p.m., a pure from the kitchen. The jellied cranberry saud gravy, candied baby Five surveyors tasted five surveyors felt the bread was pastelike  At 1:45 p.m., cook # determines the amou pureed foods. She s consistency.  At 1:50 p.m., the diet what was the facility thickener to the pure	e lunch tray was requested a tray contained turkey, be, whipped potatoes, turkey carrots, bread and cake. If the pureed meal tray. All a turkey was bland and the in texture.  was asked how she and of thickener to add to the tated she goes by  ary manager was asked policy was for adding and add additional to	F 36	4	1-15-16	
	could affect the flavo probably take away f The dietary manager expectations of the o pureed foods. she st after heating." 483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and	was asked what were her cok when preparing the ated, "They should taste it	F 37	F371  The facility will continue to ensure that for prepared, distributed and served under sa conditions.  Food is being served in a sanitary manner staff.	nitary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
	i !	375094	B. WING			(	-
NAME OF D	ROVIDER OR SUPPLIER			91	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	07/2015
POWIL OF F	NOVIDEN ON BOLL PER		1		125 SOUTH MEMORIAL		į
MANORC	ARE HEALTH SERVICES	-TULSA	Ţ		ULSA, OK 74129		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	(0)		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	•	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	1	COMPLETION DATE
F 371	Continued From page		FS	371	Residents residing in the facility have the be affected by this practice.	potential	to j-15-16
	under sanitary condit	ions	;				, ,,,
	,				Dietary staff will be re-educated on prope gloves and serving food in a sanitary man		
	:				The Administrator, Food Service Director	and/or	
	(				designee will conduct random audits weel	dy for 60	
	This REQUIREMENT by:	is not met as evidenced	-		days to monitor for ongoing compliance.		
	1 * :	n, staff interview, and review		1	Audit findings and trends will be reported	to the	
	of facility policy and procedures, it was			i	QA Committee for oversight and	. 1. 1	
determined the facility failed to serve food in a			ļ	recommendations for changes to plan as n	eeca.		
sanitary manner for one (noon meal on 11/30/15)				ĺ			
		d. This had the potential to		Ì			
		no ate food prepared by the	İ				į
		residents received all		ļ			i
'	nutrition and hydratio	n via PEG tube. Findings:					
	The Dietary Procedur	es Manual, documented,					
	"Gloves used for he	indling food and eating	1	l		1	
		l whenever an un-sanitized		1		1	
	item or surface is tou	ched"		1			
	On 11/30/15 at 11:58	a.m., cook #1 was observed				Í	1
		es prior to serving the noon				1	
	meal.					i	
	She placed food item	s from the steam table onto					
		ong handled utensils. She				Ì	
		touched the food trays,		į		:	
		tensils during the meal				ĺ	1
	service.	-				Ì	
,	Cook #1 used the sar	ne gloved hands to					
		a baking sheet above the	}	1		}	
		e the rolls onto resident		ĺ			
		rved to have touched the	1			ĺ	
	tray multiple times in apart.	an attempt to pull the rolls					
f			1			!	i

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	!		, , , , , , , , ,		c		
ļ		37 <del>5</del> 0 <del>9</del> 4	B. WING_		12/07/2015		
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	i-TULSA		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL TULSA, OK 74129			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 441 SS=E	At 12:13 p.m., cook at pads on her hands or remove gravy from the to serving rolls with he not observed changing the meal service. On 12/02/15 at 1:45 as the could have done meal service to avoid items. She stated she serve the rolls but ha makes it easier to put the what is the policy or food items. The dietal should have broken the serving, and used to resident's trays.  483.65 INFECTION CONTRAD, LINENS  The facility must estall infection Control Prosafe, sanitary and could be prevent the dof disease and infection Control The facility must estall Program under which (1) Investigates, continuite facility; (2) Decides what productions on the facility; (2) Decides what productions of the serving the serving the facility; (2) Decides what productions of the facility; (2) Decides what productions of the facility; (2) Decides what productions of the facility; (2) Decides what productions of the facility is the facility; (2) Decides what productions of the facility is the facility; (2) Decides what productions of the facility is the facility; (2) Decides what productions of the facility is the facility is the facility; (2) Decides what productions of the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is the facility is th	et was observed placing hot wer her same gloves to be stove. She then returned er gloved hands. She was ang her gloves at any time ce.  I.m., cook #1 was asked if anything different during the cross contamination of food e should have used tongs to dused her hands because it lithe rolls apart.  Ary manager was asked using gloved hands to serve my manager stated cook #1 he rolls apart prior to longs to place them on the CONTROL, PREVENT  Ablish and maintain an gram designed to provide a mifortable environment and evelopment and transmission on.  Program blish an Infection Control		F441 The facility will continue to establish a Infection Control Program that provide sanitary environment to help prevent the and transmission of disease and infection.  Resident # 17 no longer resides in the fine Resident #18's catheter is being stored.  Residents residing in the facility with on Catheters have the potential to be affect practice.  The Director of Nursing and/or designed conduct random audits weekly for 60 defor ongoing compliance.	s a safe, e development on. acility. appropriately. axygen and/or acd by this		
		d of incidents and corrective		Audit findings and trends will be report QA Committee for oversight and recommendations for changes to plan a			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE	SURVEY
ı		375094	B. WING			1 .	C 07/2015
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-TULSA		STREET ADDRESS, CITY, STATE, ZIP CO 2425 SOUTH MEMORIAL TULSA, OK 74129	ODE		VII.Z010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 441	prevent the spread of isolate the resident.  (2) The facility must present direct contact will train than the safer each direct contact will train than the safer each direct contact will train than the safer each direct contact will train than the safer each direct contact will train than the safer each direct contact will train than the safer each direct contact will train than the safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact will be safer each direct contact wi	d of Infection in Control Program ident needs isolation to infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if insmit the disease. equire staff to wash their ct resident contact for which eated by accepted	F4	441			1-15-76
	ensure:  a. oxygen tubing was (#17) of seven sample received oxygen them to affect 14 residents received oxygen them b. an indwelling urina stored on the floor for residents observed w	ry catheter bag was not one (#18) of three sampled					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
	1	375094	B. WING			C <b>12/07/2015</b>
	ROVIDER OR SUPPLIER  ARE HEALTH SERVICES	-TULSA		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL TULSA, OK 74129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		LD 8E	(X5) COMPLETION DATE
F 441	urinary catheters. Fir A policy titled, Cathet documented: Purpose: To recommon care hygiene for patic catheters:14. Check that tubic bag in catheter bag in 1. Resident #17 was 11/20/15 with diagnor respiratory failure and pulmonary disease with A care plan, dated 11 "FocusHas/At rist related to pneumonia GoalMaintain pater respiratory distress" Interventions/Tasks physician order O4 [s SOB to keep O2 sat ]%" On 11/30/15 at 9:15 a observed in her bed. cannula were observer resident's bed. At 9:15 a.m., LPN #2	with the facility with indwelling andings:  er Care: Indwelling Catheter, and the steps of catheter ents with indwelling and individual actions and included acute of chronic obstructive eith acute exacerbation.  #21/15, documented, a for respiratory impairment, COPD  at airwayWill have no acute a compared than or equal to 192  a.m., the resident was a coxygen tubing and nasaled on the floor beside the lives asked what is the lives asked what is the lives asked what is the lives asked what is the lives asked what is on	F	441		1-15-16

<u> </u>	O I OIX INCOION IN CE OF	MEDIO ND CEITHOLO				V	3. 0000 000 T
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	1		}		,		С
	<u> </u>	375094	B. WING			12	/07/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANODO	i Loc ucaltu ecouese	TI 1 CA		2	425 SOUTH MEMORIAL		
MANURU	ARE HEALTH SERVICES	PIOLOA		1	TULSA, OK 74129		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	(J)		PROVIDER'S PLAN OF CORRECTION	***	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 441	Continued From page	e 37	F	441			1-15-16
	She was then asked	how should oxygen be					
		se. She stated the tubing	}				
		e usually stored in a bag.					
!	7						}
	She was asked to ob	serve the oxygen tubing in					
	the resident's room.	She was then asked if she			1		(
	observed any concern	ns. She stated, "Yeah, it's					
	on the floor."						
İ	On 12/03/15 at 3:10 g	o.m., the administrator was	- (				
!	·-	aff store oxygen tubing and	-				
		they are not in use. She					i .
	stated, "Off the floor."	,					
	She was then notified stated, "Ok."	of the observation. She					
	2 Resident #18 was	admitted to the facility with	1				
		uded fracture of the left					
		etention and diabetes					,
	mellitus type two.				`		ĺ
:	An admission assess	ment, dated 11/13/15,	ļ				
!		dent was cognitively alert in					j
		n making. She required	}				}
		from staff with transfers,					ĺ
	dressing and hygiene	. She had an indwelling					
	urinary catheter. She	was always incontinent of	1		1		1
	bowel.						
	المسام موام معمد الأ	14CI4E dogumented					
	A care plan, dated 11	velling urinary catheter					
	needed due to urinar				·		
	riboded date to distillat	, common					ļ
	GoalWill have no a	cute complications of					
	urinary catheter use						
		i '_					ļ <b>(</b>
	Interventions/Tasks	Report any changes in					

	1	MEDICAID SERVICES	T				7. 0930-0391
STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375094	B. WING			1	C
		375054	O. MING.			12	/07/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HANODO	Ade ligal til bedyddio	THOL		24	426 SOUTH MEMORIAL		
MANORGA	ARE HEALTH SERVICES	FICESA		Т	ULSA, OK 74129		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE
TAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ue	
			1				1 15 1/
F 441	Continued From page	e 38	F.	441			1-15-16
	amount and color, or	odor of urineCatheter					]
	care"		1				Į į
			Ì				
	On 11/30/15 at 9:00	a.m., during a general tour of	1				<b>!</b>
		ent was observed in her					( [
	- ,	e room was open. Her					
		was observed on the floor					: 
	and uncovered.						
	At 9:49 am CNA #2	was asked how a resident's					}
		should be stored to prevent	1				1
		on. She stated, "I'm not	}				i
	sure."	an one oatou, in her		;			
							į
	She was then asked	if it is acceptable for a					
		to be stored on the floor.					Ì
	She stated, "No."						[
	1						ļ <u></u>
	On 12/03/15 at 3:10	o.m., the administrator was					
į	asked how urinary ca	theter bags should be		ı			
<u> </u>	stored to prevent pos	sible contamination. She	-				į <b>į</b>
ļ	stated, "Off the floor."	•		ĺ			i l
. ۱			1				ļ <b>[</b>
		f of the observation. She	ĺ	1			'
	stated, "Ok."		1 _				]
		IPTLY NOTIFY PHYSICIAN	↓ F	505	~~~~		
SS≍E į̇́	OF LAB RESULTS		1		The facility will continue to ensure that th		an
				Ì	is promptly notified of abnormal lab result	ts.	1
		nptly notify the attending			Resident #4 has been reviewed and the ph	·miaian b	
	physician of the findir	ngs.			been notified of abnormal lab results.	ysician n	ias
,	!		]	,	occu notation of gonorium isto leatiffs.		1
	This REOUREMENT	is not met as evidenced			Residents residing in the facility with order	ers for lal	bs
	by:				have the potential to be affected by this pr		ļ
	-	in, staff interview, and record	]				
; [		ined the facility failed to act	1		Licensed staff will be re-educated on the lab tracking guideline to ensure timely physician notification of		
		atory values for one (#4) of		Ì			
		ts whose laboratory values	1		abnormal lab results.		1
	igar campioa rooidon	)	1				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	O I ON WILDIOANE &	MEDICAID SERVICES				CINIC IA	J. 0330-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		375094	B. WING_			1	C /07/2015
NAME OF P	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	,			24	25 SOUTH MEMORIAL		
MANORO	ARE HEALTH SERVICES	S-TULSA	Ì		JLSA, OK 74129		
	. CLBALA DV CO	PATENTAL OF DESIGNATION	L			· · · · · · · · · · · · · · · · · · ·	T
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
,					The Director of Nursing and/or designee	vill	1-15-16
F 505	Continued From pag	e 39	F 5	05	conduct random audits weekly for 60 days		itor
	were reviewed. This	had the potential to affect all		;	for ongoing compliance.		
		ided in the facility. Findings:			for oribanis combined		
					Audit findings and trends will be reported	to the	
	A facility policy titled,	Laboratory Tracking	Ì		QA Committee for oversight and		
	Guidelines, dated 08	/2014, documented,			recommendations for changes to plan as r	eeded.	
	"Reported to the at		Į				1
	immediately if ordere	d STAT or results are in					!
	critical or panic value		i				
	for other lab results.						
	Resident #4 was admitted to the facility on			ļ			
	03/29/13 with diagno			Ì			
		sease without heart failure,					
		cy, urinary tract infections,					<u> </u>
	anemia, and gastroe	•					
	A comprehensive ma	etabolic panel laboratory					
	1 -	05/14/14, documented,	ì	!			
	"ALB [albumin] 3.3						
	ted [albeitha] o.o.	(Or Maryon					
	A significant change	assessment, dated 10/08/15,					
	documented he was			- {			
		cision making skills. He					
		ssistance of one staff person		; 			ĺ
	for eating and weigh	ed 154 lbs.	 				
	A care plan, updated	10/18/15, documented,					
		status as evidenced by					ļ
	significant weight los	s. Poor appetite. Now		İ			
		meals/intakeGoal: Will				•	
	experience no furthe	significant weight					ļ <b>Ì</b>
	lossInterventions/T	asks: Administer					ļ <b>!</b>
	medications as order	i · · · · · · · - · · · · · · · · ·					j
	foodsObtain labs a						
	physician of results	<b>7</b>		İ			;
		nt record, dated November					
		physician order originally		}			
	nated (19/39/13 for a	CRC CMP TSH FLP R-12	§	J.			1 <b>1</b>

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
				·			С
		375094	B. WING_			12/	07/2015
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
MANORCA	ARE HEALTH SERVICES	LTUI SA	1	242	25 SOUTH MEMORIAL		
MUNICING	in installed	1000	l	TU	ILSA, OK 74129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG	Continued From page in May.  The clinical record did results from May 201  A physician telephone documented, "CBC  A comprehensive me report, dated, 11/14/1 (3.6-5.1)"  The laboratory report [PA-c] at 2030 [8:30 porders" The report documentation the plf follow-up to the abnoon 12/03/15 at 9:30 asked if he was made values from the 11/14 metabolic panel report no. He further stated the lab results sheet,  On 12/03/15 at 9:35 awas responsible to er lab work is completed.	d not contain laboratory 5. e order, dated 11/14/15, c CMP STAT"  tabolic panel laboratory 5, documented, "ALB1.9  documented, "Spoke with o.m.] 11/14/15no new did not contain nysician was faxed a copy or rmal labs.  a.m., physician #1 was e aware of the abnormal lab l/15 comprehensive rt from the lab. He stated from the documentation on his PA-c was informed.  a.m., RN #2 was asked who issure the required annual l. She stated the nurses are		505		TE .	1-15-16
	On 12/03/15 at 9:45 a what lab results from reported to the PA-c. range lab values."	at required labs are done.  a.m., LPN #7 was asked the 11/14/15 CMP were She stated, "All of the out of  physician was notified via the stated, "I am not sure."	continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the continued to the contin				
	On 12/03/15 at 10:25	a.m., PA#1 as asked if she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
!	· !	375094	B. WING_				C 107/2015
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-TULSA				24	TREET ADDRESS, CITY, STATE, ZIP CODE 125 SOUTH MEMORIAL ULSA, OK 74129		0172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 505	work dated 11/14/15, recall being contacted received approximate it was difficult to reme. She was asked if an concern. She stated previous labs to comp	notified of the abnormal lab She stated she did not d. She further stated she sly 80 calls per weekend, so	F	505			J-15-16
	faxed to her or the ph not know.  She was asked if she weekend to assess it abnormal lab values. 483.75(I)(1) RES RECORDS-COMPLE LE  The facility must mair resident in accordance standards and practic accurately documents systematically organic. The clinical record mainformation to identify resident's assessment services provided; the	She stated no.  TE/ACCURATE/ACCESSIB  Intain clinical records on each se with accepted professional reset that are complete; and readily accessible; and red.  Just contain sufficient the resident; a record of the resists; the plan of care and	F	514	The facility will continue to maintain clinic on each resident in accordance with accept professional standards and practices that accomplete; accurately documented and read accessible.  Resident # 1 no longer resides in the facility Residents residing in the facility that requiveights have the potential to be affected by practice.  Nursing staff will be re-educated on the guobtaining and documenting weekly weight	ted te ty.  re week! y this  ideline fi	<b>y</b>
		is not met as evidenced			The Director of Nursing and/or designee w conduct random audits weekly for 60 days for ongoing compliance.		tor

C 12/07/201  NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES-TULSA  C 12/07/201  STREET ADDRESS, CITY, STATE, ZIP CODE 2425 SOUTH MEMORIAL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2425 SOUTH MEMORIAL			375094	B. WING			_	
TULSA, OK 74129		0	S-TULSA		2425 SOUTH MEMORIAL	CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
F 514 Continued From page 42 by: Based on clinical record review, staff interviews and review of facility policy and procedure, it was determined the facility falled to document weekly weights for one (#1) of five sampled residents reviewed with routine orders for weights. This had the potential to affect all 71 residents Identified by the facility whose weights are obtained routinely. Findings: A facility policy titled, Clinical Record System-Overview, documented: "Clinical records are maintairied on each patient that are complete, readily accessible and systematically organized. A complete clinical record reports the actual experience of the individual and contains sufficient information to validate patient status and outcomes of carle provided"  Resident #1 was admitted to the facility on 11/04/15 with diagnoses which included cerebrovascular disease, left hemiparesis, dysarthria, and diabetes melitius type II.  Monthly physician's orders, dated December 2015, documented, "Weight Order11/04/15-Weekty Weight for 28 days (4 weeks)"  A restment administration record, dated November 2015, documented, "Weekty weights x 4 weeks then monthly."  According to the treatment administration record, weights were to be done by the day shift on 11/4/15, 11/1/11/5, 11/18/15, and 11/25/15.  The weights were reviewed on the treatment record. The admission weight done on 11/4/15	bilad with ico FAS Rico as a Rico d M2C w AN4 A will T	by: Based on clinical recamd review of facility determined the facility weights for one (#1) or reviewed with routine had the potential to a identified by the facility obtained routinely. Findings: A facility policy titled, System-Overview, do records are maintaine complete, readily accorganized. A comple actual experience of sufficient information and outcomes of care Resident #1 was adm 11/04/15 with diagnos cerebrovascular diseadysarthria, and diabet Monthly physician's o 2015, documented, "Order11/04/15-Wee weeks)"  A treatment administr November 2015, docid weeks then monthly According to the treat weights were to be de 11/4/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15, 11/11/15	cord review, staff interviews policy and procedure, it was y failed to document weekly of five sampled residents or orders for weights. This affect all 71 residents ity whose weights are  Clinical Record ocumented: "Clinical ed on each patient that are exessible and systematically et clinical record reports the the individual and contains to validate patient status e provided"  Initted to the facility on ses which included asse, left hemiparesis, ites mellitus type II.  Incorders, dated DecemberWeight ekly Weight for 28 days (4)  Tation record, dated umented, "Weekly weights x y."  Imment administration record, one by the day shift on (18/15, and 11/25/15.	F 5	QA Committee for oversigh	nt and	•	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		375094	B. WING			C 12/07/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	1 12/0//2010		
MANORC	ARE HEALTH SERVICES	e-tulsa		2425 SOUTH MEMORIAL TULSA, OK 74129				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCES	AN OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA GIENCY)	1		
F 514	Continued From page was documented as		F :	514		1-15-16		
	The space for the we	ight documentation on						
		ight documentation on als of LPN #4 but no weight.						
	The space for the we 11/25/15 was blank.	ight documentation on						
	asked for the weekly She stated the weigh the treatment admini	a.m., the administrator was weights for the resident. Its should be documented on stration record and she o provide the requested surveyor.						
	treatment administrat	DN showed the surveyor the tion record, which had all recorded. The DON was had been added since						
-	weights. The DON p which documented, " Weekly178.6178. was the only docume These weights corres recorded on the treat The DON stated she	4179.8177.6" This ntation on the sticky note. ponded to the four weights ment administration record. was unaware of who had						
	At 10:30 a.m., the ac surveyor and stated s the late documentation	hts, but would look into it.  Iministrator approached this he was unhappy regarding n of weights on the resident. For would be an internal situation.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	1	375094	B. WING_			C 12/07/2015
	ROVIDER OR SUPPLIER	-TULSA		STREET ADDRESS, CITY, STATE, ZIP 2425 SOUTH MEMORIAL TULSA, OK 74129	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN O  (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	THE APPROPRIA	
F 514	the weights on the resadministration record	o.m., the DON was asked if sident's treatment were accurate. She stated	F	514		1-15-16
	done on 11/04/15.  She was asked who after the copy had be	nce in the admission weight had recorded the weights en provided on 11/30/15. how. That's the investigation				
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	:					
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