| STATEMENT | OF DEFICIENCIES OF CORRECTION | E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | TE SURVEY MPLETED |
|-------------------------------|---|---|-----------------------------|--|---|------------------------------|
| | | 375519 | B. WING _ | | 07 | /23/2015 |
| | PROVIDER OR SUPPLIER | | · | STREET ADDRESS, CITY, STATE, ZIP CODE 1061 NORTH ACCESS ROAD CALERA, OK 74730 | | |
| (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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMEN | TS | F 00 | 0 | | |
| F 157 SS=E | conducted on 07/2 07/23/15. | nd relicensure survey was 0/15, 07/21/15, 07/22/15, and TFY OF CHANGES E/ROOM, ETC) | F 15 | 7 | | |
| | consult with the resknown, notify the resknown, notify the reor an interested far accident involving I injury and has the printervention; a sign physical, mental, or deterioration in heat status in either life clinical complication significantly (i.e., a existing form of tre consequences, or a treatment); or a det the resident from the §483.12(a). The facility must all and, if known, the resident rights underegulations as specified in §483.1 resident rights underegulations as specified in Section. The facility must re the address and physical for the resident from the section. | ediately inform the resident; sident's physician; and if esident's legal representative nily member when there is an the resident which results in potential for requiring physician ificant change in the resident's r psychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge ne facility as specified in so promptly notify the resident resident's legal representative member when there is a roommate assignment as I5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update none number of the resident's e or interested family member. | | F 157 RECEIVE AUG 1 7 2015 Long Term Care 1. Resident #25 has comp antibiotics and no wou odor is present at this to Wound care will conti to be provided daily por physician's orders. Physician's orders. Physician's orders. Physician's orders. Physician's orders. Physician's orders were inserviced regarding p ulcers, wounds, wound and prompt notification physician. | oleted ind time. nue er her tysician tly of 15 all ressure i odors | 08/18/15 |
| Slia | merent | DERISUPPLIER REPRESENTATIVE'S SIGN | | Administrator | | (X6) DATE 8/13/19 |
| ther safegua slowing the d | rds provide sufficient pro date of survey whether o the date these docume | ptection to the patients. (See Instruction r not a plan of correction is provided. F | s.) Except for nursing i | ution may be excused from correcting prov for nursing homes, the findings stated above nomes, the above findings and plans of corr s are cited, an approved plan of correction | re are disclos rection are di | able 90 days sclosable 14 |

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| | | AND HUMAN SERVICES | | | PRINTED: FORM A OMB NO. | APPROVED |
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| | T of deficiencies of correction | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 · · | TIPLE CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 375519 | B. WING | | 07/2 | 3/2015 |
| NAME OF | PROVIDER OR SUPPLIER | · · · · · · · · · · · · · · · · · · · | · | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CALERA | MANOR, LLC | | | 1061 NORTH ACCESS ROAD CALERA, OK 74730 | | |
| (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 CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | VLD BE | (X5) COMPLETION DATE |
| F 157 | Continued From pa | ge 1 | F1 | 57 | | : |
| | by: Based on record re observation, it was ensure the physicia a potential for a req intervention for one sampled whose me The facility failed to noticing a wound or which delayed a tre The Director of Nur residents who resid Findings: The facility's 'Care a Ulcer' policy docum "if a pressure ulce nurse is responsible skin, including stage drainage and color provided. Notification when a new pressu when treatment is n 1. Resident #25 wa 01/02/13. Diagnose cellulitis/abscess, si disorders, pain, abn weakness, muscula Alzheimer's Disease A significant change documented the res impaired; required e activities of daily livi | and Prevention of Pressure ented the following: er is present, the licensed a to record condition of the e, size, site, depth, color, as well as the treatment on of the physician is required re ulcer is identified as well as ot effective." as admitted to the facility on es included pressure ulcers, kin and subcutaneous tissue formal loss of weight, muscle assessment, dated 11/17/14, sident's cognition was severely extensive assistance with ng (ADLs) and did not | | 2. All residents are poter affected by this allege deficient practice. 3. DON, ADON, and M Nurse will do weekly measurements of all pressure areas together Staging of wounds wildone by DON or RN will mon the skin book daily for compliance and to ensithe physician has been notified promptly of a decline. QA committee will monitor monthly compliance. RECEIVED AUG 17 2015 Long Term Care | ed DS er. Il be only, itor r sure 1 ny se for | |
| FORM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID; D1H911 | | Facility ID: NH070301 If conti | inuation sheet I | Page 2 of 30 |

| STATEMENT OF DEFICIENCES (N1) PERVICEATION NUMBER: (P2) MUITURE CONSTRUCTION (P3) ONE SIMPLE (P | | | AND HUMAN SERVICES | | | | | FORM | 08/10/2015 APPROVED 0938-0391 |
|--|-----------|--|--|---------|-----------------|---------------------------------------|---------------------------------|----------|-------------------------------------|
| MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CALERA, MANOR, LLC JOINT ACCESS ROAD CALERA, MANOR, LLC CALERA, VA 1730 Provide and the control of period control of the control | STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | TRUCTION | | (X3) DAT | E SURVEY |
| NAME OF PROVIDER OR SUPPLIER SIMUMARY STATEMENT OF DEFIDENCIES SIMUMARY STATEMENT OF DEFIDENCIES CALERA MANOR, LLC D PROVIDER'S FLAN OF CORRECTION CALERA, OK 74730 CALERA, OK 74730 PREFX REGULATORY OR USE DENTIFYING NUMBER PLAN OF CORRECTION CALERA, OK 74730 F157 Confinued From page 2 ambutate; was always incontinent of bowel and bladder; and had two stage II pressure ulcors with oschar being the most severe tissue type. F 157 A skin assessment, dated 01/19/15, documented a stage II pressure ulcor on the resident's right hip with measure 2.5 x 2.0 x 2.2 centimeter (cm) with granutation, undermining, and drainage. F 157 The following were skin assessments and physician's order, dated 01/12/15, documented to clean the area to the right hip with wound deenser (WC), pat dry, apply Santy to wound bed, pack with Santy Cover gauze; cover with non border form dressing and secure with tape daily x 14 days. MEECEIVED AUG 17 2015 02/02/15stage II2.3 x 1.5 x 2.0 cm with slough and drainage. A physician's order, dated 03/20/15, documented to continue the previous order. A physician's order, dated 03/20/15, documented to continue the previous order. Aug 17 2015 Long Term Care Long Term Care A physician's order, dated 03/20/15, documented to continue the previous order. Long Term Care A physician's order, dated 03/20/15, documented to continue the previous order. Long Term Care | | | 375519 | B, WING | | · · · · · · · · · · · · · · · · · · · | | 07/: | 23/2015 |
| CALERA, OK 74730 CALERA, OK 74730 CM ID PREFX TAG EAUMARY STATEMENT OF DEFIDIENCIES (EAU DEFIDIENCIES) (EAU DEFIDIENCY MIST RE PRECIDED BY FULL RESULTORY ON LG DEMITTYNG INFORMATION) PREFX PREFX PREFX PREFX TAG PREFX PREFX CACESAREFIEWED TO THE APPROPRATE CACESAREFIEWED | NAME OF | PROVIDER OR SUPPLIER | · · | · | STREET | ODRESS, CITY, STAT | E, ZIP CODE | | |
| CALLER, PROVIDENCE PLAN OF CONNECTION PREFIX TAG CALLER, PROVIDENCE PLAN OF CONNECTION EACH CORRECTION ACTION ON LSC DENTIFYING INFORMATION D PREFIX TAG D PREFIX D PREFIX TAG D PREFIX TAG D PREFIX TAG D PREFIX TAG D PREFIX TAG D PREFIX TAG D PREFIX D | CALERA | MANOR, LLC | | | | | 5 | | |
| Pricing TAG REGULTION OR LSC IDENTIFYING INFORMATION) PREFX TAG REGULTION OR LSC IDENTIFYING INFORMATION) PREFX TAG REGULTION OR LSC IDENTIFYING INFORMATION) Could and the test of test | 07121210 | | | | CALER | 4, OK 74730 | | | |
| ambulate; was always incontinent of bowel and biadder; and had two stage II pressure ulcers with eschar being the most severe tissue type. A skin assessment, dated 01/19/15, documented a stage II pressure ulcer on the resident's right hip which measured 2.5 x 2.0 x 2.2 centimeter (cm) with granutation, undermining, and drainage. The following were skin assessments and physician's orders for the pressure ulcer on the resident's right hip: A physician's order, dated 01/22/15, documented to clean the area to the right hip with wound bed, pack with Santyl cover gauze; cover with non border form dressing and secure with tape daily x 14 days. D1/26/15stage II2.3 x 1.5 x 2.0 cm with slough, undermining, drainage and odor. (There was no documentation of the physician's being notified about the odor to the pressure ulcer.) D2/02/15stage II2.3 x 1.5 x 2.0 cm with slough and drainage. A physician's order, dated 02/05/16, documented to continue the previous order. A physician's order, dated 02/05/16, documented to clean the right hip wound with WC, pat dry, apply Santyl to wound bed, pack with Santyl covered gauze; cover with non border foam and abdominal (ABD) pad and secure with tape daily x 14 days. D3/30/15stage II1.3 x 1.0 x 3.0 cm with | PREFIX | (EACH DEFICIENC) | MUST BE PRECEDED BY FULL | PREFI | | (EACH CORRECTIVE ROSS-REFERENCED | ACTION SHOULD TO THE APPROPR | BE | (X5) COMPLETION DATE |
| x 14 days. 03/30/15stage II1.3 x 1.0 x 3.0 cm with | F 157 | ambulate; was alwa bladder; and had tw eschar being the m A skin assessment, a stage II pressure hip which measured (cm) with granulatio The following were physician's orders for resident's right hip: A physician's order, to clean the area to cleanser (WC), pat bed, pack with Sant non border foam dra daily x 14 days. 01/26/15stage II slough, undermining was no documentat notified about the oc 02/02/15stage II slough and drainage A physician's order, to continue the prev A physician's order, to clean the right hip apply Santyl to woun covered gauze; cove | ays incontinent of bowel and /o stage II pressure ulcers with ost severe fissue type. dated 01/19/15, documented ulcer on the resident's right $1.2.5 \times 2.0 \times 2.2$ centimeter in, undermining, and drainage. skin assessments and or the pressure ulcer on the dated 01/22/15, documented the right hip with wound dry, apply Santyl to wound yl cover gauze; cover with essing and secure with tape -2.3 x 1.5 x 2.0 cm with g, drainage and odor. (There ion of the physician being dor to the pressure ulcer.) -2.3 x 1.5 x 2.0 cm with bios order. dated 02/05/15, documented lous order. dated 03/20/15, documented wound with WC, pat dry, nd bed, pack with Santyl er with non border foam and | F1 | 57 | REC | CEIVE Ug 1 7 2015 | | |
| | | x 14 days. ` | | | | | | | |
| | 09404005 | | ······································ | | Equility (D) 11 | | الاستقصام ال | | Data 0 400 |

| STATEMENT | CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION 375519 | | | | CONSTRUCTION | (X3) D | O. 0938-0391 ATE SURVEY OMPLETED |
|--------------------------|--|--|-------------------|-----|--|--------------------------------|--|
| | | 375519 | B. WING | i | | 0 | 7/23/2015 |
| | PROVIDER OR SUPPLIER MANOR, LLC | | - 1 , | 106 | EET ADDRESS, CITY, STATE, ZI 1 NORTH ACCESS ROAD LERA, OK 74730 | | |
| (X4) ID Prefix Tag | (EACH DEFICIENCY | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HEAPPROPRIATE | (X5) COMPLETION DATE |
| F 157 | Continued From pa undermining and di | rainage. | F ′ | 157 | | | |
| | slough, underminin was no documenta | 1.3 x 1.0 x 2.5 cm with g, drainage, and odor. (There tion of the physician being dor to the pressure ulcer at | | | : : | | |
| | | 1.3 x 1.0 x 2.0 cm with g, drainage, and odor. | | | | | |
| | the resident was to milligram one table ulcer. (The treatme | dated 04/16/15, documented receive Bactrim DS 800-160 t twice a day for hip pressure ant for the pressure ulcer was fiter the odor was first noticed | | | | | |
| · • • | to clean the right hij layer of Vasolex oin | dated 04/20/15, documented o wound with WC, apply thin tment and Vaseline gauze; ABD pad daily x 14 days. | · - | ίκ | • | , | |
| | | 1.0 x 0.5 x 1.0 cm with g, drainage and odor. | | | | | |
| | why the physician h ten days later after ulcer had first been did not feel the odo but had been from i 483.20(g) - (j) ASSE | | F2 | 278 | | | |
| | The assessment m resident's status. | ust accurately reflect the | | | | | |

Facility ID: NH070301

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| | RS FOR MEDICARE | & MEDICAID SERVICES | (X2) #41 11 TI | IPLE CONSTRUCTION | |). 0938-039 Te survey |
|--------------------------|---|--|---------------------|---|--|---------------------------|
| | OF DEPOILNOILS | IDENTIFICATION NUMBER: | - · | IG | | MPLETED |
| | | 375519 | B. WING | | 07 | /23/2015 |
| VAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CALERA | MANOR, LLC | | | 1061 NORTH ACCESS ROAD CALERA, OK 74730 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE | (X5) COMPLETIO DATE |
| F 278 | each assessment v participation of hea A registered nurse | must conduct or coordinate with the appropriate Ith professionals. must sign and certify that the | F 27 | F 278 | | |
| | | o completes a portion of the ign and certify the accuracy of | | | | 08/18/1 |
| | willfully and knowing false statement in a subject to a civil mo \$1,000 for each ass willfully and knowing to certify a material resident assessment penalty of not more assessment. | d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each | | On 7/27/15 a signific change assessment w completed on Reside #25 to correct the stat of wounds from stag to unstageable. On 7 a bladder assessment completed on Reside #47. Resident #47 w | vas nt ging e II V27/15 was nt | |
| | material and false s This REQUIREMEN by: Based on record re interview, it was det ensure resident ass the residents' status sampled residents v reviewed. The quar | NT is not met as evidenced eview, observation and ermined the facility failed to sessments accurately reflected s for two (#25 and #47) of 29 whose assessments were rterly assessment, dated | | found to be frequentl incontinent. The 3/2 assessment for Resid #47 was modified to correct the inaccurac On 7/27/15 DON, Al and MDS Nurse mea all pressure areas tog DON checked the acc | 2/15 ent y. DON, sured ether. | |
| | inaccurately staged resident #25. The a | ignificant change d 11/17/14 and 07/05/15, had the pressure sores for admission assessment, dated surately assessed resident #47 | | of the staging of all pressure areas at that As of 8/12/15 all resi have had a new bowl | dents | |

Facility ID: NH070301

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If continuation sheet Page 5 of 30

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PRINTED: 08/10/2015 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | e survey Pleted |
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| | | 375519 | B, WING | | | 07/: | 23/2015 |
| | PROVIDER OR SUPPLIER | | | 10 | REET ADDRESS, CITY, STATE, ZIP CODE 61 NORTH ACCESS ROAD ALERA, OK 74730 | | 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION) | ID PREFID TAG | T | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DBE | (X5) COMPLETIO DATE |
| F 278 | | it of urine. ed five residents with pressure ents occasionally or frequently | F 2 | 78 | bladder evaluation completed to ensure the accuracy of their assessments. | 3 | |
| | 03/09/15. The resi | Resident #47 was admitted to the facility on 09/15. The resident's diagnoses included eractive bladder, congestive heart failure, and | | | 35 residents are potenti affected by this alleged deficient practice. | - | |
| | documented the re- A score of 21-15 in candidate for bowe The admission ass | er evaluation, dated 03/09/15, sident had a total score of 18. dicated the resident may be a I and bladder training. essment, dated 03/22/15, sident's cognition was intact | | | DON, ADON, and MD Nurse will measure all pressure areas together weekly. Staging of wounds will be done by DON or RN only. Black | | • |
| | documented the re- frequently incontine good candidate for A significant change documented the re- | ntinent. er evaluation, dated 06/07/15, sident had scored 18, was ent of bladder and may be a bowel and bladder training. e assessment, dated 06/22/15, sident's cognition was intact incontinent of urine. | | | evaluations will be completed by MDS Nu and DON will review for accuracy. QA committ will monitor monthly for compliance. | or ee | |
| | A care plan, dated 06/22/15, documented the resident had an overactive bladder and experienced incontinent episodes of dribbling. On 07/22/15 at 12:36 p.m., the minimum data set | | | | | | |
| | (MDS) coordinator resident becoming i | was interviewed regarding the incontinent of urine per the ent after being in the facility for | | | ily ID: NH070301 If continua | | Page 6 of 3 |

| | | AND HUMAN SERVICES | | | | APPROVED 0. 0938-0391 |
|--------------------------|--|---|---------------------|--|---------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 375519 | 8. WING | | 07 | /23/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | Lange and a second a | | FREET ADDRESS, CITY, STATE, ZIP | | |
| CALERA | MANOR, LLC | | 1 | 061 NORTH ACCESS ROAD ALERA, OK 74730 | *** *** | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | id Prefix Tag | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE | (X5) COMPLETION DATE |
| F 278 | shown the two MDS admission assessm documenting the re urine and three mol assessment, dated resident was freque MDS coordinator sa between the two as the resident would would change them | The MDS coordinator was S assessments with the nent, dated 03/22/15, sident was always continent of nths later the significant 06/22/15, documenting the ently incontinent of urine. The nid she thought the confusion sessments was due to the fact wet her depends at night but before the staff knew she nt. The MDS coordinator said | F 278 | | | |
| | Nursing (DON) was The DON said the a 03/22/15, was proba | 0 a.m., the Director of shown the two assessments. admission assessment, dated ably wrong. The DON said the he mornings have always | | | | |
| | looked at the admis 03/22/15, document continent of urine. I was asking the wro understand what I w admission assessm | 9 a.m., the MDS coordinator sion assessment, dated ting the resident was always The MDS coordinator stated, " ong question and they did not vas asking. I think the ent was wrong." She said the en continent of urine since the ed to the facility. | - | | · . | |
| | 01/02/13. Diagnose cellulitis/abscess, sl disorders, pain, abn | is admitted to the facility on es included pressure ulcers, kin and subcutaneous tissue ormal loss of weight, muscle r disuse atrophy, anxiety, and | | | | |
| | A skin assessment, | dated 11/17/14, documented | | | | |
| ODH CHIS 26 | 67(02-09) Previous Versions | Obsolete Event ID: D1H911 | Faci | Ity ID: NH070301 | If continuation she | Dana 7 of 30 |

| | | AND HUMAN SERVICES | | | | FORM | : 08/10/2015 APPROVED . 0938-0391 | |
|---------------|---|--|--------------|----|---|------------|---|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | e survey Ipleted | |
| | | 375519 | B. WING | | <u> </u> | 07/23/2015 | | |
| NAME OF | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| CALERA | MANOR, LLC | | | | 061 NORTH ACCESS ROAD ALERA, OK 74730 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | l di | | PROVIDER'S PLAN OF CORRECT | | (76) | |
| PREFIX TAG | (EACH DEFICIENCY | 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 278 | Continued From pa | ge 7 | F2 | 78 | | | | |
| | which measured 3.0 slough, and drainag | ulcer to the resident's right hip 0 x 2.0 x <0.1 cm with eschar, ge. (A pressure ulcer with is considered unstageable.) | | | | | | |
| | documented the res impaired; needed e activities of daily livi ambulate; was alwa bladder; two stage I being the most seve assessment did not | e assessment, dated 11/17/14, sident's cognition was severly xtensive assistance with ng (ADLs) and did not ys incontinent of bowel and I pressure ulcers with eschar ere tissue type. (The include an unstageable e pressure ulcer dimensions.) | | | | | | |
| • | pressure ulcer on th 11/24/14stage II | kin assessments for the ne resident's right hip: -2.0 x 2.0 x <0.1 cm with | | | • • : | • | | |
| | eschar, slough, and | drainage. | | | • . | | | |
| | 12/01/14stage II eschar, slough, and | -2.0 x 2.5 x <0.1 cm with drainage. | | | | | | |
| | 12/15/14stage II eschar and slough. | -2.5 x 3.0 x <0.1 cm with | | | | | | |
| | 12/22/14stage II eschar and slough. | -3.0 x 3.5 x <0.1 cm with | | | | | | |
| | 12/29/14stage II granulation and slou | -3.0 x 3.0 x <0.1 cm with igh. | | | | | | |
| | 01/05/15stage II granulation, slough a | | | | | · | | |
| | granulation and drai | -2.5 x 2.0 x 2.0 cm with nage. (A pressure ulcer with granulation and no slough is | | | | | | |

Facility ID: NH070301

If continuation sheet Page 8 of 30

| CALERA MAN | | AND HUMAN SERVICES | | | | | FORM | 08/10/2015 APPROVED 0938-0 <u>391</u> | |
|---|---|--|--------------------|------------------|---|---------------|------------|---|--|
| CALERA MAN | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONST | RUCTION | | (X3) DATE | e Survey Pleted | |
| CALERA MAN | | 375519 | 8. WING | | | | 07/23/2015 | | |
| (X4) ID PREFIX TAGF 278Cor conF 278Cor con01/2 slou02/0 grar02/0 grar02/0 grar02/1 grar02/1 grarA sig doct pres | ROVIDER OR SUPPLIER | ······· | | | DRESS, CITY, STATE, 2 | IP CODE | | | |
| PREFIX TAG F 278 Corr con 01/2 slou 02/0 grar 02/1 grar 02/1 grar A sig doct pres one bein sign unst dime The pres 02/2 grar 02/2 | MANOR, LLC | | | | TH ACCESS ROAD OK 74730 | | | | |
| con 01/2 slou 02/0 grar 02/1 grar 02/1 grar A sig doct pres one bein sign unst dime The pres 02/2 gran 02/2 gran | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF EACH CORRECTIVE ACT DSS-REFERENCED TO DEFICIENC | FION SHOULD I | | (X6) Completion Date | |
| dime The pres 02/2 gran 04/0 | 01/26/15stage II- slough, undermining 02/02/15stage II- slough and drainag 02/09/15stage II- granulation, slough 02/16/15stage II- granulation, slough A significant change documented the res pressure ulcer, two one deep tissue injubeing the most sevent significant change a | three (III) pressure ulcer.) 2.3 x 1.5 x 2.0 cm with g, drainage and odor. 2.3 x 1.5 x 2.0 cm with e. 2.3 x 1.5 x 2.5 cm with and drainage. 2.3 x 1.5 x 2.0 cm with | F 2 | 278 | | | | | |
| slou 04/2 slou 05/1 | pressure ulcer on the 02/23/15stage II granulation, slough 04/06/15stage II slough, undermining 04/13/15stage II slough, undermining slough, undermining | 1.3 x 1.0 x 2.5 cm with g, drainage, and odor. 1.3 x 1.0 x 2.0 cm with g, drainage, and odor. 1.0 x 0.5 x 1.0 cm with g, drainage and odor. 0.8 x 0.5 cm with slough and | | Facility ID: NHI | | | | Page 9 of 30 | |

| | | AND HUMAN SERVICES | | | | FOR | D: 08/10/2015 MAPPROVED D. 0938-0391 |
|--------------------------|---|--|---------------------------------------|----------|---|--------------------------------|--|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DA | ite survey Mpleted |
| | | 375519 | B. WING | ••••• | · · · · · · · · · · · · · · · · · · · | 07 | 7/23/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| CALERA | MANOR, LLC | | | | I NORTH ACCESS ROAD LERA, OK 74730 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 278 | drainage. | ge 9 0.7 x 0.5 cm with slough and | F 2 | 78 | | | |
| | drainage. | | | | | | |
| | documented the re- pressure ulcers with severe tissue type. | nent, dated 05/20/15, sident had four stage II n eschar being the most (The quarterly assessment nstageable pressure ulcer or limensions.) | | | | | |
| | (LPN) #1 was asked ulcer was staged as a 2.0 cm depth. Th she could up-stage | am, licensed practical nurse d why the resident's pressure a stage II when the ulcer had e LPN said she did not know the wounds. She said she I nurse was supposed to ulcers. | | | • | · . | |
| | about the inaccurate documentation of the stated she inservice the issues. She sai slough or eschar she unstageable. The E nurses they could in | I pm, the DON was asked e staging and incomplete the pressure ulcers. She ad the nurses yesterday about d the pressure ulcers with ould have been staged as DON said she explained to the acrease stage severity of the the pressure ulcers could not ower stage. | | | · | · · · · | |
| | observed receiving her right hip. The p approximate 0.2 cm | • • | | | . • | • | |
| | (MDS) coordinator v assessments, dated | 0 am, the minimum data set was asked why the MDS I 11/17/14, 05/20/15, and | | | | | |
| ORM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID: D1H911 | 1 | Facility | 1D; NH070301 | If continuation shee | Down 10 of 10 |

| · · · · · | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) ML | TIDI | LE CONSTRUCTION | | NO. 0938) DATE SURV | |
|--------------------------|---|--|--------------------|------|---|-------------------------------|-------------------------|-----------------------|
| | of Deficiencies | IDENTIFICATION NUMBER: | A. BUILD | | | (/// | COMPLETE | |
| | | 375519 | B. WING | i | ····· | | 07/23/20 | 15 |
| NAME OF I | PROVIDER OR SUPPLIER | | • | S | STREET ADDRESS, CITY, STATE, ZI | P CODE | | |
| CALERA | MANOR, LLC | | | | 1061 NORTH ACCESS ROAD CALERA, OK 74730 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF 0 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ON SHOULD BE HE APPROPRIAT | COM | X5) PLETION ATE |
| F 278 | pressure ulcer. She assessments and s documented an uns instead of a stage II was asked if she ad skin and ulcers. Sh 3. Resident #25 wa 01/02/13 and had d pressure ulcers, cel subcutaneous tissur loss of weight, must disuse atrophy, anx A significant change documented the res impaired; needed et activities of daily livi ambulate; was alwa bladder; and had or ulcer, two stage II p tissue injury pressur most severe tissue assessment did not pressure ulcer or the A skin assessment, the resident had a s the right ball of her f centimeters (cm) x with a purple/red bil (The pressure ulcer instead of an unstage | clude the unstageable e reviewed the skin aid she should have stageable pressure ulcer I ulcer. The MDS coordinator stually viewed the resident's he said, "Yes". As admitted to the facility on iagnoses which included lulitis/abscess, skin and e disorders, pain, abnormal cle weakness, muscular iety, and Alzheimer's disease. As assessment, dated 02/17/15, sident's cognition was severly xtensive assistance with ng (ADLs) and did not ys incontinent of bowel and he stage one (I) pressure ressure ulcers, and one deep re ulcer with slough being the type. (The significant change include an unstageable e pressure ulcer dimensions.) dated 04/09/15, documented tage two (II) pressure ulcer on foot which measured 4.5 x 4.0 unable to determined (UTD) ster with a yellow soft center. was stagged as a stage II geable pressure ulcer.) | F 2 | 278 | | | | |
| | 04/13/15stage II | -4.5. x 4.0 cm with a red area | | | | | | |
| | 87/02_00) Provious Versions | Obsolele Event ID: D1H911 | | rac | NH070301 | If continuation a | hast the | 11 -6 20 |

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PRINTED: 08/10/2015 FORM APPROVED

| CENTE | <u>RS FOR MEDICARE</u> | & MEDICAID SERVICES | | | | <u> MR NO</u> | 0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-----------------|----------------------------|
| | F OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | LE CONSTRUCTION | (X3) DAT COM | e survey Pleted |
| | | 375519 | B. WING | 3 | | 07/ | 23/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | · · · · · · · · · · · · · · · · · · · | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| | | | | . | 1061 NORTH ACCESS ROAD | | |
| CALERA | MANOR, LLC | | | (| CALERA, OK 74730 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) Completion Date |
| F 278 | Continued From pa and yellow blister. 04/23/15stage II- blister and white sk | 1.5 x 2.0 x <0.1 cm with a | F | 278 | | | |
| | 04/27/15stage II- slough. | 1.5 x 2.0 x 0.1 cm with white | | | | | |
| | 05/04/15stage II- | 1.8 x 2.0 cm with slough. | | | | | |
| | 05/18/15stage II3.0 x 2.0 cm with unopened red eschar and slough. (The pressure ulcer with eschar and slough continues to be staged as a stage II instead of an unstageable pressure ulcer.) | | | | · · | | |
| | documented the respressure ulcers with severe tissue type. | nent, dated 05/20/15, sident had four stage II n eschar being the most (The quarterly assessment nstageable pressure ulcer or limensions.) | • | | ч | | |
| | The following are sl resident's right foot: | kin assessments for the | | | | | |
| | 05/25/15stage II- slough. | 2.7 x 2.0 cm with eschar and | | | | | |
| | 06/01/15stage II- slough. | 2.5 x 2.0 cm with eschar and | | | | | |
| | 06/08/15stage II- slough. | 2.5 x 2.5 cm with eschar and \cdot | | | | | - |
| | 06/15/15stage II- necrotic tissue, esc | 3.5 x 4.0 cm with black har, and drainage. | | | | | |
| | 06/22/15stage II- | -4.0 x 4.0 cm with slough and | | | | | |

FORM CMS-2567(02-89) Previous Versions Obsolete

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Event ID; D1H911

Facility ID: NH070301

If continuation sheet Page 12 of 30

| | TMENT OF HEALTH RS FOR MEDICARE | | | | | | | FORM | 08/10/2018 APPROVEC 0938-0391 |
|--------------------------|--|---|---|---------------------|---------|--|--------------|-------------|-------------------------------------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPP IDENTIFICATION | LIER/CLIA | | | CONSTRUCTION | | (X3) DATE | SURVEY PLETED |
| | | 37551 | 9 | B. WING | | · | | 07/2 | 23/2015 |
| NAME OF | PROVIDER OR SUPPLIER | J | | | STI | REET ADDRESS, CITY, STA | IE, ZIP CODE | | |
| CALERA | MANOR, LLC | | | | | 1 NORTH ACCESS ROA LERA, OK 74730 | 0 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENC Y MUST BE PRECEDED SC IDENTIFYING INFOR | BY FULL | jd Prefix Tag | (| PROVIDER'S PLAM (EACH CORRECTIVE CROSS-REFERENCED DEFIC | ACTION SHOUL | DBE | (X6) Completion Date |
| F 278 | Continued From pa drainage. 06/29/15stage th slough and drainag | ree (III)4.0 x 3.5 | x UTD with | F 2 | 78 | | | | |
| | A significant change documented the re- pressure ulcers with severe tissue type a (The significant cha include an unstage the pressure ulcer of | e assessment, dat sident had two sta h slough being the and received hosp ange assessment o able pressure ulce | ge II most ice services. lid not | | | . · · · | | | |
| • | On 07/20/15 at 8:58 (LPN) #1 was asked ulcer was staged as the pressure ulcer h stated the pressure staged as unstagea | d why the resident s a stage II and sta nad slough and es ulcer should have | s pressure ige III when char. She | | | • | | | |
| | On 07/22/15 at 4:1 about the inaccurate documentation of the stated she inservice the issues. The DC with slough or esch- as unstageable. The the nurses they cou- of the pressure ulce could not be staged | e staging and inco the pressure ulcers, ad the nurses yeste N said the pressu ar should have be the DON said she e Id increase the sta- ers but the pressur- | mplete She erday about re ulcers en staged xplained to ige severity e ulcers | | | | | | |
| | On 07/23/15 at 9:05 observed receiving her right foot. The j approximately 4 x 4 nurse (RN) #1 was the pressure ulcer. | a pressure ulcer tr pressure ulcer was cm with slough. asked what was th She said it was a | eatment to Registered le stage of stage III. | | | . · | | | |
| | On 07/23/15 at 10:0 | | | · | | | | | |
| ORM CMS-25 | 67(02-99) Previous Versions | Obsolete | Event ID: D1H911 | | Facilit | / ID: NH070301 | If continuat | ion sheef F | ace 13 of 30 |

| | | AND HUMAN SERVICES | . | | PRINTED: 08/10/2015 FORM APPROVED OMB NO: 0938-0391 |
|--------------------------|--|--|---------------------|---|---|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER: | 1. | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 375519 | B. WING_ | | 07/23/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | · | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| CALERA | MANOR, LLC | | | 1061 NORTH ACCESS ROAD CALERA, OK 74730 | , |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | id Prefix Tag | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION |
| F 278 | assessments, dated not include the unst reviewed the skin a should have docum pressure ulcer inste MDS coordinator wa | ge 13 was asked why the MDS I 05/20/15 and 07/05/15 did ageable pressure ulcer. She ssessments and said she ented an unstageable ad of a stage II ulcer. The as asked if she actually s skin and ulcers. She said, | F 27 | 78 | |
| F 314 SS=E | "Yes". 483.25(c) TREATM PREVENT/HEAL PI | ENT/SVCS TO RESSURE SORES | F 31 | 4 F 314 | |
| | resident, the facility who enters the facili does not develop pr individual's clinical of they were unavoidal pressure sores rece | rehensive assessment of a must ensure that a resident ity without pressure sores essure sores unless the condition demonstrates that ole; and a resident having lives necessary treatment and healing, prevent infection and rom developing. | | (a) On 7/27/15 a signif change assessment was completed on resident | #25 |
| | by: Based on record re observation, it was c ensure a resident wi treatment and service | letermined the facility failed to th pressure ulcers received ces to promote healing for esidents sampled for pressure ailed to: | | to correct the staging o wounds from Stage II t unstageable. On 8/3/1 all licensed nurses wen inserviced by our Wou Care Consultant Nurse regarding wound stage | o 5 e nd |
| | b) consistently desc pressure ulcers. | ribe the wound beds of the an about an odor from a | | 5 residents are potentia affected by this alleged deficient practice. | • • |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DAT CON | E SURVEY APLETED |
|--------------------------|---|---|---------------------|--|----------------------------------|---------------------------|
| | | 375519 | B. WING | · | 07 | /23/2015 |
| NAME OF | PROVIDER OR SUPPLIER | <u></u> | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CALERA | MANOR, LLC | | | 061 NORTH ACCESS ROAD ALERA, OK 74730 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETIO DATE |
| F 314 | pressure ulcer for te treatment. The Director of Nur residents residing in ulcers. Findings: The facility's 'Care a Ulcer' policy docum "If a pressure ulce nurse is responsible skin, including stage drainage and color provided. Notificatii when a new pressu when treatment is n 1. Resident #25 wa 01/02/13 and had d pressure ulcers, cel subcutaneous tissu loss of weight, muse disuse atrophy, anx A quarterly assess documented the res impaired; needed et activities of daily livi ambulate; was alwa bladder; and had no A skin assessment, the resident's right h ulcer which measur centimeters (cm) wi | en days which delayed the sing (DON) identified five in the facility with pressure and Prevention of Pressure ented the following: er is present, the licensed e to record condition of the e, size, site, depth, color, as well as the treatment on of the physician is required re ulcer is identified as well as iot effective. as admitted to the facility on iagnoses which included llulitis/abscess, skin and e disorders, pain, abnormal cle weakness, muscular iety, and Alzheimer's disease. ment, dated 10/14/14, sident's cognition was severly xtensive assistance with ng (ADLs) and did not tys incontinent of bowel and o pressure ulcers. | F 314 | DON, ADON, and MD Nurse will do weekly measurements of all pressure areas together. Staging of wounds will done by DON or RN only. DON or RN will monitor the skin book daily for compliance. QA Committee will review monthly for compliance. (b) On 7/27/15 DON, ADON, and MDS Nurs measured all pressure areas together. DON checked the accuracy of the staging of all pressure areas and ensured that wound beds on all pressure areas were correctly described. Others. | be i se f ure the | |

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| TATEMEN | OF DEFICIENCIES | E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ISTRUCTION | (X3) DA |). 0938-039 TE SURVEY MPLETED |
|--------------------------|--|---|-------------------|--------|---|-----------------------------------|-------------------------------------|
| | | 375519 | B. WING | · | | 07 | /23/2015 |
| | PROVIDER OR SUPPLIER | | L | 1061 N | ADDRESS, CITY, STATE, ZIP CODE ORTH ACCESS ROAD RA, OK 74730 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETIO DATE |
| F 314 | Continued From page 15 to cleanse open area to right hip with wound cleanser (WC), pat dry, apply Triple Antibiotic Ointment (TAO), and cover with border foam every (q) day times (x) 14 days, then re-evaluate. A physician's order, dated 11/14/14, documented to clean area to right hip with WC, pat dry, apply Santyl and TAO, and cover with border foam dressing daily x 14 days. | | | 314 | 8/3/15 all licensed m were inserviced by Wound Care Consul Nurse regarding stag of wounds and prope documentation of wound bed description | tant ing er | |
| | A skin assessment, dated 11/17/14, documented a stage II pressure ulcer measuring 3.0 x 2.0 x <0.1 cm with eschar, slough, and drainage. (A pressure ulcer with slough is considered unstageable.) | | | | 2. 5 residents are poten affected by this alleg deficient practice. | | |
| | documented the re pressure ulcers wit severe tissue type. The following are s physician's orders if resident's right hip: 11/24/14stage II- eschar, slough, and A physician's order, to continue with the 12/01/14stage II- eschar, slough, and 12/08/14(no stag description of wour | , dated 11/29/14, documented previous order, 2.0 x 2.5 x <0.1 cm with d drainage. e)3.0 x 3.0 cm(no | | | 3. DON, ADON, and M Nurse will do weekly measurements of all pressure areas togeth Staging of wounds v be done by DON or only. DON or RN w monitor the skin boo daily for compliance and to ensure that the wound bed is consistently describe QA Committee will review monthly for compliance. | y vill RN vill k k | |

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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|--|---|
| | | 375519 | B. WING | | 07/23/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| CALERA | MANOR, LLC | | | 1061 NORTH ACCESS ROAD CALERA, OK 74730 | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) | ILD BE COMPLETIO |
| F 314 | to clean area to rig Santyl; cover with g cover with border for 12/22/14stage II- eschar and slough. A physician's order, to administer Bactri (mg) one tablet twice | , dated 12/15/14, documented ht hip with WC, pat dry, apply gauze and Bactroban and bam daily x 14 days. 3.0 x 3.5 x <0.1 cm with dated 12/23/14, documented im DS 800-160 milligrams be a day for skin disorder. | F 314 | 1. (c) Resident #25 has completed antibiotics and no wound odor is present at this time. 0 7/24/15 all licensed nurses were inservice on pressure ulcers, wounds, wound order and prompt notification of physician. | s On ed rs, |
| 9 | granulation and slo | ge (I2.8 x 2.5 cm with | | 2. 5 residents are potent affected by this allege deficient practice. | ₽ |
| | to clean the area to apply Santyl, cover border foam dressin 01/12/15stage II- granulation and dra with a 2.0 cm depth slough or eschar is pressure ulcer.) 01/19/15stage II- granulation, undern A physician's order, to clean the area to apply Santyl to wou cover gauze; cover | dated 01/07/15, documented the right hip with WC, pat dry, with gauze, and cover with ng dally x 14 days. 2.5 x 2.0 x 2.0 cm with inage. (The pressure ulcer and granulation and no considered a stage three (III) 2.5 x 2.0 x 2.2 cm with hining, and drainage. dated 01/22/15, documented the right hip with WC, pat dry, nd bed, pack with Santyl with non border foam e with tape daily x 14 days. | | 3. DON, ADON, and M Nurse will do weekly measurements of all pressure areas togethe Staging of wounds wi be done by DON or R only. DON or RN wi monitor the skin book daily for compliance and to ensure the physician has been pro- notified of any decline Committee will review | er. II N II c omptly e. QA |

Facility ID: NH070301

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PRINTED: 08/10/2015 FORM APPROVED OMB NO. 0938-0391

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|--------------------------|--|---|-------------------|-----|---|------------|----------------------------|
| | FOF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | | | e survey Ipleted |
| | | 375519 | B, WING | ; | | 07/ | 23/2015 |
| | PROVIDER OR SUPPLIER | : | 1 | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 061 NORTH ACCESS ROAD CALERA, OK 74730 | • <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 314 | 01/26/15stage II- slough, undermining pressure ulcer with an unstageable pre documentation of th about the odor to th | 2.3 x 1.5 x 2.0 cm with g, drainage and odor. (The slough should be staged as ssure ulcer. There was no he physician being notified e pressure ulcer.) | F.: | 314 | | | |
| ! | slough and drainag | 2.3 x 1.5 x 2.0 cm with e. dated 02/05/15, documented | - | | | | |
| | to continue the prev 02/09/15stage II granulation, slough | 2.3 x 1.5 x 2.5 cm with | | | | | |
| •. | 02/16/15stage II granulation, slough | $-2.3 \times 1.5 \times 2.0$ cm with and drainage. | | | | | |
| | documented the respressure ulcer, two | e assessment, dated 02/17/15, ident had one stage one (I) stage II pressure ulcers, and iry pressure ulcer with slough are tissue type. | | | | | |
| | | in assessments and or the pressure ulcer on the | | | | | |
| | A physician's order, to continue the prev | dated 02/20/15, documented ious order. | | | | | |
| ē- | 02/23/15stage II granulation, slough a | 2.3 x 1.5 x 2.0 cm with and drainage. | | | | | |
| | undermining and dra | -2.0 x 1.5 x 3.3 cm with ainage. (The documentation he pressure ulcer's wound | | | | | |

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

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Facility ID: NH070301

If continuation sheet Page 18 of 30

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PRINTED: 08/10/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ____ 375519 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1061 NORTH ACCESS ROAD **CALERA MANOR, LLC CALERA, OK 74730** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE iD (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX TAG TAG DEFICIENCY) F 314 Continued From page 18 F 314 03/09/15---stage II---1.5 x 1.4 x 3.3 cm with undermining and drainage. 03/16/15---stage II---1.5 x 1.4 x 3.4 cm with undermining and drainage. A physician's order, dated 03/20/15, documented to clean the right hip wound with WC, pat dry, apply Santyl to wound bed, pack with Santyl covered gauze: cover with non border foam and abdomen (ABD) pad and secure with tape daily x 14 days. 03/23/15---stage II---2.2 x 1.5 x 3.4 cm with undermining and drainage. 03/30/15---stage II---1.3 x 1.0 x 3.0 cm with undermining and drainage. 04/06/15---stage II---1.3 x 1.0 x 2.5 cm with slough, undermining, drainage, and odor. (The physician was not notified of the odor from the pressure ulcer at this time.) 04/13/15---stage II---1.3 x 1.0 x 2.0 cm with slough, undermining, drainage, and odor. A physician's order, dated 04/16/15, documented Bactrim DS 800-160 mg, one tab, twice a day for diagnosis of hip pressure ulcer. (The treatment for the pressure ulcer was obtained ten days after the odor was noticed.) A physician's order, dated 04/20/15, documented to clean the right hip wound with WC, apply thin layer of Vasolex ointment and Vaseline gauze; cover with 4x4 and ABD pad daily x 14 days.

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

Facility (D; NH070301

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| | | AND HUMAN SERVICES | | | | | FORM | APPROV 0938-03 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | | (X3) DATI | E SURVEY PLETED |
| | | 375519 | B. WING | | | | 07/2 | 23/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | <u></u> | · [| | STREET ADDRESS, CITY, STATE, ZIP C | ODE | | |
| CALERA | MANOR, LLC | | | | 1061 NORTH ACCESS ROAD CALERA, OK 74730 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | id Prefi Tag | | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD | BE | (X5) Completi Date |
| F 314 | slough, underminin 04/27/15stage II- | 1.0 x 0.5 x 1.0 cm with g, drainage and odor. 1.0 x 0.5 x 1.0 cm with | F 3 | 14 | • | | | |
| | | dated 04/28/15, documented ubivite capsule every (q) | | | | | | • |
| | 05/04/15stage II0.8 x 0.5 cm with drainage. | | | | | | | |
| | 05/12/15stage II- drainage. | 0.8 x 0.5 cm with slough and | | | | | | |
| | 05/18/15stage II drainage. | 0.7 $	imes$ 0.5 cm with slough and | | | | | - | |
| - | to clean the right hip dry, apply a thin lay | dated 05/20/15, documented o pressure ulcer with WC, pat er of Vasolex ointment, cover ad; and secure with tape daily | | | · | | - | |
| | documented the res | nent, dated 05/20/15, sident had four stage II n eschar being the most | | | | | | |
| | | in assessments and or the pressure ulcer on the | • | | | | | |
| | 05/25/15stage II- | 0,5 x 0.7 cm with drainage. | | | | | - | |
| | 06/01/15stage II drainage. | 0.5 x 0.5 cm with a scab and | | | | | 1 | |
| | | -0.4 x 0.4 cm with a scab and | | | <u> </u> | | | |
| RM CMS-250 | 37(02-99) Previous Versions | Obsolele Event ID: D1H911 | | Fac | cility ID: NH070301 If c | ontinuatio | on sheet F | Page 20 of |

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| | TMENT OF HEALTH RS FOR MEDICARE | | | | | | | FORM | 08/10/2015 APPROVED 0938-0 <u>3</u> 91 |
|--------------------------|---|---|--------------------------------|--------------------|--|--|--|---|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SU IDENTIFICATIC | | | | E CONSTRUCTION | | | e survey Pleted |
| | | 375 | 519 | B. WING | ; <u>. </u> | · | | 07/: | 23/2015 |
| NAME OF | PROVIDER OR SUPPLIER | . | | | s | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | <u>, , , , , , , , , , , , , , , , , , , </u> | |
| CALERA | MANOR, LLC | | | | | 061 NORTH ACCESS RO. CALERA, OK 74730 | AD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF | ED BY FULL | ID PREFI TAG | | (EACH CORRECTA CROSS-REFERENCE | AN OF CORRECTIO /E ACTION SHOULD D TO THE APPROP ICIENCY) | 8E | (X5) COMPLETION DATE |
| F 314 | Continued From pa drainage. | ge 20 | | F | 314 | | | | |
| | 06/15/15stage II- | 0.4 x 0.4 cm w | ith a scab. | | | | | | |
| - - | A physician's order, documented to clea dry, apply a thin lay border foam dressi | an the right hip w /er of Vasolex, a | rith WC, pat ind cover with | · | | | | | |
| | 06/22/15stage II- and a scab. | 0.4 x 0.4 cm w | ith redness | | | | | | |
| | 06/29/15stage II- | 0.4 x 0.4 cm w | ith a scab. | | | | | | |
| | A physician's order, to continue the prev | | , documented | | | | | | |
| - | A significant change documented the res pressure ulcers with severe tissue type a | sident had two s n slough being ti | tage II ne most | : | | | | | |
| | The care plan, date resident had a stage hip which will heal b The following interv | e II pressure ulc by the next evalu | er to the right ation period. | | | | | | |
| | Keep the skin clean Perform treatment p improvement within physician. | ber order and if i two weeks notil | y the | | | | | | |
| | Monitor for an incre- signs/symptoms of i Assess for verbal an Administer pain me assess for effective Provide pressure re | infection. nd non-verbal si dications as ord ness. | gns of pain. ered and | | | | / | | |
| | wheel chair. Assist with turning/r | - | | | | | | | |
| ORM CMS-25 | 87(02-99) Previous Versions | Obsolele | Event ID: D1H911 | | Fac | ility ID: NH070301 | If continuati | on sheet f | Page 21 of 30 |

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| | | AND HUMAN SERVICES | | | | FORM | : 08/10/2015 1 APPROVED). 0938-0391 |
|--------------------------|---|--|-------------------|-----|---|---------|--|
| STATEMENT AND PLAN C | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | PLE CONSTRUCTION | (X3) DA | re Survey Mpleted |
| | | 375519 | B. WING | € | | 07 | /23/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | ······································ | | ł | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CALERA | MANOR, LLC | | | | 1061 NORTH ACCESS ROAD CALERA, OK 74730 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREP TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | ILD BE | (X5) Completion Date |
| F 314 | Continued From pa and as needed. | - - | F | 314 | 1 | | r |
| | limits, | d fluid intake within dietary ysician informed of her | | | | | |
| | | kin assessments for the ne resident's right hip: | | | | | |
| | 07/06/15stage II | 0.3 x 0.2 cm with a scab. | | | | | |
| | 07/13/15stage II | 0.3 x 0.2 cm with a scab | | | | | |
| | 07/20/15stage II | 0.3 x 0.2 cm with a scab. | | | | | |
| [| (LPN) #1 was asked ulcer,was staged as a 2.0 cm depth. Th she could up-stage | am, licensed practical nurse d why the resident's pressure a stage II when the ulcer had e LPN said she did not know the wounds. She said she I nurse was supposed to ulcers. | | | | | |
| | about the inaccurate documentation of th stated she inservice the issues. She sai slough or eschar sh unstageable. The E nurses they could in pressure ulcers but be staged down to le On 07/23/15 at 9:05 observed receiving a | pm, the DON was asked e staging and incomplete e pressure ulcers. She of the nurses yesterday about d the pressure ulcers with ould have been staged as DON said she explained to the prease stage severity of the the pressure ulcers could not ower stage. am, the resident was a pressure ulcer treatment to ressure ulcer was an | | | | | |
| | approximate 0.2 cm | pink open area. | | | silik-ID: M/070204 IK seedlar | | |

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Facility ID: NH070301

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PRINTED: 08/10/2015 FORM APPROVED

| | 15 FOR MEDICARE | E & MEDICAID SERVICES | | | | NNR NO | <u>. 0938-0391</u> |
|--------------------------|----------------------------------|---|---------------------|-----|--|---------------------------------------|----------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | LE CONSTRUCTION | | TE SURVEY APLETED |
| | | 375519 | B. WING | ; | | 07/23/2015 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | MANOR LLC | | 1 | 1 | 1061 NORTH ACCESS ROAD | | |
| | | | | 0 | CALERA, OK 74730 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY) | .D 8E | (X5) COMPLETION DATE |
| F 314 | 375519 | | F | 314 | | | |
| | | or the resident's right foot: | | | | · · · · · · · · · · · · · · · · · · · | / |

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

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If continuation sheet Page 23 of 30

| | | AND HUMAN SERVICES | | | | FORM | : 08/10/2015 APPROVED . 0938-0391 |
|--------------------------|--|--|-------------------|-----|--|-----------------|---|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DAT COM | e survey Ipleted |
| | | 375519 | B. WING | i | | 07/ | 23/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | · | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CALERA | MANOR, LLC | | | | 061 NORTH ACCESS ROAD CALERA, OK 74730 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 314 | 1.1. | ge 23 4.5. x 4.0 cm with a red area | F: | 314 | | | |
| | 04/23/15stage II- blister and white slo | 1.5 x 2.0 x <0.1 cm with a bugh. | | | | | |
| | right foot with woun | n the area to the ball of the d cleanser (WC), pat dry, I cover with border foam | | | | | |
| | 04/27/15stage II slough. | 1.5 x 2.0 x 0.1 cm with white | | | | | |
| | | dated 04/28/15, documented ubivite capsule daily. | | | | 4 | |
| | 05/04/15stage II | -1.8 x 2.0 cm with slough. | | | | | |
| - | to continue to clean right foot with WC, p | dated 05/06/15, documented the area to the ball of the bat dry, apply Granulex, cover iressing daily x 14 days. | | | | · | |
| | 05/12/15stage II and a scab. | 1.8 x 2.0 cm with dry skin | | | | | |
| | red eschar and slou eschar and slough o | -3.0 x 2.0 cm with unopened gh. (The pressure ulcer with continues to be staged as a n unstageable pressure | | | | | |
| | documented the res | nent, dated 05/20/15, ident had four stage II eschar being the most | | | | | |

Facility ID: NH070301

If continuation sheet Page 24 of 30

| | | AND HUMAN SERVICES | | | | NRM APPROVED |
|--------------------------|--|--|---------------------|---|---|------------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPLE CONSTRUCTION | | DATE SURVEY |
| | OF CORRECTION | IDENTIFICATION NUMBER: | | IG | | COMPLETED |
| | | 375519 | B. WING | | | 07/23/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | - | |
| CALERA | MANOR, LLC | | | 1061 NORTH ACCESS ROA CALERA, OK 74730 | D | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE HENCY) | (X5) COMPLETION E DATE |
| F 314 | Continued From pa | ae 24 | F 31 | 4 | | |
| |] | kin assessments and | | | | |
| l | | or the resident's right foot: | } | | | |
| | to clean the area to WC, pat dry, apply | dated 05/22/15, documented the ball of the right foot with Santyl, and cover with boarder s for the stage II pressure | | | | |
| | 05/25/15stage II- slough. | 2.7 x 2.0 cm with eschar and | | | | |
| | 06/01/15stage II- slough. | 2.5 x 2.0 cm with eschar and | | | | |
| | to continue to clean | dated 06/04/15, documented area to the ball of right foot ry, apply Santyl, and cover ally x 14. | | | • | |
| | 06/08/15stage II- slough. | 2.5 x 2.5 cm with eschar and | | | | • |
| | 06/15/15stage li- necrotic tissue, escl | 3.5 x 4.0 cm with black har, and drainage. | | | | |
| | to clean the right ba apply Santyl and Ba | dated 06/18/15, documented Il of foot with WC, pat dry, ictoban; and cover with d border foam daily x 14 days. | | | | |
| | 06/22/15stage II drainage. | 4.0 x 4.0 cm with slough and | | | | |
| - | | dated 06/23/15, documented right ball of foot for diagnosis | | | | |
| | A laboratory report, | dated 06/26/15, documented | | | · . | |
| ORM CMS-25 | 87(02-99) Previous Versions | Obsolete Event ID: D1H91 | 1 .1 | acility ID: NH070301 | If continuation st | neet Page 25 of 30 |

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PRINTED: 08/10/2015 FORM APPROVED

| CENTE | RS FOR MEDICARE | <u>& MEDICAID SERVICES</u> | | | 0 | <u>MB NO.</u> | 0938-0391 |
|---|--|---|---|---|---|-------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 375519 | B. WING | | ······· | 07/ | 23/2015 |
| NAME OF | PROVIDER OR SUPPLIER | • | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CALERA | MANOR, LLC | | | | 061 NORTH ACCESS ROAD SALERA, OK 74730 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 314 | the culture was positive for fluoroquinolone-resistant enterobacteriaceae. A physician's order, dated 06/26/15, documented to start Augmentin 875 milligrams (mg) two times a day x 10 days. 06/29/15stage three (III)4.0 x 3.5 x UTD with slough and drainage. (The pressure ulcer with slough was documented as a stage III and did not document whether the sloth had covered the wound bed.) A physician's order, dated 07/02/15, documented to clean the right ball of the foot with WC, pat dry, apply Santyl and Bactoban; cover with calcium alginate, 4x4 abdomen (ABD) pad, and tape daily x 14 days. A significant change assessment, dated 07/05/15, documented the resident had two stage II pressure ulcers with slough being the most severe tissue type; and received hospice services. The care plan, dated 07/05/15, documented the resident had a stage II pressure ulcer to the ball of her right foot which will heal by next evaluation period. The following interventions were to: Keep the skin clean and dry. Perform treatment per order and if no | | F | | | | |
| | Perform treatment p improvement within physician. Monitor for an incre signs/symptoms of Assess for verbal an | ber order and if no two weeks notify the ase in breakdown and infection. nd non-verbal signs of pain. dications as ordered and | | | | - | |

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

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM |): 08/10/2015 / APPROVED). 0938-0391 | |
|--------------------------|--|--|---------------------------|----|---|-------------------------------|---|--|
| | | | X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | | |
| | | 375519 | B. WING | · | | 07 | /23/2015 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| CALERA | MANOR, LLC | | | | 1061 NORTH ACCESS ROAD CALERA, OK 74730 | | | |
| (X4) ID PREFIX TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | IX | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE | (X5) COMPLETION DATE | |
| F 314 | wheel chair. Assist with turning/r and as needed. Encourage food and limits. Keep family and phy progress. The following are sl | dieving device for bed and repositioning every two hours d fluid intake within dietary ysician informed of her | F | | | | | |
| | 07/06/15stage III and drainage. 07/13/15stage III- | vsician's orders for the resident's right foot: /06/15stage III4.0 x 4.0 x UTD with slough d drainage. /13/15stage III4.0 x 4.0 x UTD with slough, crotic tissue and purulent. | | | | | | |
| | to continue to clean Santyl, and Bactoba alginate, 4 x 4 gauze days. | dated 07/16/15, documented with WC, pat dry, apply n; cover with calcium e, and border foam daily x 14 | | | • | | | |
| , | and purulent. | 4.0 x 4.0 x UTD with slough | | | | | | |
| | (LPN) #1 was asked ulcer was staged as the pressure ulcer h | am, licensed practical nurse I why the resident's pressure a stage II and stage III when ad slough and eschar. She ulcer should have been ble. | | | | | | |
| | about the inaccurate documentation of th stated she inservice | 4 pm, the DON was asked e staging and incomplete e pressure ulcers. She d the nurses yesterday about d the pressure ulcers with | | | | | | |

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| | | AND HUMAN SERVICES | 1 | F | TED: 08/10/2015 ORM APPROVED NO. 0938-0391 |
|--------------------------|--|---|---------------------|--|--|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | |) DATE SURVEY COMPLETED |
| | | 375519 | B. WING | | 07/23/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | (I | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| CALERA | MANOR, LLC | | | 1061 NORTH ACCESS ROAD | |
| | | | γ-·,, | CALERA, OK 74730 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY) | E COMPLETION |
| F 314 | | - | F 314 | 4 | |
| | unstageable. The I nurses they could in | nould have been staged as DON said she explained to the ncrease the stage severity of but the pressure ulcers could to a lower stage. | | | |
| F 425 SS≖E | observed receiving her right foot. The approximately 4 x 4 nurse (RN) #1 was the pressure ulcer. 483.60(a),(b) PHAR | cm with slough. Registered asked what was the stage of She said it was a stage III. MACEUTICAL SVC - | F 425 | | |
| | drugs and biologica them under an agre §483.75(h) of this p | art. The facility may permit el to administer drugs if State y under the general | | F 425 | 08/18/15 |
| | (including procedure acquiring, receiving, | drugs and biologicals) to meet | | 1. On 7/23/15 the expired Phenergan suppositories belonging to resident #44 were removed from active inventory. On 7/23/15 the | |
| | a licensed pharmac | nploy or obtain the services of ist who provides consultation a provision of pharmacy ty. | | three boxes of expired flu vaccine that was facility stock were removed from active inventory. On 8/3/1 all licensed nurses and CMA's were inserviced | 5 |
| | This REQUIREMEN | IT is not met as evidenced | | by a pharmacy employee | |
| DRM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID: D1H911 | Fa | cillty ID: NH070301 If continuation s | heet Page 28 of 30 |

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| = = | | AND HUMAN SERVICES | | | | FORM | APPROVED | |
|--|--|---|--------------------|---------------------------------------|--|---|----------------------------|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED | | |
| | | B. WING | ; | | 07/23/2015 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| CALERA | MANOR, LLC | | | | 1061 NORTH ACCESS ROAD CALERA, OK 74730 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | | | (X5) COMPLETION DATE | |
| F 425 | ¹²⁵ Continued From page 28 by: Based on record review, observation, and interview, it was determined the facility failed to ensure timely identification and removal of expired medications from the current medication supply for one (#44) of six residents sampled for medications. The facility failed to remove 12 expired Phenergan suppositories and 24 expired doses of flu vaccine from the medication room's refrigerator. This had the potential to affect all 49 residents residing in the facility who received medications per the Director of Nursing. Findings: The facility's policy and procedure documented: "Pharmacy Policies and Proceduresinsure that all product (medication/supplies) in the Pharmacy's inventory is rotated and/or reviewed on a consistent basis to prevent having expired medication/supplyThe Pharmacy Manager will delegate to appropriate personnel the task of ensuring that all 'out dated' or 'expired' product/drug/supplies are removed from the pharmacy's inventory. This process will be done on at least a monthly basis. All expired medications/supplies will be removed from the active inventory and destroyed or returned for credit per the pharmacy's standard of practice in compliance with the State Board of Pharmacy Rules and Regulations." On 07/23/15 at 10:42 a.m., a tour of the medication storage room was conducted. The refrigerator was observed to contain a plastic | | F ² | | regarding checking of expiration dates and the process of reordering medications. On 8/5/15 our Pharmacy Technician did a complete audit of all medications in house. 2. All residents are potentia affected by this alleged deficient practice. | | | |
| | | | | - | Pharmacy Technician or I will audit all in house medications monthly to e all medications are remov from active inventory prio to reaching their expiration date. CMA's will check expiration dates prior to giving a medication to a resident. QA Committee will review monthly for compliance. | nsure ved or | | |
| | The label on the pac | | | Fac | llity ID: NH070301 If continuati | on sheet (| Page 29 of 30 | |

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PRINTED: 08/10/2015 FORM APPROVED OMB NO 0938-0391

| | OT ON MEDIOANE | & MEDICAID SERVICES | ~~~~~~~ | · · · · · · · · · · · · · · · · · · · | <u>v</u> | WR NO. 0938- | -038 |
|--------------------------|--|---|---------------------|---|--|---|------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION | | (X3) DATE SURVE COMPLETED | |
| | | 375519 | B. WING | | | 07/23/201 | 15 |
| | ROVIDER OR SUPPLIER | · . | | STREET ADDRESS, C 1061 NORTH ACCES CALERA, OK 747 | SS ROAD | , | |
| (X4) ID Prefix TAG | (EACH DEFICIENCY | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | id Prefix Tag | ((EACH COR | R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY) | BE COMPU | |
| | been obtained from 2014. The expiratio (mg) suppositories The medication roo three boxes (24 dos that was facility stor flu vaccine was 06/3 On 07/23/15 at 10:4 Aide (CMA) #1 was for checking the me The CMA reported 1 the facility's medica came and checked The CMA was aske been last checked. On 07/23/15 at 11:2 (ADM) was informed medications found i | ed to resident #44 and had the pharmacy in November on date on the 12.5 milligram was October 2014. Immediate on the 12.5 milligram was October 2014. Immediation also contained ses) of Fluarix (flu vaccine) ck. The expiration date on the 30/15. If 4 a.m., Certified Medication asked who was responsible edications expiration dates. The company which supplied tions had a staff member who the medications every month. d when the medications had She stated, "This month." IO a.m., the Administrator d of the observed expired in the medication room's DM reported the facility would | F4 | 25 | | | |
| | · | | | | | | |
| NRM CMS 266 | 7(02-99) Previous Versions | Obsolete Event (D:D1H91) | L, | Facility ID: NH070301 | lf continuati | on sheet Page 30 | |