STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375499	A. BUILDING _____ B. WING _____	12/16/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOOD MANOR NURSING CENTER	**2800 NORTH HICKORY STREET CLAREMORE, OK 74017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to notify a resident's physician and family member timely when a resident had a change in condition for 1 (#1) of 4 sampled residents whose records were reviewed for a change in condition. The administrator identified 122 residents resided in the facility. Findings: A facility policy, revised August 2011, documented, . A facility must immediately . notify the resident's legal representative . when there is .A significant change in the resident's physical, mental, or psychosocial status . Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A nurse's admission assessment, dated 09-28-15, documented the resident had a surgical incision to the right hip. A skin observation tool, dated 09-30-15, documented the resident had shearing on her left and right buttocks. The tool documented the wound on the right buttock measured 1.0 centimeters (cm) long x 0.6 cm wide x 0.1 cm deep and the left buttock measured 1.8 cm long x 0.6 cm wide x 0.1 deep. A physician's telephone order, dated 09-30-15, documented an order to apply Hydrogel to both buttock areas and cover with a dry dressing twice a day for shearing. There was no documentation to show the family was notified of the skin breakdown. An admission assessment, dated 10-05-15, did not document the resident's cognitive status. The assessment documented the resident required extensive assistance with most activities of daily living, and had one stage II pressure ulcer. A skin observation tool, dated 10-05-15, documented the resident had a 3.2 centimeter (cm) long by 2.5 cm wide by 0.1 cm deep raw area on her sacrum. There was no documentation to show the physician or the family had been notified of the skin breakdown to the resident's sacrum. A skin observation tool, dated 10-11-15, documented a 6.0 cm long by 5.8 cm wide by 1.5 cm deep unstageable pressure wound to the resident's coccyx. A physician's telephone order, dated 10-11-15, documented an order for [REDACTED]. There was no documentation to show the family had been notified of the skin breakdown to the resident's coccyx or the need for an anitbiotic. A Social Services progress note, dated 10-14-15 at 5:50 p.m., documented, Spoke with resident son (name deleted) about residents 20 day being Saturday. Son had questions about mothers progress as well as medication. Care plan has been set for 10/16/15. A wound care specialist initial evaluation, dated 10-14-15, documented resident #1 had an unstageable wound to her medial sacrum. The evaluation documented the wound measured 8.0 cm long by 5.0 cm wide and the depth was unmeasurable. There was no documentation to show the resident's family had been notified of the worsening of the wound to the resident's sacrum. A health status note, dated 10-18-15, documented the resident had been transferred to the hospital for an evaluation and the family had been notified. On 11-17-15, the resident's physician stated he was unsure if the resident was admitted with the wound to her coccyx. He stated he monitored the surgical wound and it was healing well. He stated that he was notified of the unstageable wound to the coccyx and immediately referred this to the wound physician. On 11-17-15 at 10:10 a.m., licensed practical nurse (LPN) #1 was asked what the facility policy was on notifying family members of a change in a resident's condition. LPN #1 stated any change in condition, wound development, medications, any change, was to be reported to the family member immediately unless the family requested otherwise. LPN #1 was asked if resident #1's family had been notified of a change in condition. LPN #1 stated he was unsure. On 11-17-15 at 10:40 a.m., the facility administrator was asked if resident #1's family had been made aware of changes in the resident's condition. She stated yes. She stated the family member had requested a copy of the physician's orders [REDACTED].#1's plan of care and changes in condition and therefore the family had been made aware of changes to resident #1's condition. On 11-17-15 at 10:50 a.m., LPN #2 was asked if resident #1's family had been notified of a change in condition. LPN #2 stated she was unsure but she had provided the family member a copy of the physician's orders [REDACTED]. LPN #2 stated the family seemed knowledgeable regarding medications prescribed for resident #1. On 11-24-15 at 2:20 p.m., RN #1 was asked if resident #1's family members had been notified of a change in condition. RN #1 stated she had notified the family of resident #1's change in condition and transfer to the hospital on 10-18-15. RN #1 stated she was unsure if family members had been advised of other changes in resident #1's condition. On 12-16-15 at 10:08 a.m., LPN #6 was asked about resident #1's wounds. LPN #6 stated when resident #1 was admitted to the facility she had a red bottom. LPN #6 stated approximately two days later the resident's bottom looked like it was opeing up and the skin was sloughing off. LPN #6 was asked if she had contacted the resident's primary care physician (PCP) regarding the change in the resident's condition as the resident now had an open area on her bottom. She stated she had not notified the physician. LPN #6 stated she had been told by the director of nursing (DON) at that time to contact the wound care specialist. LPN #6 was asked when had she contacted the wound care specialist. She stated approximately one week later.
F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure a resident assessment accurately reflected a resident's status for one (#1) of six sampled residents whose assessments were reviewed. The administrator identified 122 residents who resided in the facility. Findings: Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A skin observation tool, dated 09-30-15, documented resident #1 had two open areas located on her right and left buttocks. The skin observation tool documented the right buttock had 1.0 centimeter (cm) length by 0.6 cm width by 0.1 cm depth open area. The skin observation tool documented the left buttock had a 1.8 cm length by 1.0 cm width by 0.1 depth open area. An admission assessment, dated 10-05-15, documented resident #1 required extensive assistance with most activities of daily

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) living (ADLs) and had one stage 2 pressure ulcer. The admission assessment did not contain documentation of resident #1's cognitive status, pain, or the correct number of pressure ulcers. The admission assessment documented dashes had been placed in the cognitive status, pain, and pressure ulcer sections of the assessment. An administration progress note, dated 10-18-15, documented resident #1 had been transferred to the hospital for evaluation and treatment. On 12-16-15 at 4:30 p.m., the MDS/LPN coordinator was asked if a resident's assessment had dashes instead of numerical values what did that mean. The MDS/LPN coordinator stated dashes meant the required interview needed to get a numerical value had not been performed during the look back period. The MDS/LPN coordinator was asked if resident #1's assessments were complete and accurate. She stated no. She stated if the skin observation tool documented resident #6 had two open areas on her buttocks then the admission assessment should have documented two pressure ulcers instead of one.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure a comprehensive care plan had been completed for 1 (#1) of 1 sampled residents whose records were reviewed. The administrator identified 122 residents resided in the facility. Findings: Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. An admission assessment, dated 10-05-15, did not document the resident's cognitive status. The assessment documented resident #1 required extensive assistance with most activities of daily living, and had one stage 2 pressure ulcer. A care area assessment (CAA) summary, dated 10-05-15, documented the following areas had triggered: communication, urinary incontinence, falls, nutritional status, and pressure ulcer. The CAA had been signed by the registered nurse as completing the care plan decision making on 10-26-15. Resident #1's clinical record did not contain a comprehensive care plan. On 11-24-17 at 2:00 p.m., the minimum data set/licensed practical nurse (MDS/LPN) coordinator was asked if resident #1 had a comprehensive care plan. She stated no. She stated she had only been the MDS coordinator since 10-27-15. She was asked when a resident's comprehensive care plan should be developed. She stated 7 days after the admission assessment was completed.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure residents did not develop pressure ulcers and received care and interventions to prevent and treat pressure ulcers by failing to: ~ ensure thorough and accurate assessments were performed of pressure ulcers; ~ consistently provide wound care treatments as ordered by the physician; ~ develop care plans for the prevention and treatment of [REDACTED].>~ monitor resident's weights as ordered by the physician; ~ notify the dietician of severe weight loss for a resident with pressure ulcers; ~ notify the physician of severe weight loss, the development of new areas of skin breakdown in a timely manner, or of recommendations by a wound care physician for needed laboratory testing; and ~ obtain a [MEDICATION NAME] lab test as recommended by the wound physician for one (resident #1) of six sampled residents with pressure ulcers. The resident developed an unstageable necrotic pressure ulcer with a wound infection, was transferred to the hospital and died ten days later due [MEDICAL CONDITION]. Findings: Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A physician's admission order, dated [DATE], documented to obtain a weight every 72 hours for two administrations and to obtain a weekly weight for 4 weeks. A facility Weights and Vitals Summary sheet, dated [DATE], documented the resident weighed 142.7 pounds. A Nursing Admission Screening/History, documented the resident had two surgical incisions to the right hip, eight blisters to the bilateral lower extremities and one Stage I pressure ulcer to the right inner ankle. No areas of skin breakdown were identified to the buttocks, sacrum or coccyx areas. A skin observation tool, dated [DATE], documented the resident had shearing on her left and right buttocks. The tool documented the wound on the right buttock measured 1.0 centimeters (cm) long x 0.6 cm wide x 0.1 cm deep and the left buttock measured 1.8 cm long x 0.6 cm wide x 0.1 deep. A physician's telephone order, dated [DATE] at 9:50 a.m., documented apply Hydrogel and cover both buttock areas with dry dressing twice a day for shearing. The order summary sheet and the treatment administration record (TAR) documented the Hydrogel start date was to be on [DATE]. The [DATE] TAR was blank for the Hydrogel treatment to be provided on the evening shift on [DATE]. An [DATE] TAR documented, Obtain weight every 72 hours for 2 administrations -Order Date- [DATE] 1800 The TAR documented this was due on [DATE]. The area to document that the weight was obtained on [DATE] was blank. A facility WEEKLY PRESSURE SORE QI (quality indicator) LOG form, dated [DATE], documented the resident had a facility acquired stage II sacral wound with the treatment of [REDACTED]. A Treatment Administration Record (TAR), dated [DATE], did not contain documentation that wound care treatment had been completed on the day shift on [DATE]. A TAR for [DATE] documented the resident's weekly weight was to be obtained on [DATE]. The area to document the weight was obtained was blank. A Braden Scale for Predicting Pressure Sore Risk, dated [DATE], documented the resident was at risk for developing a pressure sore. An admission assessment, dated [DATE], did not contain documentation of the resident's cognitive status. The assessment documented the resident required extensive assistance with most activities of daily living including bed mobility and had one stage II pressure ulcer. A review of the clinical record documented no care plan had been developed that identified the resident to be at risk for pressure ulcers or to address her current skin breakdown and treatments. A Skin Observation Tool, dated [DATE], documented the resident had a raw area on her sacrum. The tool documented the area measured 3.2 cm long x 2.5 cm wide x 0.1 cm deep. There was no documentation of a full assessment of the resident's wound characteristics. There was no documentation to show the physician had been notified of the skin breakdown to the resident's sacrum. A facility Weekly Pressure Ulcer Sore QI Log, dated [DATE], documented the sacral wound measured 3.2 cm long x 2.5 cm wide x 0.1 cm deep. The log documented the wound had drainage but no odor. There was no documentation of a full assessment of the resident's wound characteristics. A TAR, dated [DATE] documented no wound care treatment had been completed on [DATE] on the evening shift. A TAR, dated [DATE] documented no wound care treatment had been completed on [DATE] on the day shift. A TAR for [DATE] documented the resident's weekly weight was to be obtained on [DATE]. The area to document that the weight was obtained was blank. A Skin Observation Tool, dated [DATE] at 7:25 p.m., documented the resident had an unstageable pressure ulcer to the coccyx that measured 6cm long x 5.8 cm wide with a depth of 1.5cm. There was no documentation of a full assessment of the resident's wound characteristics.

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 2) A physician's orders [REDACTED].Apply to coccyx topically every day shift for wound cleanse wound to coccyx with wound cleanser, apply santyl and cover with dry dressing. A physician's orders [REDACTED]. A facility Weights and Vitals Summary, dated [DATE], documented the resident weighed 131 pounds. The summary documented the resident had an 11.7 pound weight loss since admission. This was a severe weight loss of 8.1% in 15 days. The weights and vitals summary report documented only two weights had been obtained for the resident, the weight of 142.7 on [DATE] and this weight of 131 on [DATE]. A facility Skin Observation Tool, dated [DATE] at 3:06 p.m., documented the resident had an unstageable pressure ulcer to the coccyx measuring 8.0 cm long x 5.0 cm wide, with a depth that was not measurable. There was no documentation of a full assessment of the resident's wound characteristics. A wound care specialist initial evaluation, dated [DATE], documented the resident had an unstageable (due to necrosis) pressure wound of the medial sacrum. The wound size was 8 x 5 x not measurable cm. There was moderate serous exudate and 100% thick adherent devitalized necrotic tissue. Recommendations included, Gel cushion to chair, group-2 mattress . The evaluation also documented the resident's appetite was poor, a [MEDICATION NAME] was recommended and the wound was foul smelling. A physician's orders [REDACTED].Give 1 tablet by mouth two time a day for Wounds for 28 Administrations. A nurse's note, dated [DATE] at 8:39 a.m., documented, Gel cushion has been ordered. Group 2 mattress is now on the resident's bed. A facility Weekly Pressure Sore QI Log, dated [DATE], documented the resident had a facility acquired pressure ulcer to the coccyx that measured 8.0 cm long x 5.0 cm wide. The log documented the depth was not measurable, the wound had an odor and drainage, and was treated with Santyl. A nurse's note, dated [DATE] at 7:45 a.m., documented, Heard resident hollering for help. Upon entering room found resident in a full body shiver and covered completely up. Resident denies being cold. Upon further assessment found resident to have purple hands bilaterally. V.S. (vital signs) T (temperature) - 99.3 temporal P (pulse) - 55 R (respirations) - 24 BP (blood pressure) - ,[DATE] O2 (oxygen) Sat (saturation) room air - 78%. Notified Dr. (name deleted). A progress note, dated [DATE] at 8:46 a.m., documented the resident was sent to the hospital. An Emergency Department record from the hospital documented the visit date was [DATE] at 10:02 a.m. A nursing progress note from the emergency department, performed on [DATE] at 10:30 a.m., documented, incontinent care provided - pt arrives from Nursing home with diaper with loose stool present - stool also present into lower section of deep open wound . An ED (Emergency Department) Physician Note, dated [DATE] at 10:45 a.m., documented: .Wound infection - complicated . dose weight 52.2Kg (kilograms) (114.8 pounds) . Large sacral ulcer: ,[DATE]cm x ,[DATE]cm area of deep ulceration with purulent drainage, very malodorous . A Discharge Summary from the hospital, dated [DATE], documented: .date of death : [DATE] at 04:06 (4:06 a.m.) Reason For Admission: Sepsis due to severe unstageable sacral decubitus wound. Cause of Death: 1. [MEDICAL CONDITION] secondary to [MEDICAL CONDITION] 2.[MEDICAL CONDITION], severe, secondary to unstageable sacral decubitus wound. 3. Sacral decubitus wound due to pressure ulceration; patient appeared to have been left in her own feces and urine for extended periods of time causing severe breakdown, not present at time of previous and recent discharge from the hospital. Hospital Course: The patient was a [AGE] year-old female who had recently been admitted for [MEDICAL CONDITION]. She was readmitted from the nursing facility that she had been discharged to. Upon arrival in the emergency room she was noted to have vital signs consistent with SIRS (Systemic [MEDICAL CONDITION] Response Syndrome) criteria and a source of infection from either significant diarrhea or the severe decubitus wound. The patient had a very large amount of necrotic tissue present in this wound that was extremely deep, likely to the level of the bone, but this could not be seen due to the large amount of stool that was in the wound at the time of the patient's presentation. Upon my visit in the emergency room , I discussed with the patient who is awake and alert and well oriented at the time that at her age and with her current nutritional status and overall health, I found it very unlikely that she would ever recover from such a wound and that it would likely require multiple surgeries, [DEVICE] and aggressive wound therapy to even make an attempt at this wound being healed. I also discussed aggressive management and treatment of [REDACTED]. Unfortunately the patient did not die in a quick manner but she was kept comfortable for the length of her stay . On [DATE], the resident's physician stated he was unsure if the resident was admitted with the wound to her coccyx. He stated he monitored the surgical wound and it was healing well. He stated that he was notified of the unstageable wound to the coccyx and immediately referred this to the wound physician. On [DATE] at 10:08 a.m., licensed practical nurse (LPN) #6 was contacted regarding the wound care she had provided for the resident. The LPN stated when the resident was admitted to the facility she had a red bottom. The LPN stated approximately two days later the resident's bottom looked like it was opening up and the skin was sloughing off. The LPN was asked if she had contacted the resident's primary care physician regarding the change in the resident's condition as the resident now had an open area on her bottom. She stated she had not notified the physician. The LPN stated she had been told by the director of nursing at that time to contact the wound care specialist. The LPN was asked when had she contacted the wound care specialist. She stated approximately one week later. On [DATE] at 11:15 a.m., the assistant director of nursing (ADON) was asked if a [MEDICATION NAME] lab test had been performed for the resident. The ADON stated she did not know but she would go and check. On [DATE] at 12:15 p.m., the certified dietary manager (CDM) was asked what happened when a resident experienced weight loss. She stated she was notified by nursing staff and she would immediately notify the dietician either by phone or fax. The CDM stated the dietician had remote access from home and was able to view the resident charts. The CDM stated the dietician would either write new orders or fax new orders to the facility as warranted. She stated she would then inform the nursing staff of order changes. The CDM was asked what interventions would be put in place for a resident who experienced weight loss until the dietician evaluated the resident. She stated she would wait for the dietician's recommendation. The CDM was asked if she had notified the dietician of the resident's weight loss. She stated she could not remember, but thought she had. She stated she would look for documentation related to notifying the dietician. The CDM was unable to produce any documentation that the dietician had been notified of the resident's weight loss. On [DATE] at 4:50 p.m., the dietician was asked if she had seen resident #1. She stated she had not visited the resident, however she had reviewed the resident's record on [DATE] when she made rounds. She stated she wrote progress notes on [DATE], but the resident had already been admitted to the hospital. The dietician was asked if she had been notified by the CDM by phone or fax regarding the resident's weight loss. She stated she had not been notified of the resident's weight loss. She stated the CDM had not been performing clinical duties until [DATE]. On [DATE] at 4:00 p.m., the ADON reported to the survey team that she could not find any documentation to show the resident's [MEDICATION NAME] lab test had been done. The ADON was asked if she knew why the [MEDICATION NAME] had not been done. The ADON was asked if a physician other than the resident's primary care physician (PCP) made a recommendation that a lab test be done would the staff carry out the order. She stated if another physician made a recommendation for a lab test the nursing staff would need to contact the PCP to ensure the PCP wanted to carry through with the recommendation. The ADON was asked if the resident's PCP had been notified of the wound specialist's recommendation that a [MEDICATION NAME] lab test be done. She stated she did not know.

F 0502 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.**

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F 0502 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure an order and/or recommendation to obtain a urinalysis (UA) and [MEDICATION NAME] laboratory (lab) tests were followed through for 1 (#1) of 1 sampled resident whose records were reviewed for physician ordered and/or recommended labs. The administrator identified 122 residents resided in the facility. Findings: Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A telephone physician order, dated 10-14-15, documented an order to obtain a UA for resident #1. A wound specialist initial evaluation progress note, dated 10-14-15, documented the wound specialist had recommended a [MEDICATION NAME] lab test for resident #1. On 12-16-15 resident #1's clinical record was reviewed. The clinical record did not contain any documentation the UA and [MEDICATION NAME] had been done. On 12-16-15 at 11:15 a.m., the assistant director of nursing (ADON) was asked if resident #1's UA and [MEDICATION NAME] lab tests had been performed. The ADON stated she did not know but she would go and check. On 12-16-15 at 4:00 p.m., the ADON reported to the survey team that she could not find any documentation resident #1's UA and [MEDICATION NAME] lab tests had been done. The ADON was asked if she knew why the UA and [MEDICATION NAME] had not been done. She stated the UA had been too difficult to obtain. The ADON was asked if a physician other than the resident's primary care physician (PCP) made a recommendation that a lab test be done would the staff carry out the order. She stated if another physician made a recommendation for a lab test the nursing staff would need to contact the PCP to ensure the PCP wanted to carry through with the recommendation. The ADON was asked if resident #1's PCP had been notified of the wound specialist's recommendation that a [MEDICATION NAME] lab test be done. She stated she did not know.