STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375098	A BUILDING _____ B WING _____	01/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-MIDWEST CITY	2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110

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F 000	INITIAL COMMENTS A recertification survey was conducted on 01/04/16 through 01/07/16 and 01/11/16. Below is a list of abbreviations used throughout this survey: @ - at ^ - increase + - plus 0130 - 1:30 a.m. 3-11 - evening shift A/R - adverse reaction ABH - Ativan/Benadryl/Haldol ABT - antibiotic BID - twice a day BLE - bilateral lower extremities C - with CHF - Congestive Heart Failure Cm - centimeters COPD - Chronic Obstructive Pulmonary Disease CVA - Cerebral Vascular Disease D - day DON - Director of Nursing DR - dining room drsg - dressing d/t - due to E. Coli - Escherichia coli ER - Emergency Room GERD - Gastric Esophageal Reflux Disease Hr - hour III - three IV - Intravenous LPN - Licensed Practical Nurse MAR - medication administration record MDS - Minimum Data Set MG/mg - milligrams ML - milliliter	F 000		

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 000	Continued From page 1 NS - normal saline PCN - Penicillin PEG - Percutaneous Endoscopic Gastrostomy PO/po - by mouth PRN - as needed Pt/pt - patient Q -every Qhs - every night Qsh - every shift RN - Registered Nurse S.E. - side effects S/S - signs and symptoms TAR - treatment administration record TID - three times a day UTI - urinary tract infection VSS - vital signs stable w/c - wheelchair x -times	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on employee file review and staff interview, it was determined the facility failed to complete criminal background checks for one (CNA #1) of five employees whose personnel files were reviewed. The Resident Census and Condition Report, dated 01/04/16, documented 73 residents who	F 226		

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F 226	Continued From page 2 resided in the facility. Findings: A facility document titled, Patient Protection Practice Guide, documented, "The purpose of the 'Guide' is to assist each center in implementation of an abuse prevention system... Employee Screening...The center utilizes the employee screening process to identify information from... State licensing boards and registries, Criminal background checks..." A review of the employee file for CNA #1, documented a hire date of 11/05/15. There was no documentation in the employee file of a criminal background check. On 01/11/16 at 3:00 p.m., the Administrator was asked for any criminal background checks for CNA #1. At 3:30 p.m., the Administrator stated, "There were no background checks for [CNA#1]."	F 226		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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F 280	Continued From page 3 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure care plans were revised after falls for one (#2) of nine residents whose clinical records were reviewed for falls. The Resident Census and Conditions Report dated 01/04/16, documented 73 residents resided in the facility. Findings: Resident #2 had diagnoses which included chronic pain, dementia, aphasia, diabetes, COPD, CHF and osteoarthritis. A care plan, initiated on 02/11/10, documented, "At risk for falls due to use of psychotropic medications, general weakness, and history of falls."	F 280		

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F 280	Continued From page 4 An incident report, dated 02/27/15 at 9:30 a.m., documented, " ..Fall without injury (or minor i [sic] res found on floor in dining room..." There were no new interventions identified on the care plan. An incident report, dated 03/09/15 at 4:30 a.m., documented, "...Location of Incident: Patient's Room...Fall without injury (or minor i [sic] resident found on floor next to bed..." There were no new interventions identified on the care plan. An incident report, dated 03/12/15 at 3:15 a.m., documented, "...Fall without injury (or minor i [sic] found by Can [sic] lying on floor next to bed...assisted back to bed, VSS and neuro,s [sic] started, skin tears to right arm cleaned with NS and steri strips applied, drsg applied..." There were no new interventions identified on the care plan. An incident report, dated 06/02/15 at 5:30 a.m., documented, "...Fall without injury (or minor i [sic] resident was found on the floor between her bed and recliner. Resident is not able to tell us how she fell..." There were no new interventions documented on the care plan. On 01/04/15 at 1:00 p.m., the DON was asked where the interventions for falls would be documented. She stated, "On the care plans." She was asked if they are documented on the incident reports. She stated, "No, only on the	F 280		

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F 280	Continued From page 5 care plans." On 01/05/16 at 12:00 p.m., the MDS Coordinator was asked if the resident's care plan was updated with each fall. She stated, "The falls are not documented on the care plan each time under the problem section but each fall is care planned with an intervention and dated under the interventions." At 1:50 p.m., the DON was asked if there should be new interventions with each fall occurrence. She stated, "Yes." She was asked how the facility ensured that new interventions were initiated and placed on the care plans. She stated, "It is discussed in the eagle room every morning."	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview, it was determined the facility failed to ensure the resident's care was coordinated with the hospice agency to ensure psychotropic medications were not increased without indication for an increase for one (#1) of five sampled residents who received hospice services	F 309		

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F 309	Continued From page 6 The Resident Census and Conditions report, dated 01/04/16, documented seven residents received hospice services. Findings: A policy, Phase 3: Implement, dated 2015, documented, "...Unnecessary drugs 1.. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate therapy): or (ii) For excessive duration: or (iii) Without adequate monitoring: or (iv) Without adequate indications for its use: or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued: or (vi) Any combinations of the reasons above..." Resident #1 was readmitted to the facility on 08/22/15 with diagnoses which included Parkinson's Disease, anxiety and depression. He was admitted to hospice on 08/26/15 with diagnoses which included failure to thrive and chronic obstructive pulmonary disease. The post hospital physician's orders, dated 08/22/15, documented the resident was to receive Xanax 0.25 mg TID and Ativan 0.5 mg TID PRN. Both of these were antianxiety medications. A physician's order, dated 10/01/15, documented to decrease the Xanax to 0.25 mg every eight hours PRN.	F 309		

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The October 2015 MAR documented the resident had been administered one PRN Xanax 0.25 mg on 10/01/15, 10/02/15, 10/12/15 for increased anxiety and on 10/15/15 for increased anxiety with cough. The resident had been diagnosed with an upper respiratory infection the previous week.

Twenty two nursing progress notes were documented between 10/01/15 and 10/17/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses.

A hospice nursing note, dated 10/15/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day".

A nursing progress note, dated 10/17/15, documented, "New order for Ativan 0.5 mg tid. May give Xanax 0.25 tid until Ativan arrives the [sic] change Xanax to tid prn..."

A physician's order, dated 10/17/15, documented to hold the Ativan until available. The Xanax 0.25 mg was to be administered TID until the Ativan was available and then was to be decreased to TID PRN. No written order for the Ativan change was located.

The October 2015 MAR contained no documentation the resident had been administered a PRN Xanax from 10/15/15 through 10/22/15.

A hospice nursing note, dated 10/22/15, documented the resident had anxiety "@ X's" and

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F 309	Continued From page 8 "pt. sleeps 16 + hrs a day". A physician's order, dated 10/22/15, documented to increase the Xanax to 0.25 mg two tabs (0.5 mg) every 4 hours PRN for restlessness. Two hospice nursing notes, dated 10/23/15 and 10/26/15, documented the resident's anxiety status had been deferred. The October 2015 MAR documented the resident had been administered one PRN Xanax on 10/24/15 and 10/25/15. Twelve nursing progress notes were documented from 10/17/15 through 10/29/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses. A hospice nursing note, dated 10/29/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". It also documented the resident complained of a nonproductive cough "and he can't get anything up. [Physician's name deleted] notified [and] received new orders..." The note documented the hospice nurse had notified the attending physician of the resident's status and had received new orders. A physician's order, dated 10/29/15, documented to increase the Ativan to 0.5 mg every six hours routinely for the diagnosis of anxiety as manifested by restlessness. A hospice nursing note, dated 10/30/15, documented the resident's anxiety status had	F 309		

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F 309	Continued From page 9 been deferred. The November 2015 MAR documented the resident had been administered one PRN Xanax on 11/02/15. The next time the PRN Ativan was administered was on 11/19/15. A hospice nursing note, dated 11/05/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". A hospice nursing note, dated 11/06/15, documented the resident's anxiety status had been deferred. Six nursing progress notes were documented from 10/29/15 through 11/12/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses. A hospice nursing note, dated 11/12/15, documented the resident had anxiety "@ X's [increased]" and "pt. sleeps 16 + hrs a day". It also documented, "...pt. reports [increased] anxiety [and] thick sputum that makes him gag [and] vomit. [Physician's name deleted] notified [and] new orders received..." The note documented the hospice nurse had notified the attending physician of the resident's status and had received new orders. A physician's order, dated 11/12/15, documented to increase the Ativan to 0.5 mg two tabs (1 mg) every eight hours routinely for the diagnosis of anxiety as manifested by restlessness.	F 309		

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F 309	Continued From page 10 On 01/05/16 at 5:00 p.m., the DON was asked to locate the documentation of behaviors which indicated the need for the increase in the antianxiety medications. On 01/06/16 at 2:55 p.m., the DON stated there was documentation in the hospice notes about the resident's behaviors. She was asked if the facility should have also documented those behaviors. She stated the hospice nurse is in the facility everyday and "They probably talk so much they don't think about documenting it." On 1/11/16 at 10:50 a.m., the hospice nurse was asked what she would do if a resident complained of increased anxiety. She stated she would call the physician and talk to the facility nurse. She was asked if she ever checked the MARs for the use of PRN medications before calling the physician. She stated she "could do that." She was asked, if she reviewed the MARs and observed the resident had not been administered a PRN medication for two weeks, would she call the physician. She stated she would probably ask the facility nurse to give the resident a PRN dose and monitor them. At 11:05 a.m., the DON stated the hospice nurse had trained in the facility the previous week. The DON stated she had not had a chance to coordinate care with her. The DON was asked if she had located any facility documentation regarding the resident's behaviors. She stated, "No."	F 309		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 11 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure thorough incontinent care was provided for one (#8) of four sampled residents whose incontinent care was observed The Resident Census and Conditions report, dated 01/04/15, documented 21 residents were occasionally or frequently incontinent of bowel and 11 residents had indwelling or external catheters. Findings: Resident #8 had diagnoses which included chronic kidney disease, bipolar disorder, neuromuscular dysfunction of bladder, Rheumatoid arthritis and paraplegia. A care plan, revised on 11/26/12, documented, "...Focus Use of indwelling urinary catheter for neurogenic bladder and urinary retention... Interventions...Catheter care every shift and as needed..." A quarterly assessment, dated 11/19/15, documented the resident was independent in	F 312		

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F 312	Continued From page 12 cognitive skills for daily decision making. She required extensive assistance of two people for transfers. She required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. She had a limitation in range of motion of the bilateral lower extremities. She was not ambulatory. She had an indwelling urinary catheter and was always incontinent of bowel. The TAR for January 2016 documented the resident was to receive catheter care every shift. On 01/05/16 at 10:30 a.m.,the provision of incontinent care for the resident was observed. CNA #2 and CNA #3 were asked who was responsible for providing catheter care for the resident. CNA #2 stated, "That's what we are gonna do." The resident stated that she had an accident at 12:30 a.m. and was not sure how well she was cleaned. As care was initiated, the resident was observed to have dried brown feces on her buttocks. CNA #2 stated, "Still got a little." There was no observation of catheter care provided to the resident at this time. At 10:45 a.m., CNA #2 and CNA #3 were asked how often incontinent care was offered to the resident. CNA #3 stated, "In the morning and she will let us know." At 11:00 a.m., LPN #2 was asked who was responsible for performing catheter care. She stated, "We do." She was asked to clarify. She stated the nurses were responsible. She was observed to check the TAR and stated, "Every shift."	F 312		

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F 312	Continued From page 13 LPN #2 was informed of the need to observe the catheter care for the day shift. No observation of catheter care was observed on the day shift. On 01/06/16 at 9:00 a.m., LPN #2 was asked if catheter care was given during the day shift on 01/05/16. She stated, "No, she was already up in her chair."	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to provide supervision to prevent falls and to consistently identify and implement interventions to aid in the prevention of falls for one (#2) of nine sampled residents whose clinical records were reviewed for falls. The Resident Census and Conditions report, dated 01/04/16, documented 73 residents resided in the facility. Findings: Resident #2 had diagnoses which included	F 323		

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F 323	Continued From page 14 chronic pain, dementia, aphasia, diabetes, COPD, CHF and osteoarthritis. A care plan, intiated on 02/11/10, documented, "At risk for falls due to use of psychotropic medications, general weakness, and history of falls." Interventions included: "...Bed in low position. Date initiated: 02/11/2010... Do not lock brakes on rock and go chair (frustrates resident when she can not move about) Date initiated 12/16/2014... Early AM riser. Get resident up and out of bed early in the morning. Date initiated: 10/22/2014... Encourage activities when resident is up is up [sic] Date initiated: 11/11/2014... Encourage and assist as needed to wear proper and non slip footwear. Date Initiated: 02/11/2010... Have commonly used articles within easy reach. Date Initiated: 09/14/2013... If resident appears restless or anxious in bed, assist resident into rock and go chair for diversion. Date Initated: 01/08/2015... Notify physician, family, and hospice of any falls. Date Initiated: 06/10/2014... Nurse to check on patient frequently. Date Initiated: 02/11/2010...	F 323		

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F 323	Continued From page 15 Place no skid material in wheelchair. Date InitiatedL 11/24/2014... Report development of pain, bruises, change in mental status, ADL function, appetite, or neurological status per facility guidelines post fall. Date Initiated: 05/31/2012... Rock and go wheelchair. Date Initiated: 11/12/2014... Toilet resident before and after meals before laying down and upon rising and during the night while awake. Date Initiated: 08/08/2014... Wide bed. Date Initated: 11/11/2014..." An incident report, dated 02/27/15 at 9:30 a.m., documented, "...Fall without injury (or minor i [sic] res found on floor in dining room..." There were no interventions documented on the incident report. There were no new interventions identified on the care plan. An incident report, dated 03/09/15 at 4:30 a.m., documented, "...Location of Incident: Patient's Room...Fall without injury (or minor i [sic] resident found on floor next to bed..." There were no interventions documented on the incident report. There were no new interventions identified on the care plan.	F 323		

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F 323	Continued From page 16 An incident report, dated 03/12/15 at 3:15 a.m., documented, "...Fall without injury (or minor i [sic] found by Can [sic] lying on floor next to bed...assisted back to bed, VSS and neuro,s [sic]started, skin tears to right arm cleaned with NS and steri strips applied, drsg applied..." There were no interventions documented on the incident report. There were no new interventions identified on the care plan. An incident report, dated 05/21/15 at 11:00 p.m., documented, "...Fall without injury (or minor i Resident upside down with torso on the ground with feet in bed tangled in blankets. Assist back to bed with extensive assist x 3..." An update to the careplan, initiated on 05/22/15, documented, "Medication review." An incident report, dated 06/02/15 at 5:30 a.m., documented, "...Fall without injury (or minor i [sic] resident was found on the floor between her bed and recliner. Resident is not able to tell us how she fell..." There were no interventions documented on the incident report. There were no new interventions documented on the care plan. An incident report, dated 07/20/15 at 6:30 p.m., documented, "...Fall without injury (or minor i resident found on floor beside the patients bed. slid from wheelchair. sitting on buttocks. no head injury."	F 323		

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F 323	Continued From page 17 There were no interventions documented on the incident report. An update to the care plan, initiated on 07/21/15, documented, "Do not leave unattended in wheelchair while in room." An update to the care plan, intiated on 08/28/15, documented, "Keep wheelchair slightly reclined when in use." An update to the care plan, initiated on 09/17/15, documented, "assist resident to bed if sleeping in chair..." An incident report, dated 09/29/15 at 10:00 p.m., documented, "...Location of Incident: Hallway...Fall without injury (or minor i Pt was reaching forward and fell out of wheelchair...Gotten back into chair, taken to room and put in to bed 0.1cm skin tear to L side of forehead, ice applied..." There were no interventions documented on the incident report. Updates to the care plan, initiated on 09/30/15, documented: "non slip grip mat in wc. Tilt wheelchair seat." An incident report, dated 10/09/15 at 9:15 p.m., documented, "...Location of Incident: Patient's Room...Fall without injury (or minor i This nurse was on the hall passing meds and heard this res make a thud noise. Went this nurse went to investigate this nurse found this resident witting [sic] on floor on the left side of bed with legs	F 323		

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F 323	Continued From page 18 extended..." There were no interventions documented on the incident report. Updates to the care plan, initiated on 10/12/15, documented, "Ensure resident is tired before putting to bed. Get out of bed and into wheelchair if restless." A significant change assessment, dated 12/06/15, documented the resident was moderately impaired in cognitive skills of daily decision making. She required extensive assistance of one person for transfers, dressing, toileting and personal hygiene. She used a wheelchair for primary mobility. The resident was not ambulatory. On 01/04/15 at 1:00 p.m., the DON was asked where the interventions for falls would be documented. She stated, "On the care plans." She was asked if they are documented on the incident reports. She stated, "No, only on the care plans." On 01/05/16 at 12:00 p.m., the MDS Coordinator was asked if the resident's care plan was updated with each fall. She stated, "The falls are not documented on the care plan each time under the problem section but each fall is care planned with an intervention and dated under the interventions. At 1:50 p.m., the DON was asked if there should be new interventions with each fall occurrence. She stated, "Yes." She was asked how the facility ensured that new interventions were initiated and placed on the care plans. She stated "It is	F 323		

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F 323	Continued From page 19 discussed in the eagle room every morning."	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure: ~ an antianxiety medication was not increased without indications for the increases for one (#1) of nine sampled residents who received	F 329		

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F 329	Continued From page 20 antianxiety medications: ~ side effects for antipsychotic medications were monitored for three (#2, 4 and #8) of six sampled residents who received antipsychotic medications; ~ side effects for antianxiety medications were monitored for three (#2, 3 and #8) of nine sampled residents who received antianxiety medications; and ~ side effects of antidepressant medications were monitored for one (#8) of seven sampled residents who received antidepressant medications. The Resident Census and Conditions report, dated 01/04/16, documented nine residents received antipsychotic medications, 22 residents received antianxiety medications, and 32 residents received antidepressant medications. Findings: A policy, Phase 3: Implement, dated 2015, documented, "...Unnecessary drugs 1...Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate therapy): or (ii) For excessive duration: or (iii) Without adequate monitoring: or (iv) Without adequate indications for its use: or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued: or (vi) Any combinations of the reasons above..."	F 329		

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1. Resident #1 was readmitted to the facility on 08/22/15 with diagnoses which included Parkinson's Disease, anxiety and depression. He was admitted to hospice on 08/26/15 with diagnoses which included failure to thrive and chronic obstructive pulmonary disease.

The post hospital physician's orders, dated 08/22/15, documented the resident was to receive Xanax 0.25 mg TID and Ativan 0.5 mg TID PRN. Both of these were antianxiety medications.

A physician's order, dated 10/01/15, documented to decrease the Xanax to 0.25 mg every eight hours PRN.

The October 2015 MAR documented the resident had been administered one PRN Xanax 0.25 mg on 10/01/15, 10/02/15, 10/12/15 for increased anxiety and on 10/15/15 for increased anxiety with cough. The resident had been diagnosed with an upper respiratory infection the previous week.

Twenty two nursing progress notes were documented between 10/01/15 and 10/17/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses.

A hospice nursing note, dated 10/15/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day".

A nursing progress note, dated 10/17/15,

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F 329	Continued From page 22 documented, "New order for Ativan 0.5 mg tid. May give Xanax 0.25 tid until Ativan arrives the [sic] change Xanax to tid prn..." A physician's order, dated 10/17/15, documented to hold the Ativan until available. The Xanax 0.25 mg was to be administered TID until the Ativan was available and then was to be decreased to TID PRN. No written order for the Ativan change was located. The October 2015 MAR contained no documentation the resident had been administered a PRN Xanax from 10/15/15 through 10/22/15. A hospice nursing note, dated 10/22/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". A physician's order, dated 10/22/15, documented to increase the Xanax to 0.25 mg two tabs (0.5 mg) every 4 hours PRN for restlessness. Two hospice nursing notes, dated 10/23/15 and 10/26/15, documented the resident's anxiety status had been deferred. The October 2015 MAR documented the resident had been administered one PRN Xanax on 10/24/15 and 10/25/15. Twelve nursing progress notes were documented from 10/17/15 through 10/29/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses.	F 329		

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F 329	Continued From page 23 A hospice nursing note, dated 10/29/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". It also documented the resident complained of a nonproductive cough "and he can't get anything up. [Physician's name deleted] notified [and] received new orders..." A physician's order, dated 10/29/15, documented to increase the Ativan to 0.5 mg every six hours routinely for the diagnosis of anxiety as manifested by restlessness. A hospice nursing note, dated 10/30/15, documented the resident's anxiety status had been deferred. The November 2015 MAR documented the resident had been administered one PRN Xanax on 11/02/15. The next time the PRN Ativan was administered was on 11/19/15. A hospice nursing note, dated 11/05/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". A hospice nursing note, dated 11/06/15, documented the resident's anxiety status had been deferred. Six nursing progress notes were documented from 10/29/15 through 11/12/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses.	F 329		

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F 329	Continued From page 24 A hospice nursing note, dated 11/12/15, documented the resident had anxiety "@ X's [increased]" and "pt. sleeps 16 + hrs a day". It also documented, "...pt. reports [increased] anxiety [and] thick sputum that makes him gag [and] vomit. [Physician's name deleted] notified [and] new orders received..." A physician's order, dated 11/12/15, documented to increase the Ativan to 0.5 mg two tabs (1 mg) every eight hours routinely for the diagnosis of anxiety as manifested by restlessness. On 01/05/16 at 5:00 p.m., the DON was asked to locate the documentation of behaviors which indicated the need for the increase in the antianxiety medications. On 01/06/16 at 2:55 p.m., the DON stated there was documentation in the hospice notes about the resident's behaviors. She was asked if the facility should have also documented those behaviors. She stated the hospice nurse is in the facility everyday and "They probably talk so much they don't think about documenting it." On 01/11/16 at 10:50 a.m., the hospice nurse was asked what she would do if a resident complained of increased anxiety. She stated she would call the physician and talk to the facility nurse. She was asked if she ever checked the MARs for the use of PRN medications before calling the physician. She stated she "could do that." She was asked, if she reviewed the MARs and observed the resident had not been administered a PRN medication for two weeks, would she call the physician. She stated she would probably	F 329		

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F 329	Continued From page 25 ask the facility nurse to give the resident a PRN dose and monitor them. At 11:05 a.m., the DON was asked if she had located any facility documentation regarding the resident's behaviors. She stated, "No." 2. Resident #2 had diagnoses which included chronic pain, dementia, aphasia, diabetes, COPD, CHF and osteoarthritis. A care plan, dated 02/11/10, documented, "...Focus At risk for adverse effects related to: use of antianxiety medication... Interventions...Monitor for dizziness, drowsiness, blurred vision and orthostatic hypotension..." A treatment administration record, dated November 2015, documented, "...ABH GEL 1-25-1 GEL APPLY 1 TOPICALLY .5XD (five times a day)...MONITOR FOR S/S OF SIDE EFFECTS, INITIALS INDICATE ABSENCE OF SIDE EFFECTS..." ABH gel contains the antianxiety medication, Ativan, and the antipsychotic medication, Haldol. There was no documentation of the monitoring of side effects for the ABH gel administration in the resident's clinical record for November 2015. 3. Resident #8 had diagnoses which included chronic kidney disease, bipolar disorder, neuromuscular dysfunction of bladder, Rheumatoid arthritis and paraplegia. A care plan, dated 10/18/09, documented, "...Focus	F 329		

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F 329	Continued From page 26 At risk for adverse effects related to: use of antidepression medication...antianxiety medication...antipsychotic medication... Goal...to show minimal/no side effects of medications taken... Interventions...Antianxiety- Monitor... Antidepressants- Monitor... Antipsychotic- Monitor..." A monthly physician's order, dated May 2015, documented, "... EXCITALOPRAM OXALATE 20MG...LEXAPRO 1 TAB BY MOUTH DAILY... DOXEPIN HCL 50MG...1 CAP BY MOUTH AT BEDTIME...MONITOR SIDE EFFECTS INITIALS INDICATE ABSENCE OF S/S OF SIDE EFFECTS... HALOPERIDOL 1MG...1 TAB BY MOUTH AT BEDTIME...MONITOR SIDE EFFECTS INITIALS INDICATE ABSENCE OF S/S OF SIDE EFFECTS... PROTRIPTYLINE HCL 5MG...VIVACTIL 1 TAB BY MOUTH THREE TIMES DAILY...MONITOR SIDE EFFECTS INITIALS INDICATE ABSENCE OF S/S OF SIDE EFFECTS... Klonopin 0.5mg...daily @ HS for anxiety..." Lexapro, Doxepin and Vivactil are all antidepressant medications. Haldol is an antipsychotic medication. Klonopin is an antianxiety medication. There was no documentation in the resident's clinical record of the monitoring of side effects for	F 329		

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F 329	Continued From page 27 the administration of the Lexapro, Doxepin, Haldol, Vivactil and Klonopin for the month of May 2015. An admission physician's order, dated 10/07/15, documented, "...Lexapro 20 mg...QD...(check) for S/S of A/R...(check) Qsh [sic]... Doxepin 50 mg...QD...(check) for S/S of A/R...Qsh [sic]... Clonazepam 0.5mg...Q HS..." A medication administration record, dated October 2015, documented, "...Haldol 0.5mg...q H.S... Ativan 0.5 mg...q BID PRN..." Clonazepam and Ativan are both antianxiety medications. There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Lexapro, Doxepin, Clonazepam, Haldol and Ativan for the month of October 2015. A monthly physician's order, dated November 2015, documented, "...Ativan 0.5 mg...Bid prn...for anxiety...monitor for s/s of side effects. Initials indicate absence of S.E..." There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Ativan for the month of November 2015. A monthly physician's order, dated November 2015, documented, "...HALOPERIDOL 0.5MG...HALDOL 1 TAB BY MOUTH AT BEDTIME...MONITOR FOR S/S OF SIDE	F 329		

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F 329	Continued From page 28 EFFECTS, INITIALS INDICATE ABSENCE OF SIDE EFFECTS..."	F 329		

A medication administration record, dated December 2015, documented, "...LORAZEPAM...ATIVAN 1 TAB BY MOUTH TWICE DAILY AS NEEDED FOR ANXIETY...MONITOR FOR S/S OF SIDE EFFECTS, INITIALS INDICATE ABSENCE OF SIDE EFFECTS...

There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Haldol and Ativan for the month of December 2015.

On 01/04/16 at 2:00 p.m., the DON was asked what the facility policy was for monitoring side effects of psychotropic medications. She stated, "Side effects are documented each shift on the MAR. Initials mean there are no side effects." She was asked who was responsible for documenting the side effect monitoring. She stated, "The nurses do."

At 2:15 p.m., LPN #5 was asked what medications were monitored for side effects. She stated antianxiety, antidepressants and antipsychotics were monitored. She was asked where it was documented. She stated, "On the MAR."

4. Resident #3 was admitted with diagnoses which included Alzheimer's, depressive disorder and anxiety.

A physician's order, dated 06/19/15, documented, "...Ativan 0.5 mg PO QID..."

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F 329	Continued From page 29 There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Ativan for the month of June 2015. A physician's order, dated 09/10/15, documented, "... Ativan 0.5 mg one tab by mouth every 4 hours as needed...monitor for s/s of side effects, initials indicate absence of side effects..." There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Ativan for the month of September 2015. 5. Resident #4 was admitted with diagnoses which included dementia, psychosis and general anxiety disorder. A physician's order, dated July 2015, documented, "...Risperidone [antipsychotic medication] 1 mg one tab po bid...." There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Risperidone for the month of July 2015. A medication administration record, dated October 2015, documented, "...RISPERIDONE...0.5MG...1 TAB TWICE DAILY...MONITOR FOR S/S OF SIDE EFFECTS, INITIALS INDICATE ABSENCE OF SIDE EFFECTS." There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the	F 329		

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F 329	Continued From page 30 Risperidone for the month of October 2015. On 01/04/16 at 2:00 p.m., the DON was asked what the facility policy was for monitoring side effects of psychotropic medications. She stated, "Side effects are documented each shift on the MAR. Initials mean there are no side effects." She was asked who was responsible for documenting the side effect monitoring. She stated, "The nurses do."	F 329		
F 332 SS=E	483 25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a medication error rate of less than 5% for three (#16, #17 and #18) of eight residents observed during the medication passes. The medication error rate was 16% which resulted from four errors in 25 opportunities. The Resident Census and Conditions report, dated 01/05/16, documented 73 residents resided in the facility. Findings: 1. Resident #16 was admitted to the facility with diagnoses which included, CVA, coronary artery disease, COPD, and hypertension.	F 332		

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F 332	Continued From page 31 A physician's telephone order, dated 12/31/15, documented, "...Coreg to 3.125 mg po BID..." A medication administration record, dated January 2016, documented, "...Carvedilol 3.125MG TABLET (RP: COREG) 1 TAB BY MOUTH TWICE DAILY..." On 01/05/16 at 9.13 a.m., the surveyor observed LPN #1 as she prepared the Coreg medication for administration to the resident. The medication was viewed by the surveyor and the label gave instruction to "...1 TAB BY MOUTH TWICE DAILY..." The LPN was observed to crush the medication and place in a cup. She was observed as she administered the medication thru the resident's peg tube. At 3:15 p.m., LPN #1 was asked how it is ensured that the medications are administered as ordered. She stated, "I look at the MAR." She was asked to confirm the direction label of the Coreg medication. She confirmed the medication label documented the medication was to be given by mouth. She was then asked how she administered the medication to the resident. She stated, "I have a crush order." She was asked if she gave the medication by mouth or by tube. She stated the medication was given by tube. 2. Resident #17 was readmitted to the facility on 12/03/15 with diagnosis which included, hypertension, GERD, weakness and COPD. A hospital discharge instruction form, dated 12/03/15, documented, "...Stopped buspirone tablet 5MG..."	F 332		

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F 332	Continued From page 32 There was no documentation for the administration of the Buspar 5MG on the facility readmission orders dated 12/03/15. A monthly physician's order report, dated January 2016, documented "...DOCUSATE SODIUM 100MG...1 CAP BY MOUTH DAILY..." There was no documentation of an order for the administration of the Buspar 5MG. On 01/05/16 at 10:05 a.m., the surveyor observed LPN #2 as she prepared the morning medication administration to the resident. There was no Docusate Sodium in the medication cart. LPN #2 stated, "I have to go check the medication room." LPN #2 returned to the medication cart and stated, "I am out of Colace, it is not here from the pharmacy. I will call the doctor and get the medication placed on hold." The surveyor observed LPN #2 as she continued to prepare the medications. There were no observations of the LPN verifying the medications with the MAR as she prepared each medication. The surveyor observed the LPN punch a pill into the medication cup. The medication was viewed by the surveyor and the label documented, "...Buspar 5 mg..." The LPN was observed to administer the medication to the resident. There was no documentation for an order for the administration of the Buspar 5MG on the January 2016 MAR. She was asked how the facility ensured medications were available for administration to the residents. She stated, "I try to order them	F 332		

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when I have one or two days left or 3-11 will order them." She was asked who was responsible for ordering medications. She stated, "We all are."

On 01/06/16 at 9:00 a.m., LPN #2 was asked if the Docusate Sodium was administered on 01/05/16 upon receipt from the pharmacy. She stated, "No, we didn't get it in until late last night. I gave it this morning."

She was asked if there was an order for the Buspar administration. She stated, "She was just started on it before she went to the hospital." She verified there was no order documentation for the administration of the Buspar upon readmission to the facility.

She was asked who was responsible for the readmission order documentation. She stated, "Whoever gets the resident back. We have a 3-11 admission nurse. She does what she can."

She was asked who was responsible for removing the discontinued medications from the cart. She stated, "Whoever the nurse is that readmitted them."

3. Resident #18 was admitted to the facility on 01/04/16 with diagnoses which included right hip fracture, diffuse Large B Cell Lymphoma, depression and pain.

An admission physician order, dated 01/04/16, documented, "...Posaconazole 300 mg po daily..."

On 01/05/16 at 9:45 a.m., the surveyor observed LPN #1 as she prepared the morning medication for administration to the resident. There was no observation of the Posaconazole in the

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F 332	Continued From page 34 medication cart. At 9:48 a.m , LPN #1 asked LPN #4 to assist in locating the medication from the medication room. At 9:50 a.m., LPN #4 returned and stated the medication was not in the medication room. She stated she called the pharmacy and the medication is unavailable until later in the day. At 9:51 a.m., LPN #1 was asked how the facility ensured medications were available for use. She stated, "Normally the pharmacy will call to report that they can't provide the medication and we will call the physician for a change or hold orders." She was asked if it was reported to her that the medication was not available. She stated, "No. The last shift didn't say anything about it in report." At 10:30 a.m., LPN #1 approached the surveyor and stated, "The pharmacy called and the medication won't be in until tomorrow." She was asked when the facility was notified on 01/04/16 that the medication was unavailable should the physician have been notified. She stated, "Yes."	F 332		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		

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F 425	Continued From page 35 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to have pharmacy procedures in place to ensure timely acquisitions of medications for four (#1, 3, 17 and #18) of nine sampled residents whose records were reviewed. The Resident Census and Conditions Report, dated 01/04/16, documented 73 residents resided in the facility. Findings: A facility policy, titled Medication Shortages/Unavailable Medications, documented, "...Procedure... 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of	F 425		

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F 425	Continued From page 36 medication administration, Facility staff should immediately take action... 2. If a medication shortage is discovered during normal Pharmacy hours...Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery... 4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions..." 1. Resident #3 was admitted with diagnoses which included Alzheimer's, depressive disorder and anxiety. The physician's order, dated 06/19/15, documented, "...Ativan 0.5 mg qid..." The medication administration record, dated June 2015, documented, "...Ativan 0.5 mg PO QID... 06/21 9a...ativan 0.5mg 0 given - 0 available... 1p...ativan 0.5mg 0 given - 0 available... 1700 (5 p.m.)...ativan 0.5mg - awaiting pharmacy delivery called pharmacy @1730 (5:30 p.m.)... 2100 (9 p.m)....ativan 0.5mg awaiting delivery..." On 01/06/15 at 12:30 p.m., LPN #3 was asked why the Ativan 0.5 mg QID, which was ordered by the physician on 06/19/15, was not placed on the medication administration record until 06/21/15. She stated, "I don't know." She was asked what did it mean when the initials on the medication administration record were circled. She stated, "Well, either it wasn't given	F 425		

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F 425	Continued From page 37 or maybe not here." 2. Resident #1 was readmitted to the facility on 08/22/15 with diagnoses which included Parkinson's Disease, anxiety and depression. He was admitted to hospice on 08/26/15 with diagnoses which included failure to thrive and chronic obstructive pulmonary disease. A physician's order, dated 08/22/15, documented the resident was to be administered Ativan 0.5 mg three times a day. The October MAR documented the Ativan was held on 10/17/15 at 8:00 a.m. and 2:00 p.m. The nurse's medication notes located on the back of the MARs documented, "...Ativan on hold see nn [nurses notes]..." A nurse's note, dated 10/17/15 at 8:55 a.m., documented, "New order for Ativan 0.5 mg tid. May give Xanax tid until Ativan arrives the [sic] change Xanax to tid PRN..." A physician's order, dated 11/12/15, documented to increase the Ativan to 1 mg every eight hours. The November 2015 MAR documented the Ativan had not been administered all three doses on 11/18/15. The back of the MAR documented, "11/18/15 6am...Ativan 0.5mg 2 tabs - not given - awaiting new script from physician... 11/18/15 1200 [noon]...Ativan 0.5mg not given d/t pharmacy..." No explanation was documented for the third missed dose. On 01/05/16 at 5:00 p.m., the DON was asked if she could locate the reason the Ativan had not been administered on 10/17/15 and 11/18/15.	F 425		

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F 425	Continued From page 38 On 01/06/16 at 2:55 p.m., the DON was asked again about the Ativan not being available. She stated she thought there had been an order change on those days. She was informed there had been no change documented and was asked to locate the date the medications had been reordered. On 01/11/16 at 10:40 a.m., the DON was asked if she had located the dates the Ativan had been reordered. She stated, "No, I didn't dig that deep into it." She stated she would look for the dates. She was asked what the policy was on reordering medications. She stated the policy was to reorder three days before the medication would be out and to fax the physician if a new prescription was required for the reorder. No documentation of the dates the Ativan had been reordered were presented prior to the survey exit. 3. Resident #17 was admitted with diagnosis which included hypertension, GERD, weakness and COPD. A monthly physician's order report, dated January 2016, documented, "...DOCUSATE SODIUM 100MG...1 CAP BY MOUTH DAILY..." On 01/05/16 at 10:05 a.m., the surveyor observed LPN #2 as she prepared the morning medication administration to the resident. There was no Docusate Sodium observed in the medication cart. LPN #2 stated, "I have to go check the medication room." LPN #2 returned to the medication cart and stated, "I am out of Colace, it	F 425		

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is not here from the pharmacy. I will call the doctor and get the medication placed on hold."

She was asked how the facility ensured medications were available for administration to the residents. She stated, "I try to order them when I have one or two days left or 3-11 will order them." She was asked who was responsible for ordering medications. She stated, "We all are."

On 01/06/16 at 9:00 a.m., LPN #2 was asked if the Docusate Sodium was administered on 01/05/16 upon receipt from the pharmacy. She stated, "No, we didn't get it in until late last night. I gave it this morning."

4. Resident #18 was admitted to the facility on 01/04/16 with diagnoses which included right hip fracture, diffuse Large B Cell Lymphoma, depression and pain.

An admission physician's order, dated 01/04/16, documented, "...Posaconazole 300 mg po daily..."

On 01/05/16 at 9:45 a.m., the surveyor observed LPN #1 as she prepared the morning medication for administration to the resident. There was no observation of the Posaconazole in the medication cart.

At 9:48 a.m., LPN #1 asked LPN #4 to assist in locating the medication from the medication room.

At 9:50 a.m., LPN #4 returned and stated the medication was not in the medication room. She stated she called the pharmacy and the medication is unavailable until later in the day.

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F 425	Continued From page 40 At 9:51 a.m., LPN #1 was asked how the facility ensured medications were available for use. She stated, "Normally the pharmacy will call to report that they can't provide the medication and we will call the physician for a change or hold orders." She was asked if it was reported to her that the medication was not available. She stated, "No. The last shift didn't say anything about it in report." At 10:30 a.m., LPN #1 approached the surveyor and stated, "The pharmacy called and the medication won't be in until tomorrow."	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 41 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure recurrent urinary tract infections were unavoidable and that thorough incontinent care was provided to remove fecal material and catheter care was performed for one (#8) of six sampled residents whose clinical records were reviewed for urinary tract infections related to catheter care. The Resident Census and Conditions report, dated 01/04/16 documented there were 11 residents who had indwelling urinary catheters. Findings: Resident #8 had diagnoses which included chronic kidney disease, bipolar disorder, neuromuscular dysfunction of bladder, Rheumatoid arthritis and paraplegia.	F 441		

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F 441	Continued From page 42 A care plan, revised on 11/26/12, documented, "...Focus Use of indwelling urinary catheter for neurogenic bladder and urinary retention... Interventions...Catheter care every shift and as needed .." A urine culture and sensitivity report, dated 01/29/15, documented, "...ORG#1 [organism #1] >100,000 colonies/ml ORG #1 ESBL Pos. (resistant to all Cephalosporins and Penicillins) ORG#2 >100,000 Colonies/ml Organism #1: Escherichia coli... Organism #2: Enterococcus spp..." Escherichia coli and Enterococcus are both organisms that live in the digestive tract. A urine culture and sensitivity report, dated 03/26/15, documented, "...ORG#1 100,000 colonies/ml... Organism #1: Escherichia coli..." A urine culture and sensitivity report, dated 06/07/15, documented, "...>100,000 colonies /ml Organism #1: Escherichia coli..." A hand-written note on the lab report documented, "6/9/15 allergic to Sulfa PCN Send to ER for IV ABT therapy." A hospital progress note, dated 09/03/15, documented, "...UTI c E. Coli..." A urine culture and sensitivity report, dated 10/01/15, documented, "...ORG#1 100,000 colonies/ml... Organism #1: Escherichia coli..."	F 441		

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	375098	A. BUILDING _____ B. WING _____	01/11/2016

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F 441	Continued From page 43 A quarterly assessment, dated 11/19/15, documented the resident was independent in cognitive skills for daily decision making. She required extensive assistance of two people for transfers. She required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. She had functional limitation in range of motion of the bilateral lower extremities. She was not ambulatory. She had an indwelling urinary catheter and was always incontinent of bowel. On 01/05/16 at 10:30 a.m.,the provision of incontinent care for resident #8 was observed. CNA #2 and CNA #3 were asked who was responsible for providing catheter care for the resident. CNA #2 stated, "That's what we are gonna do." The resident stated that she had an accident at 12:30 a.m. and was not sure how well she was cleaned. As care was initiated the resident was observed to have dried brown feces on her buttocks. CNA #2 stated, "Still got a little." There was no observation of catheter care provided to the resident at this time. At 11:00 a.m., LPN #2 was asked who was responsible for performing catheter care. She stated, "We do." She was asked to clarify. She stated the nurses were responsible. She was observed to check the TAR and stated, "Every shift." LPN #2 was informed of the need to observe the catheter care for the day shift. No observation of catheter care was observed on the day shift.	F 441		

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F 441	Continued From page 44 On 01/06/16 at 9:00 a.m., LPN #2 was asked if catheter care was given during the day shift on 01/05/16. She stated, "No, she was already up in her chair." At 11:00 a.m., Physician #1 was asked if the resident was at risk for the recurrent E. coli infections due to improper incontinent care and failure to perform incontinent care in a timely manner. He stated, "It is possible. She also has an indwelling catheter which places her at risk." Physician #1 was informed of the incontinent care observation and observation of dried feces. He stated, "That could be a reason. I will put her on Hyprex and see what happens." On 01/11/16 at 10:45 a.m., the DON was asked how often catheter care is provided to the residents. She stated, "Typically every shift or as ordered." She was asked who is responsible for providing catheter care. She stated, "The nurse on the hall." She was asked how recurrent infections are monitored. She stated , "We do monthly track and trending reports." She was asked what the facility policy was for a resident with recurrent urinary tract infections. She stated, "It depends. Staff inservices."	F 441		

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LL000	Initial Comments A recertification survey was conducted on 01/04/16 through 01/07/16 and 01/11/16. Below is a list of abbreviations used throughout this survey: @ - at ^ - increase + - plus 0130 - 1:30 a.m. 3-11 - evening shift A/R - adverse reaction ABH - Ativan/Benadryl/Haldol ABT - antibiotic BID - twice a day BLE - bilateral lower extremities C - with CHF - Congestive Heart Failure Cm - centimeters COPD - Chronic Obstructive Pulmonary Disease CVA - Cerebral Vascular Disease D - day DON - Director of Nursing DR - dining room drsg - dressing d/t - due to E. Coli - Escherichia coli ER - Emergency Room GERD - Gastric Esophageal Reflux Disease Hr - hour III - three IV - Intravenous LPN - Licensed Practical Nurse MAR - medication administration record MDS - Minimum Data Set MG/mg - milligrams ML - milliliter NS - normal saline PCN - Penicillin	LL000		

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LL000	Continued From page 1 PEG - Percutaneous Endoscopic Gastrostomy PO/po - by mouth PRN - as needed Pt/pt - patient Q -every Qhs - every night Qsh - every shift RN - Registered Nurse S.E. - side effects S/S - signs and symptoms TAR - treatment administration record TID - three times a day UTI - urinary tract infection VSS - vital signs stable w/c - wheelchair x -times	LL000		
LL023	63 O.S. § 1-1947(I) Criminal History Background Checks 1. Upon receipt of the written consent and identification required under subsection H of this section, an employer shall submit an applicant ' s name, any aliases, address, former states in which the applicant resided, social security number, and date of birth, through an Internet portal maintained by the Department, as provided in subsection V of this section, for the purpose of conducting a check of all relevant registries established pursuant to federal and state law and regulations for any findings barring employment. If the findings of the check do not reveal any basis that would prevent the employment of the applicant pursuant to subsection D of this section, and where the applicant does not have a monitored employment record pursuant to the provisions in subsection S of this section, the Department shall authorize the collection and submission of fingerprints through an authorized	LL023		

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LL023	Continued From page 2 collection site to the Bureau for the performance of a criminal history record check on the applicant, pursuant to Section 150.9 of Title 74 of the Oklahoma Statutes and in accordance with U.S. Public Law 111-148. Results of such search conducted through both the Bureau and FBI databases shall be returned electronically to the Department. 2. The Bureau shall retain one set of fingerprints in the Automated Fingerprint Identification System and submit the other set to the FBI for a national criminal history records search. 3. Fingerprint images may be rejected by the Bureau or the FBI. A rejection of the fingerprints by the Bureau or the FBI shall require the applicant to be fingerprinted again. 4. The applicant shall have ten (10) calendar days, after receipt of authorization as provided in this subsection, to submit his or her fingerprints through an authorized collection site or his or her application shall be deemed withdrawn and the applicant shall be required to commence the application process from the beginning. This Rule is not met as evidenced by: Based on employee file review and staff interview, it was determined the facility failed to complete criminal background checks for one (CNA #1) of five employees whose personnel files were reviewed. The Resident Census and Condition Report, dated 01/04/16, documented 73 residents who resided in the facility.	LL023		

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LL023	Continued From page 3 Findings: A facility document titled, Patient Protection Practice Guide, documented, "The purpose of the 'Guide' is to assist each center in implementation of an abuse prevention system... Employee Screening...The center utilizes the employee screening process to identify information from... State licensing boards and registries, Criminal background checks..." A review of the employee file for CNA #1, documented a hire date of 11/05/15. There was no documentation in the employee file of a criminal background check. On 01/11/16 at 3:00 p.m., the Administrator was asked for any criminal background checks for CNA #1. At 3:30 p.m., the Administrator stated, "There were no background checks for [CNA#1]."	LL023		
LL361	310:675-9-5.1.(c)(2)(D)(E) RESIDENT PAIN ASSESSMENT (A) Residents shall be screened for the presence of pain at least once every 30 days and whenever vital signs are taken. (i) Licensed nursing staff shall perform the screening at least once every 30 days. Certified nurse aides may perform the screening more frequently as needed.	LL361		

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LL361	Continued From page 4 (ii) The screening instrument shall grade the intensity and severity of pain using a resident-specific pain scale; (B) An individualized pain assessment shall be conducted by a registered nurse for each resident: (i) In conjunction with the admission, quarterly and annual assessments required at OAC 310:675-9-5.1.(c)(1)(F); and (ii) With onset of pain not previously addressed in a care plan or physician's orders. (C) The goal is to alleviate or minimize pain while assisting the resident to maintain as high a level of functioning as possible. The pain assessment shall include, but not be limited to: (i) A statement of how the resident describes the pain; (ii) Intensity and severity of pain graded using a resident-specific pain scale; (iii) Recent changes in pain; (iv) Location(s); (v) Onset and duration of pain, such as new pain within the last 3 days, recent pain within the last 3 months, or more distant pain greater than 3 months; (vi) Type of pain reported or represented by resident, such as constant or intermittent, and duration or frequency of pain; (vii) Current pain measured at its least and greatest levels; (viii) Aggravating and relieving factors; (ix) Treatment including a review of all therapies, including medication, and the regimen used to minimize pain; (x) Effects of pain and effectiveness of therapy on physical and social functions; (xi) Resident's treatment preferences and	LL361		

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LL361	Continued From page 5 emotional responses to pain, including resident's expectations and how resident coped with pain; and (xii) If applicable, refer to pain assessment tool for the cognitively impaired. (D) Results shall be recorded in the resident's clinical record showing changes in pain scale and changes in level of functioning. The physician shall be contacted as necessary. (E) Pain shall be treated promptly, effectively and for as long as necessary. This Rule is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to perform a comprehensive pain assessment by a registered nurse on admission, with a significant change, annually and quarterly for five (#2-5 and #9) of nine sampled residents whose records were reviewed for comprehensive pain assessments. The Resident Census and Conditions Report, dated 01/04/16, documented 73 residents resided in the facility. Findings: 1. Resident #9 was admitted on 07/10/15 with diagnoses which included dementia with behaviors and generalized pain.	LL361		

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LL361	Continued From page 6 A pain assessment had been completed on 07/10/15 and 07/20/15 by an LPN. A pain assessment had been completed on 07/29/15 and 08/07/15 by an RN. No other pain assessments completed by an RN were located in the record. On 01/11/16 at 11:05 a.m., the DON was asked if she could locate the comprehensive pain assessments for the July admission and the October quarterly. At 11:20 a.m., the DON presented the pain assessment dated 07/29/15. She was asked if since this had been performed 19 days after the admission, did she consider this an admission assessment. She stated, "No." She was asked if she had located an RN assessment for October. She stated there was not one for October. 2. Resident #2 had diagnoses which included chronic pain, dementia, aphasia, diabetes, COPD, CHF and osteoarthritis. A significant change assessment, dated 12/06/15, documented the resident was moderately impaired in skills of daily decision making. There were no quarterly comprehensive pain assessments for the last 12 months in the resident's clinical record. 3. Resident #3 was admitted to the facility on 05/02/15 with diagnoses which included Alzheimer's disease and depression. No comprehensive pain assessments for the	LL361		

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LL361	Continued From page 7 August and November quarters had been completed by a registered nurse. 4. Resident #4 was admitted to the facility on 05/13/15 with diagnoses which included dementia and general anxiety. No comprehensive pain assessments by a registered nurse had been completed on admit in May or in August and November 5. Resident #5 was admitted with diagnoses which included Alzheimer's disease, neurogenic bladder and anxiety. There were 11 'Pain Assessment in Advanced Dementia Scales' completed from January through December 2015. These scales only addressed one (signs of pain) of the 12 elements required in a comprehensive pain assessment. There was no quarterly comprehensive pain assessments performed by a registered nurse during the last 12 month period. On 01/05/16 at 4:15 p.m., the DON was asked who documented the pain evaluations or assessments. She stated, "It's whoever." She was asked if the RN conducted comprehensive pain assessments quarterly. She stated, "No."	LL361		
LL771	310:675-7-11.1(a) MEDICATION RECORDS The facility shall maintain written policies and procedures for safe and effective acquisition, storage, distribution, control, and use of medications and controlled drugs.	LL771		

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LL771	Continued From page 8	LL771		

This Rule is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to have pharmacy procedures in place to ensure timely acquisitions of medications for four (#1, 3, 17 and #18) of nine sampled residents whose records were reviewed.

The Resident Census and Conditions Report, dated 01/04/16, documented 73 residents resided in the facility.

Findings:

A facility policy, titled Medication Shortages/Unavailable Medications, documented, "...Procedure...

1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take action...

2. If a medication shortage is discovered during normal Pharmacy hours...Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery...

4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions..."

1. Resident #3 was admitted with diagnoses

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LL771	Continued From page 9 which included Alzheimer's, depressive disorder and anxiety. The physician's order, dated 06/19/15, documented, "...Ativan 0.5 mg qid..." The medication administration record, dated June 2015, documented, "...Ativan 0 5 mg PO QID... 06/21 9a...ativan 0.5mg 0 given - 0 available... 1p...ativan 0.5mg 0 given - 0 available... 1700 (5 p.m.)...ativan 0.5mg - awaiting pharmacy delivery called pharmacy @1730 (5:30 p.m.)... 2100 (9 p.m)....ativan 0.5mg awaiting delivery..." On 01/06/15 at 12:30 p.m., LPN #3 was asked why the Ativan 0.5 mg QID, which was ordered by the physician on 06/19/15, was not placed on the medication administration record until 06/21/15. She stated, "I don't know." She was asked what did it mean when the initials on the medication administration record were circled. She stated, "Well, either it wasn't given or maybe not here." 2. Resident #1 was readmitted to the facility on 08/22/15 with diagnoses which included Parkinson's Disease, anxiety and depression. He was admitted to hospice on 08/26/15 with diagnoses which included failure to thrive and chronic obstructive pulmonary disease. A physician's order, dated 08/22/15, documented the resident was to be administered Ativan 0.5 mg three times a day. The October MAR documented the Ativan was held on 10/17/15 at 8:00 a m. and 2:00 p.m. The	LL771		

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LL771	Continued From page 10 nurse's medication notes located on the back of the MARs documented, "...Ativan on hold see nn [nurses notes]..." A nurse's note, dated 10/17/15 at 8:55 a.m., documented, "New order for Ativan 0.5 mg tid. May give Xanax tid until Ativan arrives the [sic] change Xanax to tid PRN..." A physician's order, dated 11/12/15, documented to increase the Ativan to 1 mg every eight hours. The November 2015 MAR documented the Ativan had not been administered all three doses on 11/18/15. The back of the MAR documented, "11/18/15 6am...Ativan 0.5mg 2 tabs - not given - awaiting new script from physician... 11/18/15 1200 [noon]...Ativan 0.5mg not given d/t pharmacy..." No explanation was documented for the third missed dose. On 01/05/16 at 5:00 p.m., the DON was asked if she could locate the reason the Ativan had not been administered on 10/17/15 and 11/18/15. On 01/06/16 at 2:55 p.m., the DON was asked again about the Ativan not being available. She stated she thought there had been an order change on those days. She was informed there had been no change documented and was asked to locate the date the medications had been reordered. On 01/11/16 at 10:40 a.m., the DON was asked if she had located the dates the Ativan had been reordered. She stated, "No, I didn't dig that deep into it." She stated she would look for the dates. She was asked what the policy was on reordering medications. She stated the policy was to	LL771		

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LL771	Continued From page 11	LL771		

reorder three days before the medication would be out and to fax the physician if a new prescription was required for the reorder.

No documentation of the dates the Ativan had been reordered were presented prior to the survey exit.

3. Resident #17 was admitted with diagnosis which included hypertension, GERD, weakness and COPD.

A monthly physician's order report, dated January 2016, documented, "...DOCUSATE SODIUM 100MG...1 CAP BY MOUTH DAILY..."

On 01/05/16 at 10:05 a.m., the surveyor observed LPN #2 as she prepared the morning medication administration to the resident. There was no Docusate Sodium observed in the medication cart LPN #2 stated, "I have to go check the medication room." LPN #2 returned to the medication cart and stated, "I am out of Colace, it is not here from the pharmacy. I will call the doctor and get the medication placed on hold."

She was asked how the facility ensured medications were available for administration to the residents. She stated, "I try to order them when I have one or two days left or 3-11 will order them." She was asked who was responsible for ordering medications. She stated, "We all are."

On 01/06/16 at 9:00 a.m., LPN #2 was asked if the Docusate Sodium was administered on 01/05/16 upon receipt from the pharmacy. She stated, "No, we didn't get it in until late last night. I gave it this morning."

4. Resident #18 was admitted to the facility on

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LL771	Continued From page 12 01/04/16 with diagnoses which included right hip fracture, diffuse Large B Cell Lymphoma, depression and pain. An admission physician's order, dated 01/04/16, documented, "...Posaconazole 300 mg po daily..." On 01/05/16 at 9:45 a.m., the surveyor observed LPN #1 as she prepared the morning medication for administration to the resident. There was no observation of the Posaconazole in the medication cart. At 9:48 a.m., LPN #1 asked LPN #4 to assist in locating the medication from the medication room. At 9:50 a.m., LPN #4 returned and stated the medication was not in the medication room. She stated she called the pharmacy and the medication is unavailable until later in the day. At 9:51 a.m., LPN #1 was asked how the facility ensured medications were available for use. She stated, "Normally the pharmacy will call to report that they can't provide the medication and we will call the physician for a change or hold orders." She was asked if it was reported to her that the medication was not available. She stated, "No. The last shift didn't say anything about it in report." At 10:30 a.m., LPN #1 approached the surveyor and stated, "The pharmacy called and the medication won't be in until tomorrow."	LL771		
LL784	310:675-7-12.1(h) INCIDENT REPORTS	LL784		

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LL784	Continued From page 13 All incident reports shall be reviewed by the director of nursing and the administrator and shall include corrective action taken where health and safety are affected. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document corrective actions/interventions on the facility incident reports related to falls for three (#2, 3 and #9) of six sampled residents whose records were reviewed for falls. The Resident Census and Conditions, dated, 01/04/16, documented 73 residents resided in the facility. Findings: 1. Resident # 9 was admitted to the facility on 07/10/15 with diagnoses which included muscle weakness and dementia with behaviors. The resident had experienced five falls since admission. The incident reports on the falls did not contain any corrective actions or interventions put into place after the falls. On 01/04/15 at 1:00 p.m., the DON was asked where the interventions for falls would be documented. She stated, "On the care plans." She was asked if they are documented on the incident reports. She stated, "No, only on the care plans."	LL784		

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LL784	Continued From page 14 2. Resident #2 had diagnoses which included chronic pain, dementia, aphasia, diabetes, COPD, CHF and osteoarthritis. An incident report, dated 02/27/15, documented, "...Fall without injury..." There were no interventions documented on the incident report. An incident report, dated 03/09/15, documented, "...Fall without injury..." There were no interventions documented on the incident report. An incident report, dated 03/12/15, documented, "...Fall without injury..." There were no interventions documented on the incident report. An incident report, dated 06/02/15, documented, "...Fall without injury..." There were no interventions documented on the incident report. An incident report, dated 10/09/15, documented, "...Fall without injury..." There were no interventions documented on the incident report. A significant change assessment, dated 12/06/15, documented the resident was moderately impaired in cognitive skills of daily decision making. She required extensive assistance of one person for transfers, dressing, toileting and personal hygiene. She used a wheelchair for	LL784		

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LL784	Continued From page 15 primary mobility. On 01/04/15 at 1:00 p.m., the DON was asked where the interventions for falls would be documented. She stated, "On the care plans." She was asked if they are documented on the incident reports. She stated, "No, only on the care plans." On 01/05/16 at 12:00 p.m., the MDS Coordinator was asked if the resident's care plan was updated with each fall. She stated, "The falls are not documented on the care plan each time under the problem section but each fall is care planned with an intervention and dated under the interventions. At 1:50 p.m., the DON was asked if there should be new interventions with each fall occurrence. She stated, "Yes." She was asked how the facility ensured that new interventions were initiated and placed on the care plans. She stated "It is discussed in the eagle room every morning." 3. Resident #3 was admitted with diagnoses which included Alzheimer's, depressive disorder and anxiety. Facility incident reports, dated 06/10/15, 06/19/15, 07/09/15 and 07/18/15 documented falls. The incident reports did not contain any corrective action/interventions related to that particular fall. On 01/04/15 at 1:00 p.m., the DON was asked where the interventions for falls would be documented. She stated, "On the care plans." She was asked if they are documented on the incident reports. She stated, "No, only on the care plans."	LL784		

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LL810	310:675-7-17.1(a) INFECTION CONTROL The facility shall have an infection control policy and procedures to provide a safe and sanitary environment. The policy shall address the prevention and transmission of disease and infection. The facility, and its personnel, shall practice the universal precautions identified by the Centers for Disease Control. All personnel shall demonstrate their knowledge of universal precautions through performance of duties. This Rule is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure recurrent urinary tract infections were unavoidable and that thorough incontinent care was provided to remove fecal material and catheter care was performed for one (#8) of six sampled residents whose clinical records were reviewed for urinary tract infections related to catheter care. The Resident Census and Conditions report, dated 01/04/16 documented there were 11 residents who had indwelling urinary catheters. Findings: Resident #8 had diagnoses which included chronic kidney disease, bipolar disorder, neuromuscular dysfunction of bladder, Rheumatoid arthritis and paraplegia.	LL810		

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LL810	Continued From page 17 A care plan, revised on 11/26/12, documented, "...Focus Use of indwelling urinary catheter for neurogenic bladder and urinary retention... Interventions...Catheter care every shift and as needed..." A urine culture and sensitivity report, dated 01/29/15, documented, "...ORG#1 [organism #1] >100,000 colonies/ml ORG #1 ESBL Pos. (resistant to all Cephalosporins and Penicillins) ORG#2 >100,000 Colonies/ml Organism #1: Escherichia coli... Organism #2: Enterococcus spp..." Escherichia coli and Enterococcus are both organisms that live in the digestive tract. A urine culture and sensitivity report, dated 03/26/15, documented, "...ORG#1 100,000 colonies/ml... Organism #1: Escherichia coli..." A urine culture and sensitivity report, dated 06/07/15, documented, "...>100,000 colonies /ml Organism #1: Escherichia coli..." A hand-written note on the lab report documented, "6/9/15 allergic to Sulfa PCN Send to ER for IV ABT therapy." A hospital progress note, dated 09/03/15, documented, "...UTI c E. Coli..." A urine culture and sensitivity report, dated 10/01/15, documented, "...ORG#1 100,000 colonies/ml... Organism #1: Escherichia coli..."	LL810		

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LL810	Continued From page 18 A quarterly assessment, dated 11/19/15, documented the resident was independent in cognitive skills for daily decision making. She required extensive assistance of two people for transfers. She required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. She had functional limitation in range of motion of the bilateral lower extremities. She was not ambulatory. She had an indwelling urinary catheter and was always incontinent of bowel. On 01/05/16 at 10:30 a.m.,the provision of incontinent care for resident #8 was observed. CNA #2 and CNA #3 were asked who was responsible for providing catheter care for the resident. CNA #2 stated, "That's what we are gonna do." The resident stated that she had an accident at 12:30 a.m. and was not sure how well she was cleaned. As care was initiated the resident was observed to have dried brown feces on her buttocks. CNA #2 stated, "Still got a little." There was no observation of catheter care provided to the resident at this time. At 11:00 a.m., LPN #2 was asked who was responsible for performing catheter care. She stated, "We do." She was asked to clarify. She stated the nurses were responsible. She was observed to check the TAR and stated, "Every shift." LPN #2 was informed of the need to observe the catheter care for the day shift. No observation of catheter care was observed on the day shift. On 01/06/16 at 9:00 a.m., LPN #2 was asked if catheter care was given during the day shift on	LL810		

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LL810	Continued From page 19 01/05/16. She stated, "No, she was already up in her chair." At 11:00 a.m., Physician #1 was asked if the resident was at risk for the recurrent E. coli infections due to improper incontinent care and failure to perform incontinent care in a timely manner. He stated, "It is possible. She also has an indwelling catheter which places her at risk." Physician #1 was informed of the incontinent care observation and observation of dried feces. He stated, "That could be a reason. I will put her on Hyprex and see what happens." On 01/11/16 at 10:45 a.m., the DON was asked how often catheter care is provided to the residents. She stated, "Typically every shift or as ordered." She was asked who is responsible for providing catheter care. She stated, "The nurse on the hall." She was asked how recurrent infections are monitored. She stated , "We do monthly track and trending reports." She was asked what the facility policy was for a resident with recurrent urinary tract infections. She stated, "It depends. Staff inservices."	LL810		
LL816	310:675-9-1.1.(b)(1)(2) BASIC NURSING AND PERSONAL CARE (b) Basic nursing and personal care shall be provided for residents as needed. (1) Nursing care shall include, but not be limited to:	LL816		

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LL816	Continued From page 20 (A) Encouraging residents to be active and out of bed for reasonable time periods. (B) Measuring resident temperature, blood pressure, pulse and respirations at least once every thirty days and more frequently if warranted by the resident's condition, with the results recorded in the clinical record. (i) Measuring resident weight at least once every thirty days and more frequently if warranted by the resident's condition, with the results recorded in the clinical record. (ii) Measuring resident pain whenever vital signs are taken and more frequently if warranted by the resident's condition, with the results recorded in the clinical record. (C) Offering fluids, and making fluids available, to maintain proper hydration. (D) Following proper nutritional practices for diets, enteral and parenteral feedings and assistance in eating. (E) Providing proper skin care to prevent skin breakdown. (F) Providing proper body alignment. (G) Providing supportive devices to promote proper alignment and positioning. (H) Turning bed residents every two hours or as needed, to prevent pressure areas, contractures, and decubitus. (I) Performing range of motion exercises in accordance with individual assessment and care plans. (J) Ensuring that residents positions are changed every two hours or as needed when in a chair and are toileted as needed. (K) Establishing and implementing bowel and bladder programs to promote independence, or developing toileting schedules to promote continence. (L) Performing catheter care with proper	LL816		

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positioning of bag and tubing at all times.
(M) Recording accurate intake and output records for residents with tube feedings or catheters.
(N) Assessing the general mental and physical condition of the resident on admission.
(O) Updating the assessment and individual care plan when there is a significant change in the resident's physical, mental, or psychosocial functioning.
(P) Recognizing and recording signs and symptoms of illness or injury with action taken to treat the illness or injury, and the response to treatments and medications.
(2) Personal care shall include, but not be limited to:
(A) Keeping residents clean and free of odor.
(B) Keeping bed linens clean and dry.
(C) Keeping resident's personal clothing clean and neat.
(D) Ensuring that residents are dressed appropriately for activities in which they participate; bedfast/chairfast residents shall be appropriately dressed and provided adequate cover for comfort and privacy.
(E) Ensuring that the resident's hair is clean and groomed.
(F) Providing oral hygiene assistance at least twice daily with readily available dental floss, toothbrush and dentifrice. A denture cleaning/soaking device and brush shall be available and maintained for each resident as needed.
(G) Keeping toenails and fingernails clean and trimmed.

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This Rule is not met as evidenced by:
Based on observation, record review and staff and resident interview, it was determined the facility failed to ensure the resident's care was coordinated with the hospice agency to ensure psychotropic medications were not increased without indication for an increase for one (#1) of five sampled residents who received hospice services

The Resident Census and Conditions report, dated 01/04/16, documented seven residents received hospice services.

Findings:

A policy, Phase 3: Implement, dated 2015, documented, "...Unnecessary drugs
1...Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
(i) In excessive dose (including duplicate therapy): or
(ii) For excessive duration: or
(iii) Without adequate monitoring: or
(iv) Without adequate indications for its use: or
(v) In the presence of adverse consequences which indicate the dose should be reduced or

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LL816	Continued From page 23 discontinued: or (vi) Any combinations of the reasons above..." Resident #1 was readmitted to the facility on 08/22/15 with diagnoses which included Parkinson's Disease, anxiety and depression He was admitted to hospice on 08/26/15 with diagnoses which included failure to thrive and chronic obstructive pulmonary disease. The post hospital physician's orders, dated 08/22/15, documented the resident was to receive Xanax 0.25 mg TID and Ativan 0.5 mg TID PRN. Both of these were antianxiety medications. A physician's order, dated 10/01/15, documented to decrease the Xanax to 0.25 mg every eight hours PRN. The October 2015 MAR documented the resident had been administered one PRN Xanax 0.25 mg on 10/01/15, 10/02/15, 10/12/15 for increased anxiety and on 10/15/15 for increased anxiety with cough. The resident had been diagnosed with an upper respiratory infection the previous week. Twenty two nursing progress notes were documented between 10/01/15 and 10/17/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses. A hospice nursing note, dated 10/15/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day".	LL816		

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LL816	Continued From page 24 A nursing progress note, dated 10/17/15, documented, "New order for Ativan 0.5 mg tid. May give Xanax 0.25 tid until Ativan arrives the [sic] change Xanax to tid prn..." A physician's order, dated 10/17/15, documented to hold the Ativan until available. The Xanax 0.25 mg was to be administered TID until the Ativan was available and then was to be decreased to TID PRN. No written order for the Ativan change was located. The October 2015 MAR contained no documentation the resident had been administered a PRN Xanax from 10/15/15 through 10/22/15. A hospice nursing note, dated 10/22/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". A physician's order, dated 10/22/15, documented to increase the Xanax to 0.25 mg two tabs (0.5 mg) every 4 hours PRN for restlessness. Two hospice nursing notes, dated 10/23/15 and 10/26/15, documented the resident's anxiety status had been deferred. The October 2015 MAR documented the resident had been administered one PRN Xanax on 10/24/15 and 10/25/15. Twelve nursing progress notes were documented from 10/17/15 through 10/29/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses.	LL816		

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LL816	Continued From page 25 A hospice nursing note, dated 10/29/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". It also documented the resident complained of a nonproductive cough "and he can't get anything up. [Physician's name deleted] notified [and] received new orders..." The note documented the hospice nurse had notified the attending physician of the resident's status and had received new orders. A physician's order, dated 10/29/15, documented to increase the Ativan to 0.5 mg every six hours routinely for the diagnosis of anxiety as manifested by restlessness. A hospice nursing note, dated 10/30/15, documented the resident's anxiety status had been deferred. The November 2015 MAR documented the resident had been administered one PRN Xanax on 11/02/15. The next time the PRN Ativan was administered was on 11/19/15. A hospice nursing note, dated 11/05/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". A hospice nursing note, dated 11/06/15, documented the resident's anxiety status had been deferred. Six nursing progress notes were documented from 10/29/15 through 11/12/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses.	LL816		

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LL816	Continued From page 26 A hospice nursing note, dated 11/12/15, documented the resident had anxiety "@ X's [increased]" and "pt. sleeps 16 + hrs a day". It also documented, "...pt. reports [increased] anxiety [and] thick sputum that makes him gag [and] vomit. [Physician's name deleted] notified [and] new orders received..." The note documented the hospice nurse had notified the attending physician of the resident's status and had received new orders. A physician's order, dated 11/12/15, documented to increase the Ativan to 0.5 mg two tabs (1 mg) every eight hours routinely for the diagnosis of anxiety as manifested by restlessness. On 01/05/16 at 5:00 p.m., the DON was asked to locate the documentation of behaviors which indicated the need for the increase in the antianxiety medications. On 01/06/16 at 2:55 p.m., the DON stated there was documentation in the hospice notes about the resident's behaviors. She was asked if the facility should have also documented those behaviors. She stated the hospice nurse is in the facility everyday and "They probably talk so much they don't think about documenting it." On 1/11/16 at 10:50 a.m., the hospice nurse was asked what she would do if a resident complained of increased anxiety. She stated she would call the physician and talk to the facility nurse. She was asked if she ever checked the MARs for the use of PRN medications before calling the physician. She stated she "could do that." She was asked, if she reviewed the MARs and	LL816		

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LL816	Continued From page 27 observed the resident had not been administered a PRN medication for two weeks, would she call the physician. She stated she would probably ask the facility nurse to give the resident a PRN dose and monitor them. At 11:05 a.m., the DON stated the hospice nurse had trained in the facility the previous week. The DON stated she had not had a chance to coordinate care with her. The DON was asked if she had located any facility documentation regarding the resident's behaviors. She stated, "No." ********** Based on observation, record review and staff interview, it was determined the facility failed to ensure thorough incontinent care was provided for one (#8) of four sampled residents whose incontinent care was observed. The Resident Census and Conditions report, dated 01/04/15, documented 21 residents were occasionally or frequently incontinent of bowel and 11 residents had indwelling or external catheters. Findings: Resident #8 had diagnoses which included chronic kidney disease, bipolar disorder, neuromuscular dysfunction of bladder, Rheumatoid arthritis and paraplegia. A care plan, revised on 11/26/12, documented, "...Focus	LL816		

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LL816	Continued From page 28 Use of indwelling urinary catheter for neurogenic bladder and urinary retention... Interventions...Catheter care every shift and as needed..." A quarterly assessment, dated 11/19/15, documented the resident was independent in cognitive skills for daily decision making. She required extensive assistance of two people for transfers. She required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. She had a limitation in range of motion of the bilateral lower extremities. She was not ambulatory. She had an indwelling urinary catheter and was always incontinent of bowel. The TAR for January 2016 documented the resident was to receive catheter care every shift. On 01/05/16 at 10:30 a.m.,the provision of incontinent care for the resident was observed. CNA #2 and CNA #3 were asked who was responsible for providing catheter care for the resident. CNA #2 stated, "That's what we are gonna do." The resident stated that she had an accident at 12:30 a.m. and was not sure how well she was cleaned. As care was initiated, the resident was observed to have dried brown feces on her buttocks. CNA #2 stated, "Still got a little." There was no observation of catheter care provided to the resident at this time. At 10:45 a.m., CNA #2 and CNA #3 were asked how often incontinent care was offered to the resident. CNA #3 stated, "In the morning and she will let us know."	LL816		

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LL816	Continued From page 29 At 11:00 a.m., LPN #2 was asked who was responsible for performing catheter care. She stated, "We do." She was asked to clarify. She stated the nurses were responsible. She was observed to check the TAR and stated, "Every shift." LPN #2 was informed of the need to observe the catheter care for the day shift. No observation of catheter care was observed on the day shift. On 01/06/16 at 9:00 a.m., LPN #2 was asked if catheter care was given during the day shift on 01/05/16. She stated, "No, she was already up in her chair."	LL816		
LL830	310:675-9-5.1.(b) WRITTEN RESIDENT ASSESSMENT The written resident assessment and care plan shall be reviewed and updated, at least quarterly, and as needed when the resident's condition indicates. This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure care plans were revised after falls for one (#2) of nine residents whose clinical records were reviewed for falls. The Resident Census and Conditions Report dated 01/04/16, documented 73 residents resided in the facility.	LL830		

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LL830	Continued From page 30 Findings: Resident #2 had diagnoses which included chronic pain, dementia, aphasia, diabetes, COPD, CHF and osteoarthritis. A care plan, initiated on 02/11/10, documented, "At risk for falls due to use of psychotropic medications, general weakness, and history of falls." An incident report, dated 02/27/15 at 9:30 a.m., documented, "...Fall without injury (or minor i [sic] res found on floor in dining room..." There were no new interventions identified on the care plan. An incident report, dated 03/09/15 at 4:30 a.m., documented, "...Location of Incident: Patient's Room...Fall without injury (or minor i [sic] resident found on floor next to bed..." There were no new interventions identified on the care plan. An incident report, dated 03/12/15 at 3:15 a.m., documented, "...Fall without injury (or minor i [sic] found by Can [sic] lying on floor next to bed...assisted back to bed, VSS and neuro,s [sic] started, skin tears to right arm cleaned with NS and steri strips applied, drsg applied..." There were no new interventions identified on the care plan. An incident report, dated 06/02/15 at 5:30 a.m., documented, "...Fall without injury (or minor i [sic] resident was found on the floor between her bed	LL830		

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LL830	Continued From page 31 and recliner. Resident is not able to tell us how she fell..." There were no new interventions documented on the care plan. On 01/04/15 at 1:00 p.m., the DON was asked where the interventions for falls would be documented. She stated, "On the care plans." She was asked if they are documented on the incident reports. She stated, "No, only on the care plans." On 01/05/16 at 12:00 p.m., the MDS Coordinator was asked if the resident's care plan was updated with each fall. She stated, "The falls are not documented on the care plan each time under the problem section but each fall is care planned with an intervention and dated under the interventions." At 1:50 p m., the DON was asked if there should be new interventions with each fall occurrence. She stated, "Yes." She was asked how the facility ensured that new interventions were initiated and placed on the care plans. She stated, "It is discussed in the eagle room every morning."	LL830		
LL846	310:675-9-9.1.(c) MEDICATION ACCOUNTABILITY (1) Medications shall be administered only on a physician's order. (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour of administration. (3) An accurate written record of medications	LL846		

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LL846	Continued From page 32 administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each Schedule II medication prescribed for a resident. (G) Medication error incident reports. (4) A resident's adverse reactions shall be reported at once to the attending physician. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure: ~ an antianxiety medication was not increased without indications for the increases for one (#1) of nine sampled residents who received antianxiety medications: ~ side effects for antipsychotic medications were monitored for three (#2, 4 and #8) of six sampled residents who received antipsychotic medications; ~ side effects for antianxiety medications were monitored for three	LL846		

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LL846	Continued From page 33 (#2, 3 and #8) of nine sampled residents who received antianxiety medications; and ~ side effects of antidepressant medications were monitored for one (#8) of seven sampled residents who received antidepressant medications. The Resident Census and Conditions report, dated 01/04/16, documented nine residents received antipsychotic medications, 22 residents received antianxiety medications, and 32 residents received antidepressant medications. Findings: A policy, Phase 3: Implement, dated 2015, documented, "...Unnecessary drugs 1...Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate therapy): or (ii) For excessive duration: or (iii) Without adequate monitoring: or (iv) Without adequate indications for its use: or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued: or (vi) Any combinations of the reasons above..." 1. Resident #1 was readmitted to the facility on 08/22/15 with diagnoses which included Parkinson's Disease, anxiety and depression. He was admitted to hospice on 08/26/15 with diagnoses which included failure to thrive and chronic obstructive pulmonary disease. The post hospital physician's orders, dated 08/22/15, documented the resident was to	LL846		

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LL846	Continued From page 34	LL846		

receive Xanax 0.25 mg TID and Ativan 0.5 mg TID PRN. Both of these were antianxiety medications.

A physician's order, dated 10/01/15, documented to decrease the Xanax to 0.25 mg every eight hours PRN.

The October 2015 MAR documented the resident had been administered one PRN Xanax 0.25 mg on 10/01/15, 10/02/15, 10/12/15 for increased anxiety and on 10/15/15 for increased anxiety with cough. The resident had been diagnosed with an upper respiratory infection the previous week.

Twenty two nursing progress notes were documented between 10/01/15 and 10/17/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses.

A hospice nursing note, dated 10/15/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day".

A nursing progress note, dated 10/17/15, documented, "New order for Ativan 0.5 mg tid. May give Xanax 0.25 tid until Ativan arrives the [sic] change Xanax to tid prn..."

A physician's order, dated 10/17/15, documented to hold the Ativan until available. The Xanax 0.25 mg was to be administered TID until the Ativan was available and then was to be decreased to TID PRN. No written order for the Ativan change was located.

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LL846	Continued From page 35 The October 2015 MAR contained no documentation the resident had been administered a PRN Xanax from 10/15/15 through 10/22/15. A hospice nursing note, dated 10/22/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". A physician's order, dated 10/22/15, documented to increase the Xanax to 0.25 mg two tabs (0.5 mg) every 4 hours PRN for restlessness. Two hospice nursing notes, dated 10/23/15 and 10/26/15, documented the resident's anxiety status had been deferred. The October 2015 MAR documented the resident had been administered one PRN Xanax on 10/24/15 and 10/25/15. Twelve nursing progress notes were documented from 10/17/15 through 10/29/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses. A hospice nursing note, dated 10/29/15, documented the resident had anxiety "@ X's" and "pt sleeps 16 + hrs a day". It also documented the resident complained of a nonproductive cough "and he can't get anything up. [Physician's name deleted] notified [and] received new orders..." A physician's order, dated 10/29/15, documented to increase the Ativan to 0.5 mg every six hours routinely for the diagnosis of anxiety as	LL846		

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LL846	Continued From page 36 manifested by restlessness. A hospice nursing note, dated 10/30/15, documented the resident's anxiety status had been deferred. The November 2015 MAR documented the resident had been administered one PRN Xanax on 11/02/15. The next time the PRN Ativan was administered was on 11/19/15. A hospice nursing note, dated 11/05/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a day". A hospice nursing note, dated 11/06/15, documented the resident's anxiety status had been deferred. Six nursing progress notes were documented from 10/29/15 through 11/12/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses. A hospice nursing note, dated 11/12/15, documented the resident had anxiety "@ X's [increased]" and "pt. sleeps 16 + hrs a day". It also documented, "...pt. reports [increased] anxiety [and] thick sputum that makes him gag [and] vomit. [Physician's name deleted] notified [and] new orders received..." A physician's order, dated 11/12/15, documented to increase the Ativan to 0.5 mg two tabs (1 mg) every eight hours routinely for the diagnosis of anxiety as manifested by restlessness.	LL846		

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LL846	Continued From page 37 On 01/05/16 at 5:00 p.m., the DON was asked to locate the documentation of behaviors which indicated the need for the increase in the antianxiety medications. On 01/06/16 at 2:55 p.m., the DON stated there was documentation in the hospice notes about the resident's behaviors. She was asked if the facility should have also documented those behaviors. She stated the hospice nurse is in the facility everyday and "They probably talk so much they don't think about documenting it." On 01/11/16 at 10:50 a.m., the hospice nurse was asked what she would do if a resident complained of increased anxiety. She stated she would call the physician and talk to the facility nurse. She was asked if she ever checked the MARs for the use of PRN medications before calling the physician. She stated she "could do that." She was asked, if she reviewed the MARs and observed the resident had not been administered a PRN medication for two weeks, would she call the physician. She stated she would probably ask the facility nurse to give the resident a PRN dose and monitor them. At 11:05 a.m., the DON was asked if she had located any facility documentation regarding the resident's behaviors. She stated, "No." 2. Resident #2 had diagnoses which included chronic pain, dementia, aphasia, diabetes, COPD, CHF and osteoarthritis. A care plan, dated 02/11/10, documented, "...Focus	LL846		

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LL846	Continued From page 38 At risk for adverse effects related to: use of antianxiety medication... Interventions...Monitor for dizziness, drowsiness, blurred vision and orthostatic hypotension..." A treatment administration record, dated November 2015, documented, "...ABH GEL 1-25-1 GEL APPLY 1 TOPICALLY .5XD (five times a day)...MONITOR FOR S/S OF SIDE EFFECTS, INITIALS INDICATE ABSENCE OF SIDE EFFECTS..." ABH gel contains the antianxiety medication, Ativan, and the antipsychotic medication, Haldol. There was no documentation of the monitoring of side effects for the ABH gel administration in the resident's clinical record for November 2015. 3. Resident #8 had diagnoses which included chronic kidney disease, bipolar disorder, neuromuscular dysfunction of bladder, Rheumatoid arthritis and paraplegia. A care plan, dated 10/18/09, documented, "...Focus At risk for adverse effects related to: use of antidepression medication...antianxiety medication...antipsychotic medication... Goal...to show minimal/no side effects of medications taken... Interventions...Antianxiety- Monitor... Antidepressants- Monitor... Antipsychotic- Monitor..." A monthly physician's order, dated May 2015, documented, "... EXCITALOPRAM OXALATE 20MG...LEXAPRO 1 TAB BY MOUTH DAILY...	LL846		

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LL846	Continued From page 39 DOXEPIN HCL 50MG...1 CAP BY MOUTH AT BEDTIME...MONITOR SIDE EFFECTS INITIALS INDICATE ABSENCE OF S/S OF SIDE EFFECTS... HALOPERIDOL 1MG...1 TAB BY MOUTH AT BEDTIME...MONITOR SIDE EFFECTS INITIALS INDICATE ABSENCE OF S/S OF SIDE EFFECTS... PROTRIPTYLINE HCL 5MG...VIVACTIL 1 TAB BY MOUTH THREE TIMES DAILY...MONITOR SIDE EFFECTS INITIALS INDICATE ABSENCE OF S/S OF SIDE EFFECTS... Klonopin 0.5mg...daily @ HS for anxiety..." Lexapro, Doxepin and Vivactil are all antidepressant medications. Haldol is an antipsychotic medication. Klonopin is an antianxiety medication. There was no documentation in the resident's clinical record of the monitoring of side effects for the administration of the Lexapro, Doxepin, Haldol, Vivactil and Klonopin for the month of May 2015. An admission physician's order, dated 10/07/15, documented, "...Lexapro 20 mg...QD.. (check) for S/S of A/R...(check) Qsh [sic]... Doxepin 50 mg...QD...(check) for S/S of A/R...Qsh [sic]... Clonazepam 0.5mg...Q HS..." A medication administration record, dated October 2015, documented, "...Haldol 0.5mg...q H.S... Ativan 0.5 mg...q BID PRN..."	LL846		

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LL846	Continued From page 40 Clonazepam and Ativan are both antianxiety medications. There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Lexapro, Doxepin, Clonazepam, Haldol and Ativan for the month of October 2015. A monthly physician's order, dated November 2015, documented, "...Ativan 0.5 mg...Bid prn...for anxiety...monitor for s/s of side effects. Initials indicate absence of S.E..." There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Ativan for the month of November 2015. A monthly physician's order, dated November 2015, documented, "...HALOPERIDOL 0.5MG...HALDOL 1 TAB BY MOUTH AT BEDTIME...MONITOR FOR S/S OF SIDE EFFECTS, INITIALS INDICATE ABSENCE OF SIDE EFFECTS..." A medication administration record, dated December 2015, documented, "...LORAZEPAM...ATIVAN 1 TAB BY MOUTH TWICE DAILY AS NEEDED FOR ANXIETY...MONITOR FOR S/S OF SIDE EFFECTS, INITIALS INDICATE ABSENCE OF SIDE EFFECTS... There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Haldol and Ativan for the month of December 2015.	LL846		

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	NH5512	A BUILDING _____ B WING _____	01/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-MIDWEST C	2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110

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LL846	Continued From page 41 On 01/04/16 at 2:00 p.m., the DON was asked what the facility policy was for monitoring side effects of psychotropic medications. She stated, "Side effects are documented each shift on the MAR. Initials mean there are no side effects." She was asked who was responsible for documenting the side effect monitoring. She stated, "The nurses do." At 2:15 p.m., LPN #5 was asked what medications were monitored for side effects. She stated antianxiety, antidepressants and antipsychotics were monitored. She was asked where it was documented. She stated, "On the MAR." 4. Resident #3 was admitted with diagnoses which included Alzheimer's, depressive disorder and anxiety. A physician's order, dated 06/19/15, documented, "...Ativan 0.5 mg PO QID..." There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Ativan for the month of June 2015. A physician's order, dated 09/10/15, documented, "... Ativan 0.5 mg one tab by mouth every 4 hours as needed...monitor for s/s of side effects, initials indicate absence of side effects..." There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Ativan for the month of September 2015. 5. Resident #4 was admitted with diagnoses	LL846		

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	NH5512	A BUILDING _____ B WING _____	01/11/2016

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LL846	Continued From page 42 which included dementia, psychosis and general anxiety disorder. A physician's order, dated July 2015, documented, " ..Risperidone [antipsychotic medication] 1 mg one tab po bid...." There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Risperidone for the month of July 2015. A medication administration record, dated October 2015, documented, "...RISPERIDONE...0.5MG...1 TAB TWICE DAILY...MONITOR FOR S/S OF SIDE EFFECTS, INITIALS INDICATE ABSENCE OF SIDE EFFECTS." There was no documentation in the resident's clinical record that the side effects were monitored for the administration of the Risperidone for the month of October 2015. On 01/04/16 at 2:00 p.m., the DON was asked what the facility policy was for monitoring side effects of psychotropic medications. She stated, "Side effects are documented each shift on the MAR. Initials mean there are no side effects." She was asked who was responsible for documenting the side effect monitoring. She stated, "The nurses do."	LL846		

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	375098	A BUILDING **01 - MAIN BUILDING 01** B WING _____	**01/07/2016**

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MANORCARE HEALTH SERVICES-MIDWEST CITY	**2900 PARKLAWN DRIVE** **MIDWEST CITY, OK 73110**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The findings on this Statement of Deficiencies demonstrate non-compliance with Title 42, Code of Regulations, §483.70(a) Life safety from fire. The requirement is not met as evidenced by the facility's failure to meet the National Fire Protection Association code(s) cited. K3 BUILDING: 0101 K6 PLAN APPROVAL: Unknown K7 SURVEY UNDER: 2000 Existing K8 S/NF TYPE OF STRUCTURE: Type V (000) One story unprotected wood frame building. Complete automatic sprinkler protection including attic spaces.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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

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K 018	Continued From page 1	K 018		

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to provide corridor doors that would resist the passage of smoke in 2 of 5 smoke compartments. This practice could affect 22 of 22 residents, who currently resided on Hall 3, as identified by the Maintenance Director on 01/06/2016. The census in the facility was 76 residents. Findings:

1. During a tour of the facility on 01/06/2016 the following resident room doors did not latch:

a. At 9:07 a m. resident room 339.

b. At 9:09 a.m. resident room 340.

2. At 9:12 a.m., Hall 3 bath shower was noted to have an gap of over a 1/2 inch at the top of the door on the latch side.

3. The maintenance supervisor was present during the tour and acknowledged the doors not latching and the gap at the top the resident room doors.

Guidance from CMS on allowable gaps around corridor doors.

Ref: S&C-07-18
Memorandum Summary
In a smoke compartment that is not fully sprinklered, a gap between the face of a corridor door and the door stop should not exceed ¼-inch,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375098	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/07/2016**

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K 018	Continued From page 2 provided that the door latch mechanism is functioning. In a smoke compartment that is fully sprinklered, a gap between the face of a corridor door and the door stop should not exceed ½-inch, provided that the door latch mechanism is functioning.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19 1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain 1 of 4 attic smoke barrier walls (Hall 3) to provide at least a 1/2 hour fire resistance. This practice affected 22 of 22 residents, who currently resided in the facility, as identified by the Maintenance Director on 01/06/2016. The facility had a census of 76 residents. Findings: 1. During an inspection of the facility on 01/06/2016 at 12:26 p.m., the following attic smoke wall observation was made. The Hall 3 smoke barrier wall around the perimeter of the	K 025		

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K 025	Continued From page 3 kitchen was noted to have two holes on the east end. One was approximately five feet from the corridor wall and the second was at the corner above the corridor wall. 2. The Maintenance Director was present during the inspection and acknowledged the holes. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 9 designated exit unlocked when the fire alarm was activated. This	K 038		

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K 038	Continued From page 4 had the potential to affect approximately 3 of 3 residents, who could ambulate independently, as identified by the Maintenance Director on 01/06/2016. The facility had a census of 76 residents. Findings: 1. A fire alarm test was conducted on 01/06/2016 at 1:06 p.m. It was noted that the service hall exit door and the activities office exit door were still locked while the fire alarm was sounding. Both doors were equipped with delayed egress locks that worked. 2 The Maintenance Director was present during the alarm test and acknowledged the doors did not unlock while the alarm was going off. 7.2 MEANS OF EGRESS COMPONENTS 7.2.1 Doors. 7.2.1.6 Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in	K 038		

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K 038	Continued From page 5 accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038		
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to perform biannual smoke sensitivity test on smoke detectors Without this biannual testing the facility had no assurance the smoke detectors would function as required for early	K 054		

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K 054	Continued From page 6 detection of smoke/fire. This has the potential to affect 76 of 76 residents who currently reside in the facility as identified by the Maintenance Director on 01/06/2016. The facility census was 76. Findings: 1. During record review on 01/06/2016 at 1:20 p.m., it was determined the last annual fire inspection dated 06/16/2015 did not document smoke sensitivity had been performed. 2. An interview was conducted with the Maintenance Director on 01/07/2016 at 8:15 a.m. and he stated the company that performs the sensitivity testing had record of doing it in 2011 and 2013 but not in 2015. NFPA 72, Sec 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument	K 054		

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K 054	Continued From page 7 (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 054		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to maintain the automatic sprinkler system in reliable working condition. One shower stall converted to a	K 062		

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K 062	Continued From page 8 storage closet did not have sprinkler protection. The Post Indicator Valve for the sprinkler system was stuck open. And the facility failed to perform quarterly sprinkler inspection for the 2nd quarter of 2015. This practice could affect 76 of 76 residents, who currently resided in the facility, as identified by the Maintenance Director. The census in the facility was 76 residents Findings: 1. During a tour of the facility on 01/06/2016 at 9:12 a.m., the following observations was made. In Hall 3 shower room a former shower stall that had been turned into a linen closet did not have a sprinkler in it. 2. At 1:11 p.m., during testing of the fire alarm an attempt was made to close the post indicator valve (main sprinkler control valve) to check the tamper switch. The Maintenance Director was unable to get the valve closed. 3. During record review on 01/06/2016 at 1:20 p.m., it was determined the only quarterly sprinkler inspection had been performed 03/31/2015. The annual sprinkler inspection was done 10/26/2015. 4. The Maintenance Director stated on 01/07/2016 that the inspection company was unable to find any other quarterly inspections for the last year. During the inspection of the facility he acknowledged the findings in items 1 and 2 above. NFPA Standard. Testing of water flow alarm devices including, but not limited to, mechanical water motor gong, vane-type water flow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. NFPA 25	K 062		

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K 062	Continued From page 9 section 2-3.3. NFPA Standard: Requires every required sprinkler system to be continuously maintained in proper operating condition. NFPA 25 table 2-1.	K 062		