STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375106	A. BUILDING _____ B. WING _____	09/07/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACE LIVING CENTER-BROOKWOOD	940 SOUTHWEST 84TH STREET OKLAHOMA CITY, OK 73139

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined the facility failed to provide assistance with incontinent care in a timely manner, leaving the resident to consume a meal in the dining room in wet, soiled, odorous clothing for one (#16) of three sampled residents reviewed for ADL (activities of daily living) assistance. The director of nurses identified an additional 39 residents who were dependant on staff for incontinent care. Findings: Resident #16 was readmitted to the facility with [DIAGNOSES REDACTED]. A care plan, last updated 08/05/16, documented the resident required assistance from two persons due to (d/t) a [MEDICAL CONDITION] in left side paralysis. The goal was for the resident to be clean, comfortable and odor free. Interventions included to change the resident's clothing if he became soiled throughout the day, provide total assistance with all care, including one-on-one assistance for meals. A quarterly assessment, dated 08/24/16, documented the resident was cognitively intact and able to make his needs known. The assessment further documented the resident required extensive assistance from two staff members for all aspects of ADLs, including eating. On 09/07/16 at 1:10 p.m., the resident was observed in the main dining room, seated upright in a reclining positioning chair. He was observed eating a meal as he was assisted by a family member. The resident was observed to be covered from his chest to his ankles with a blanket, as he ate. He was asked if he was cold. He stated, I'm freezing. The family member repositioned the blanket covering the resident. Once the blanket was moved, a strong odor of urine permeated the immediate area. The spouse was asked to raise the blanket covering the residents lower body. As the blanket was raised the resident's pants were observed to have a darkened wet spot covering the entire crotch area. The odor of urine was noted to be very strong. The family member was observed to fan her face with her hands to clear the odor from her face. The family member stated, This is how I find him every time I come in to feed him lunch. She was asked how often she came in to assist him with his meal. She stated she came every day. The resident was asked when the last time he had been repositioned or had incontinent care provided. He stated he had not been provided care or repositioned since he had been assisted out of bed that morning. He was then asked if he could recall what time he was assisted out of bed, and he stated, They usually get me up around 8:00 a.m., if not before. The resident was asked if he thought being wet was contributing to his being so cold. He stated he hadn' t thought about that but it made sense. He further stated, I probably wouldn't smell so bad either. The resident was observed to consume his meal in the dining room, covered in a blanket, in wet, odorous clothing.
F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to prevent the development of an avoidable moisture-associated skin damage (MASD) area for one (#16) of three sampled residents reviewed for assistance with activities of daily living. The facility's failure to provide incontinent care according to the resident's needs resulted in harm with MASD area to the peri-anal area. The director of nurses identified 40 residents who were dependant on staff for assistance with incontinent care. The facility census was 102. Findings: Resident #16 was readmitted to the facility with [DIAGNOSES REDACTED]. A care plan, last updated 08/05/16, documented: Focus; (Resident) requires assist x (times) 2 with ADLS (activity of daily living). He has had a [MEDICAL CONDITION] has left him paralyzed and weak. Depends on others for care. He requires total assist with all dressing of x 1-2. Goal; He will be clean, comfortable and odor free consistently over the next review period. Interventions; .change him through the day if he gets soiled. Personal hygiene; Requires total assist with all care. Does need 1:1 (one on one) assist with meals. A quarterly assessment, dated 08/24/16, documented the resident was cognitively intact and able to make his needs known. The assessment further documented the resident required extensive assistance from two staff members for all aspects of ADLs, including eating and was always incontinent of bowel and bladder. On 09/07/16 at 1:10 p.m., the resident was observed in the main dining area seated upright in a reclining positioning chair. He was observed to eat a meal as he was assisted by a family member. They were asked if his needs were being met in a timely manner by the staff. The family member responded the care was good, except she wished he could be changed more often. She was asked how often did they change him. She stated, I'm sure it's only done when they get him up and when they put him back in bed. The resident was observed to be covered from his chest to his ankles with a blanket as he ate. He was asked if he was cold. He stated, I'm freezing. The family member repositioned the blanket covering the resident. When the blanket was moved a strong odor of urine permeated the immediate area. The spouse was asked to raise the blanket covering the resident's lower body. As the blanket was raised the resident's pants were observed to have a darkened wet spot covering the entire crotch area. The odor of urine was very strong. The family member was observed to fan her face with her hands to clear the odor from her face. The family member stated, This is how I find him every time I come in to feed him his lunch. She was asked how often she came in to assist him with his meal. She stated she came every day. The resident was asked when he had last been repositioned or had incontinent care provided. He stated he had not been provided care or repositioned since he had been assisted out of bed that morning. He was then

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

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) asked if he could recall what time he was assisted out of bed, and he stated, They usually get me up around 8:00 a.m., if not before. The resident was asked if he thought being wet was contributing to his being so cold. He stated he hadn't thought about that but it made sense. They were asked why they thought he was only changed once or twice a day. The family member stated, Because it takes them a long time to put him to bed and there has to be two of them. At 1:30 p.m., certified nurse aide (CNA) #1 was interviewed and asked if she was the CNA on hall 100. She stated she was. She was asked how often dependent residents were to be checked for incontinence and/or repositioning. She stated, I check them all the time, but at least every 2 to 3 hours. She was then asked when resident #16 had last been checked, changed or repositioned in his positioning chair. She stated she had last provided incontinent care prior to taking him to activities. She was asked who had assisted her with the care. The CNA walked away without answering the question. The surveyor had observed the resident in the activity room from 9:00 a.m. to 9:45 a.m., participating in Bible study. On 09/07/16 at 1:35 p.m., licensed practical nurse (LPN) #1 was interviewed regarding the resident's care. She was asked if she was the nurse caring for him on the present shift. She stated she was. She was asked what his daily routine was. She stated he usually was given a bath before breakfast and then he went to activities. She stated, We reposition him every so often. She was asked at what point incontinent care was provided, and she stated, When we lay him down. The LPN was asked if the resident was up for breakfast, activities and then lunch, how many hours did that include. The LPN didn't answer the question, but stated, We can change him sooner, but he usually isn't ready. At 1:45 p.m., the LPN was asked if the resident could be returned to his room and provided incontinent care so an observation of his skin could be made. At 2:00 p.m., CNA #1 and the restorative aide (RA), entered the room and placed the resident in bed using a mechanical lift. When the resident was lifted from the positioning chair, the cushion on the chair was observed to be wet and odorous. The sling used to transport the resident from the chair to the bed, was also wet and odorous. As the resident was positioned on the bed, his blue sweat pants were observed to be wet over the entire crotch area and odorous. The pants were removed, and then the brief. The brief was completely saturated with urine and feces. The RA provided peri-care as the CNA positioned the resident for the care. The RA was observed to wipe and clean the peri-area thoroughly around the penis and top of the scrotal area. The resident was then repositioned onto his left and right side to cleanse the buttock area of feces. He was then positioned supine in bed and the two aides stopped and looked at the surveyor. They were asked if they were finished. The RA stated, Well no. They were asked if the residents right leg could be lifted to expose the crease of the leg at the hip area. The resident's leg was lifted as the RA cleansed the crease in a downward motion with a slightly damp incontinent wipe. The RA was observed to wipe the area very gently. The resident was observed to tense up and grimace when the staff member wiped toward the bottom of the anus area. The CNA then stated the resident had, Had the runs the past couple of days. The aides were asked to raise the resident's left leg so the anus area could be viewed as the area was cleansed. The anus area was observed to have three dime-sized open, bleeding, excoriated areas on the left side of the buttock near the anal area. As the staff cleansed the feces from the anal area, the resident was heard to say, You talk about something that hurt, now. Whew. that's sore. The scrotum was also observed to be reddened and tender as it was cleansed. The CNA was asked if those areas were there when he was changed earlier in the day, before going to activities. The CNA stated she wasn't sure. The care provided was observed to take 25 minutes to complete. At 2:30 p.m., LPN #2 was interviewed and asked when the resident's last skin assessment was completed and what her findings were. She stated she had not completed one for the current week. She was asked if she knew of any wounds the resident may have. She stated the resident previously had only some blisters along his hip areas and on the lower back area. She was asked what she thought could have caused the blisters she found. She stated, Probably from his briefs rubbing. Weekly skin assessments, dated 08/30/16 and 09/05/16, documented the resident's Braden score (an assessment to evaluate the risk of pressure ulcer development) was 12, indicating high risk, and had left sided paralysis, decreased mobility, weakness and a history of wounds. Interventions included a low air loss mattress, cushion for the positioning chair and skin prep to the heels. The assessments further documented there were no new skin issues identified and no changes to identify. Monthly ADLS records were reviewed for the month of August 2016 and September 2016. The records documented the resident was provided with incontinent care three times a day, every day during the months reviewed. The times for which incontinent care was provided, documented one time during each shift for each day. Daily medications administered included a diuretic ([MEDICATION NAME] 20 milligrams) which was administered as ordered. On 09/07/16 at 2:54 p.m., the director of nurses (DON) and corporate nurse #1 was interviewed. The DON was advised of the above observations and asked what their policy was regarding incontinent care and repositioning dependent residents. She stated all residents were to be provided with care every two hours or more often if necessary. She further stated she generally watched out for dependant residents to ensure they were not being left too long in their chairs, and that staff repositioned and changed them on a regular basis. She was advised the resident was observed from 9:00 a.m., until 2:30 p.m., with no incontinent care or assistance with repositioning provided during that time. She was asked if she was aware of the resident's skin impairment. She stated the wound nurse had advised her of the MASD area on his bottom.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to provide assistance with incontinent care for one (#16) of three residents reviewed for assistance with activities of daily living. The director of nurses identified 40 residents who were dependent on staff for incontinent care. The facility census was 102. Findings: Resident #16 was readmitted to the facility with [DIAGNOSES REDACTED]. A care plan, last updated 08/05/16, documented; Focus; (Resident) requires assist x (times) 2 with ADLS (activity of daily living). He has had a [MEDICAL CONDITION] has left him paralyzed and weak. Depends on others for care. He requires total assist with all dressing of x 1-2. Goal; He will be clean, comfortable and odor free consistently over the next review period. Interventions; .change him through the day if he gets soiled. Personal hygiene; Requires total assist with all care. Does need 1:1 (one on one) assist with meals. A quarterly assessment, dated 08/24/16, documented the resident was cognitively intact and able to make his needs known. The assessment further documented the resident required extensive assistance from two staff members for all aspects of ADLs, including eating, and was always incontinent of bowel and bladder. On 09/07/16 at 1:10 p.m., the resident was observed in the main dining area seated upright in a reclining positioning chair. He was observed to eat a meal as he was assisted by a family member. They were asked if his needs were being met in a timely manner by the staff. The family member responded the care was good, except she wished he could be changed more often. She was asked how often staff provided assistance with incontinent care. She stated, I'm sure its only done when they get him up and when they put

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F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) him back in bed. The resident was observed to be covered from his chest to his ankles with a blanket as he ate. He was asked if he was cold. He stated, I'm freezing. The family member repositioned the blanket covering the resident. When the blanket was moved around a strong odor of urine permeated the immediate area. The spouse was asked to raise the blanket covering the resident's lower body. As the blanket was raised the residents pants were observed to have a darkened wet spot covering the entire crotch area. The odor of urine was noted to be very strong. The family member was observed to fan her face with her hands to clear the odor from her face. The family member stated, This is how I find him every time I come in to feed him his lunch. She was asked how often she came in to assist him with his meal. She stated she came every day. The resident was asked when the last time staff had provided incontinent care or repositioning assistance. He stated he had not been provided care or repositioned since he had been assisted out of bed that morning. He was then asked if he could recall what time he was assisted out of bed and he stated, They usually get me up around 8:00 a.m., if not before. They were asked why they thought he was only changed once or twice a day. The family member stated, Because it takes them a long time to put him to bed and there has to be two of them. At 1:30 p.m., certified nurse aide (CNA) #1 was interviewed and asked if she was the CNA on hall 100. She stated she was. She was asked how often dependant residents were to be checked for incontinence and/or repositioning. She stated. I check them all the time, but at least every 2 to 3 hours. She was then asked when resident #16 had last been checked, changed or repositioned. She stated she had last provided incontinent care prior to taking him to activities. She was asked who had assisted her with the care. The CNA walked away without answering the question. The surveyor had previously observed the resident in the activity room from 9:00 a.m. to 9:45 a.m., participating in Bible study. On 09/07/16 at 1:45 p.m., licensed practical nurse (LPN) #1 was interviewed regarding the resident's care. She was asked if she was the nurse caring for him on the present shift and she stated she was. She was asked what his daily routine was. She stated he was usually provided a bath before breakfast, then attended activities, and stated, We reposition him every so often. She was asked at what point incontinent care was provided, and she stated, When we lay him down. The LPN was asked if the resident was up for breakfast, activities and then lunch, how many hours would that include. The LPN didn't answer the question, but stated, We can change him sooner, but he usually isn't ready. At 1:45 p.m., the LPN was asked if the resident could be returned to his room and provided incontinent care so an observation of his skin could be made. At 2:00 p.m., CNA #1 and the restorative aide (RA) , entered the room and assisted the resident to bed using a mechanical lift. When the resident was lifted from the positioning chair, the cushion on the chair was observed to be wet and odorous. The sling used to transport the resident from the chair to the bed, was also wet and odorous. As the resident was positioned on the bed, his blue sweat pants were observed to be wet over the entire crotch area and odorous. The pants were removed, and then the brief. The brief was completely saturated with urine and feces. The care provided was observed to take 25 minutes to complete. Monthly ADL records were reviewed for the month of August, 2016, and September 1-7, 2016. The records documented the resident was provided with incontinent care three times a day, every day during the months reviewed. The times for which incontinent care was provided, documented one time during each shift for each day. On 09/07/16 at 2:54 p.m., the director of nurses (DON) and corporate nurse #1 were interviewed. The DON was advised of the above observations and asked about the policy regarding incontinent care and repositioning dependant residents. She stated all residents were to be provided with incontinent care every two hours or more if necessary. She was advised the resident was observed for five hours and 30 minutes, from 9:00 a.m., until 2:30 p.m., with no staff providing incontinent care or providing assistance with repositioning.