STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375159	A. BUILDING _____ B. WING _____	10/10/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SPRINGS, A GRACE LIVING CENTER COMMUNITY	5800 WEST OKMULGEE MUSKOGEE, OK 74401

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 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 10/06/16, an Immediate Jeopardy (IJ) was determined to exist due to the facility's failure to provide adequate supervision to prevent accidents for residents #1, #2, #3, #4, #5, and #6. Residents #1, #2, #3, #4, #5, and #6 had resided in the facility on the 200 hall behind two locked doors and without supervision or staff present at all times. On 10/06/16 at 8:32 p.m., the IJ situation was verified with the Oklahoma State Department of Health. On 10/06/16 at 8:50 p.m., the director of nurses (DON) stated prior to 10/03/16 she was not aware of dedicated staff assigned to the 200 hall. The DON stated as of 10/03/16 a certified nurse aide (CNA) was assigned to the 200 hall during the day shift only. On 10/06/16 at 9:07 p.m., the administrator and the director of nurses (DON) were notified of the IJ situation related to failure to provide supervision to prevent accidents on the 200 hall. On 10/06/16 at 10:52 p.m., the plan of removal for the Immediate Jeopardy pertaining to supervision to prevent accidents was accepted. The Plan of Removal for the Immediate Jeopardy documented: As of 10-6-16 at 10:00pm, we will keep a staff member assigned to the 200 hall as long as residents are housed on the hall. All existing residents currently on the 200 hall will be moved to other areas of the facility as of 10:00pm on 10-6-16. Facility staff currently in the facility will be inserviced regarding a staff member being assigned to the 200 hall at all times as long as any residents were housed there by 10:30pm on 10-6-16. All other staff members would be inserviced by midnight on 10-6-16. All other staff will not be allowed to work until they have been inserviced. On 10/10/16, interviews were conducted with staff regarding inservices pertaining to content for Immediate Jeopardy removal. The staff stated an inservice was provided the evening of 10/06/16. The staff verbalized information provided in the inservice pertaining to the plan of removal. On 10/06/16 at 11:59 p.m., the IJ was removed when all components of the plan of removal had been completed. The deficiency remained at a pattern level of no actual harm with potential for more than minimal harm. Based on observation, interview, and record review, it was determined the facility failed to provide supervision to prevent accidents for six (#1, #2, #3, #4, #5, and #6) of six sampled residents reviewed for supervision to prevent accidents. The facility failed to provide consistent supervision to prevent accidents for the residents who resided on the 200 hall. The facility identified six residents had resided on the 200 hall since the opening of the hall for resident care on 09/22/16. Findings: 1. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The facility identified the resident was admitted to room 216 on the 200 hall. The initial care plan, dated 10/01/16, documented the resident was a full code, was independent with transfers, staff would encourage the resident to use the call light for assistance with activities of daily living (ADLs), and the resident would be assessed/treated for [REDACTED]. A nurse note, dated 10/02/16, documented the resident used a wheelchair for distance ambulation, could stand for short periods of time, and was unsteady of gait. A nurse note, dated 10/03/16, documented the resident ambulated distances in a wheelchair and the resident's gait was unsteady. The note documented the resident required the assistance of one person with activities of daily living. The resident grievance log documented on 10/03/16 resident #1 verbalized a grievance. The log documented the grievance was the facility staff took too long to answer the call light. The log documented the follow up to the grievance was the DON spoke to the resident and verbalized understanding of her concerns. The staffing sheet provided by the facility documented on 10/01/16 a certified nurse aide (CNA) was assigned to the 200 hall for the 10:00 p.m. to 6:00 a.m. shift. The sheet did not document staff was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift or the 2:00 p.m. to 10:00 p.m. shift. The staffing sheet provided by the facility documented on 10/02/16 a licensed nurse was assigned to the 200 hall for the 10:00 p.m. to 6:00 a.m. shift. The sheet did not document staff was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift or the 2:00 p.m. to 10:00 p.m. shift. The staffing sheet provided by the facility, dated 10/03/16, documented no staff was assigned to the 200 hall for any shift. The staffing sheet provided by the facility documented on 10/04/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift. The sheet did not document staff was assigned to the 200 hall for the 2:00 p.m. to 10:00 p.m. shift or the 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the facility documented on 10/05/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift. The sheet documented no staff was assigned to the 200 hall for the 2:00 p.m. to 10:00 p.m. shift or the 10:00 p.m. to 6:00 a.m. shift. On 10/06/16 at 5:17 p.m., the resident was observed in her room on the 200 hall. The resident was clean and odor-free. No staff was observed on the 200 hall. On 10/06/16 at 5:17 p.m., resident #1 stated she came to live at the facility the previous week. The resident stated staff was good, but did not always answer the call lights timely. The resident stated she had verbalized the concern to the administrator and staff. The resident stated she was fearful to be on the hall without staff present because she might fall or become ill without someone knowing. The resident stated no staff present on the hall was a dangerous situation. The resident stated she had to be careful in the bathroom to keep from falling. The resident stated she was ill at 2:00 a.m. one morning and was already in the bathroom before staff arrived to help. The resident stated she would obtain her own ice from the dining room and rarely saw staff present. The resident stated she felt alone. A nurse note, dated 10/06/16, documented the resident was moved to room 314 with permanent supervision for her safety. On 10/10/16 at 9:53 a.m., the DON was asked if concerns had been voiced related to supervision on the 200 hall. The DON stated the staff voiced concerns the first day a resident was admitted to the 200 hall due to staff not being present on the hall at all times. The DON stated all staff assigned to the 200 hall had voiced concerns. The DON stated the concerns were taken to the administrator. The DON stated the administrator had no response. On 10/10/16 at 11:27 a.m., the DON was asked if residents were safe when left unsupervised for up to two hours on the 200 hall. The DON stated she had concerns. The DON stated staffing had not changed when residents were admitted to the 200 hall.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) 2. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The facility identified the resident was admitted to room 215 on the 200 hall. The staffing sheet provided by the facility, dated 09/23/16, documented no staff was assigned to the 200 hall for any shift. The staffing sheet provided by the facility documented on 09/24/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift and the 2:00 p.m. to 10:00 p.m. shift. The sheet did not document staff was assigned to the 200 hall for the 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the facility documented on 09/25/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift and the 2:00 p.m. to 10:00 p.m. shift. The sheet did not document staff was assigned to the 200 hall for the 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the facility documented on 09/26/16 the staff assigned to the 100 hall was to also provide care for the residents who resided on the 200 hall. A physician's orders [REDACTED]. The order documented the resident was on a nothing by mouth (NPO) diet and was receiving enteral feedings. The facility identified the resident was moved to the 400 hall on 09/27/16. A physician's orders [REDACTED]., nutritional intake, or skin integrity. A readmission assessment, dated 09/30/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident needed total assistance with activities of daily living (ADLs). The assessment documented the resident was always incontinent of bowel and bladder. The assessment documented the resident received oxygen therapy via a nasal cannula, was on an anticoagulant, and had a limb restraint which was used daily. The care plan, dated 10/04/16, documented the resident had impaired cognitive function, dementia or impaired thought processes related to difficulty making decisions and multiple disease processes. The care plan documented the resident had a swallowing problem related to a cerebral vascular accident and was dependent on a feeding tube for nutrition. The care plan documented the resident used padded mittens for safety of the peg tube. The care plan documented the resident was at risk for pain related to decreased mobility, left sided [DIAGNOSES REDACTED] , and a new peg tube placement. The care plan documented the resident was dependent on staff for activities, cognitive stimulation, and social interactions related to cognitive deficits. The care plan documented the resident had a communication problem related to aphagia. The care plan documented the resident was at risk for falls related to confusion, poor communication/comprehension, was unaware of safety needs, and had vision and hearing problems. The care plan documented the resident had an ADL self care performance deficit related to left sided [DIAGNOSES REDACTED], decreased mobility and weakness. The care plan documented the resident had a psychosocial well being problem related to distractibility and inability to concentrate. The care plan documented the resident was on oxygen therapy. On 10/06/16 at 6:55 p.m., CNA #1 was asked about the staffing on the 200 hall. The CNA stated she worked the 100 and 200 hall and was assigned to provide supervision most nights. The CNA stated she couldn't just sit over there on the 200 hall. The CNA stated she made rounds on the 200 hall every 2 hours and answered the call lights as soon as she could. The CNA was asked would she be able to hear if a resident residing on the 200 hall called out for help. The CNA stated she would not be able to hear a resident if they called out for help on the 200 hall. The CNA was asked how she would know if a resident had a fall. The CNA stated she would find them when she made rounds. The CNA was asked if she was able to meet resident needs on the 200 hall. The CNA stated not all resident needs may be meet on the 200 hall. The CNA was asked if residents on the 200 hall had voiced any concerns. The CNA stated one resident verbalized she did not like being on the 200 hall alone. The CNA stated staffing was not increased when residents were admitted to the 200 hall. 3. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The initial plan of care, dated 10/04/16, documented the resident was a full code, a fall risk, had pain, and needed ADL assistance. A nurse note, dated 10/04/16, documented the resident was a smoker, on 3 liters (L) of oxygen, and was able to ambulate short distances but did get short of breath (SOB). The staffing sheet provided by the facility documented on 10/04/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift and the 2:00 p.m. to 10:00 p.m. shift. The sheet documented no staff was assigned to the 200 hall for the 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the facility documented on 10/05/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift and the 2:00 p.m. to 10:00 p.m. shift. The sheet documented no staff was assigned to the 200 hall for the 10:00 p.m. to 6:00 a.m. shift. On 10/06/16 at 4:55 p.m., the resident was observed in her room on the 200 hall. The resident was clean and odor free. No staff was observed on the 200 hall. A nurse note, dated 10/06/16, documented the resident was moved to room 114 with permanent supervision for her safety. On 10/06/16 at 4:55 p.m., resident #3 stated she came to live in the facility 2 days before. The resident stated she had lung disease and was oxygen dependent. The resident stated staff was not on the hall at all times. 4. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The five day assessment, dated 09/22/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident needed extensive assistance with ADLs and was always incontinent of bowel and bladder. The admission nurse note, dated 09/22/16, documented the resident was alert and oriented times one. The note documented the resident would require the assistance of two staff members for ADL care. The note documented the resident's speech was unclear. The note documented the resident wore a brace on his right leg, was a high fall risk, and required a wheel chair for mobility with assistance of one staff member. The staffing sheet provided by the facility, dated 09/22/16, documented no staff was assigned to the 200 hall for any shift. The staffing sheet provided by the facility, dated 09/23/16, documented no staff was assigned to the 200 hall for any shift. The care plan, dated 10/04/16, documented the resident was at risk for falls due to decreased mobility and dementia. The care plan documented the resident was NPO and had a nutritional problem. The care plan documented the resident was at risk for pressure ulcers related to decreased mobility and incontinence. The care plan documented the resident was at risk for fractures. The care plan documented the resident had impaired cognitive function related to dementia or impaired thought processes related to dementia. The care plan documented the resident had an ADL self care performance deficit related to a right femur fracture, difficulty walking, lack of coordination, muscle wasting/atrophy and decreased mobility. The care plan documented the resident had oxygen therapy related to sleep apnea. The care plan documented the resident was on intravenous therapy (IV) of normal saline related to fluid deficit. The care plan documented the resident was at risk for adverse reactions related to polypharmacy. The care plan documented the resident was on anticoagulant therapy related to deep vein thrombosis (DVT) of the lower extremity. 5. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The initial plan of care, dated 10/01/16, documented the resident was a full code, was at risk for falls, was bedfast, and needed assistance with ADLs. The admission nurse note, dated 10/01/16, documented the resident was admitted to room 215. The staffing sheet provided by the facility, dated 10/01/16, documented no staff was assigned to the 200 hall for any shift. The staffing sheets provided by the facility documented on 10/02/16 a licensed nurse was assigned to the 200 hall for the 10:00 p.m. to 6:00 a.m. shift. The sheet documented no staff was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift or the 2:00 p.m. to 10:00 p.m. shift. The staffing sheet provided by the facility, dated 10/03/16, documented no staff was assigned to the 200 hall for any shift. The staffing sheet provided by the facility documented on 10/04/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift. The sheet documented no staff was assigned to the 200 hall for the 2:00 p.m. to 10:00 p.m. shift or the 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the facility documented on 10/05/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift. The sheet documented no staff was assigned to the 200 hall for the 2:00 p.m. to 10:00 p.m. shift or the 10:00 p.m. to 6:00 a.m. shift. On 10/06/16 at 6 p.m., resident #5 stated she had been on the 200 hall but had requested to be moved. The resident stated she had to wait a long time for staff assistance. The resident stated it was too quiet on the hall. The resident stated she saw staff during the day but less on evenings and nights. The resident stated she had been incontinent of stool because she

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) did not receive assistance timely. On 10/06/16 at 7:10 p.m., CNA #2 was asked how staff were assigned to the 200 hall. The CNA stated she rotated between the 100 and 200 hall. The CNA was asked how she would know if a resident had a fallen on the 200 hall. The CNA stated she would probably find them when she made rounds on the hall. The CNA stated there was a person assigned to the 200 hall now on the 6:00 a.m. to 2:00 p.m. shift. The CNA stated they could use another CNA to provide coverage to both halls. The CNA stated they were not always able to meet resident needs in a timely manner. 6. Resident #6 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The staffing sheet provided by the facility, dated 09/23/16, documented no staff was assigned to the 200 hall for any shift. The staffing sheet provided by the facility documented on 09/24/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift and the 2:00 p.m. to 10:00 p.m. shift. The sheet documented no staff was assigned to the 200 hall for the 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the facility documented on 09/25/16 a CNA was assigned to the 200 hall for the 6:00 a.m. to 2:00 p.m. shift and the 2:00 p.m. to 10:00 p.m. shift. The sheet documented no staff was assigned to the 200 hall for the 10:00 p.m. to 6:00 a.m. shift. The admission assessment, dated 09/29/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident did not ambulate. The assessment documented the resident needed limited assistance of two staff members for toileting, extensive assistance dressing, and total assistance for bathing. The assessment documented the resident had a lower extremity impairment and used a wheelchair for mobility. The assessment documented the resident was always incontinent of bowel and frequently incontinent of urine. The assessment documented the resident was receiving IV therapy. On 10/06/16 at 7:50 p.m., the resident stated he had resided on the 200 hall. The resident stated he did not like being alone on the hall. The resident stated he ate in the dining room alone. The resident stated he had asked to be moved to another hall because he wanted to be around other people. On 10/10/16 at 11:00 a.m., the ADM was interviewed. The ADM stated no concerns had been identified concerning staffing for the 200 hall. The ADM stated he had an open door policy and a daily stand up meeting with department heads. On 10/10/16 at 2:55 p.m., the ADM was asked if staff had brought any concerns to him related to the staffing on the 200 hall. The ADM stated, Not to my memory, nothing specific. The ADM stated he did not go to the Q2 meetings because that was the responsibility of the DON.
F 0490 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Be administered in an acceptable way that maintains the 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 ensure administration effectively used their resources in a manner to promote the residents' highest levels of well being for six (#1, #2, #3, #4, #5, and #6) of six sampled residents reviewed for highest level of well being. The facility failed to provide supervision for the residents who were present on the 200 hall. The facility identified two residents who resided on the 200 hall. Findings: 1. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The initial care plan, dated 10/01/16, documented the resident was a full code, was independent with transfers, staff would encourage the resident to use the call light for assistance with activities of daily living (ADLs), and the resident would be assessed/treated for [REDACTED]. A nurse note, dated 10/02/16, documented the resident used a wheelchair for distance ambulation, could stand for short periods of time, and was unsteady of gait. On 10/06/16 at 5:17 p.m., resident #1 was observed in her room. The resident was asked if she was comfortable with staff not being on the 200 hall at all times. The resident stated she came to live in the facility the previous week. The resident stated staff was pretty good but did not always answer the call light. The resident stated she had complained to the ADM and staff were better. The resident stated it made her feel scared to be on the hall without staff present because she was concerned she could fall or have to throw up. The resident stated it was dangerous. The resident stated she had to be careful in the bathroom to keep from falling. The resident stated she was nauseated at 2 a.m. and was already in the bathroom before help came. The resident stated she would go to the dining room to get her own ice and rarely saw staff. The resident stated she felt alone. 2. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The order documented the resident was on a nothing by mouth (NPO) diet and was receiving enteral feedings. A physician's orders [REDACTED]., nutritional intake, or skin integrity. The admission assessment, dated 09/30/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident needed total assistance with activities of daily living (ADLs). The assessment documented the resident was always incontinent of bowel and bladder. The assessment documented the resident received oxygen therapy via a nasal cannula, was on an anticoagulant, and had a limb restraint which was used daily. The care plan, dated 10/04/16, documented the resident had impaired cognitive function, dementia or impaired thought processes related to difficulty making decisions and multiple disease processes. The care plan documented the resident had a swallowing problem related to a [MEDICAL CONDITION] and was dependent on a feeding tube for nutrition. The care plan documented the resident used padded mittens for safety of the peg tube. The care plan documented the resident was at risk for pain related to decreased mobility, left sided [MEDICAL CONDITION] , and a new peg tube placement. The care plan documented the resident was dependent on staff for activities, cognitive stimulation, and social interactions related to cognitive deficits. The care plan documented the resident had a communication problem related to aphagia. The care plan documented the resident was at risk for falls related to confusion, poor communication/comprehension, was unaware of safety needs, and had vision and hearing problems. The care plan documented the resident had an ADL self care performance deficit related to left sided [MEDICAL CONDITION], decreased mobility and weakness. The care plan documented the resident had a psychosocial well being problem related to distractibility and inability to concentrate. The care plan documented the resident was on oxygen therapy. 3. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The initial plan of care, dated 10/04/16, documented the resident was a full code, a fall risk, had pain, and needed ADL assistance. A nurse note, dated 10/04/16, documented the resident was a smoker, on 3 liters (L) of oxygen, and was able to ambulate short distances but did get short of breath (SOB). On 10/06/16 at 4:55 p.m., resident #3 was observed in her room. The resident was asked if she felt comfortable with staff not being present on the 200 hall at all times. The resident stated she came to live in the facility 2 days ago. The resident stated she had lung disease and was oxygen dependent. The resident stated staff was not on the hall at all times. 4. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The five day assessment, dated 09/22/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident needed extensive assistance with ADLs and was always incontinent of bowel and bladder. The admission nurse note, dated 09/22/16, documented the resident was alert and oriented to self only. The note documented the resident would require the assistance of two staff members for ADL care. The note documented the residents speech was unclear. The note documented the resident wore a brace on his right leg, was a high fall risk, and required a wheel chair for mobility with assistance of one staff member. The care plan, dated 10/04/16, documented the resident was at risk for falls due to decreased mobility and dementia. The care plan documented the resident was NPO and had a nutritional problem. The care plan documented the resident was at risk for pressure ulcers related to decreased mobility and incontinence. The care plan documented the resident was at risk for fractures. The care plan documented the resident had impaired cognitive function related to dementia or impaired thought processes related to dementia. The care plan documented the resident had an ADL self care performance deficit related to right femur fracture, difficulty walking, lack of coordination, muscle wasting/atrophy and decreased mobility. The care plan documented the resident had oxygen therapy related to sleep apnea. The care plan documented the resident was on

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F 0490 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) intravenous therapy (IV) of normal saline related to fluid deficit. The care plan documented the resident was at risk for adverse reactions related to polypharmacy. The care plan documented the resident was on anticoagulant therapy related to [MEDICAL CONDITIONS] of lower extremity. 5. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The initial plan of care, dated 10/01/16, documented the resident was a full code, was at risk for falls, was bedfast, and needed assistance with ADLs. The admission nurse note, dated 10/01/16, documented the resident was admitted to room [ROOM NUMBER]. On 10/06/16 at 6 p.m., resident #5 was observed in her room. The resident was asked why she had requested to be moved from the 200 hall. The resident stated she had to wait a long time for assistance. The resident stated it was too quiet on the hall. The resident stated she saw staff during the day but less on evenings and nights. The resident stated she had to use the bed pan and was incontinent of stool because staff took to long to provide assistance. 6. Resident #6 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission assessment, dated 09/29/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident did not ambulate. The assessment documented the resident needed limited assistance of 2 staff members for toileting, extensive assistance dressing, and total assistance for bathing. The assessment documented the resident had a lower extremity impairment and used a wheelchair for mobility. The assessment documented the resident was always incontinent of bowel and frequently incontinent of urine. The assessment documented the resident was receiving IV therapy. On 10/06/16 at 7:50 p.m., resident #6 was observed in his room. The resident was asked why he had asked to be moved from the 200 hall. The resident stated he had been on the 200 hall but didn't like it because he was alone. The resident stated he ate in the dining room alone and didn't like that. The resident stated he had asked to move to another hall because he wanted to be around other people. On 10/06/16 at 6:55 p.m., certified nurse aide (CNA) #1 was asked about the staffing on the 200 hall. The CNA stated she worked the 100 and 200 hall and was assigned to provide supervision most nights. The CNA stated she couldn't just sit over there on the 200 hall. The CNA stated she made rounds on the 200 hall every 2 hours and answered the call lights as soon as she could. The CNA was asked if she would be able to hear a resident if the called out for help. The CNA stated she would not be able to hear a resident if they called out for help. The CNA was asked how she would know if a resident had a fall. The CNA stated she would find them when she made rounds. The CNA was asked if she was able to meet the residents needs on the 200 hall. The CNA stated there may be things they don't get on the 200 hall. The CNA was asked if any residents had complained about staffing on the 200 hall. The CNA stated only one resident had complained about being on the 200 hall by herself. The CNA stated staffing was not increased when the residents were admitted to the 200 hall. On 10/06/16 at 7:10 p.m., CNA #2 was asked how staff were assigned to the 200 hall. The CNA stated shed rotated between the 100 and 200 halls. The CNA was asked how she would know if a resident had a fall on the 200 hall. The CNA stated she would probably find them when she made rounds on the hall. The CNA stated there was a person assigned to the 200 hall now on the 6 to 2 shift. The CNA stated they could use another CNA when having to cover both halls. The CNA stated they were not always able to meet the residents needs in a timely manner. On 10/06/16 at 7:20 p.m., LPN #1 was interviewed regarding the staffing for the 200 hall. The LPN stated she covered the short 100 hall and covered the residents on the 200 hall. The LPN stated she passed medications to the residents and had 12 to 16 residents to which she provided care. The LPN stated rounds were made frequently. The LPN was asked if she was comfortable covering residents on the 200 hall with staff not being on the hall at all times. The LPN stated she was not comfortable with the situation and had originally refused to care for residents on the 200 hall but was now covering the hall because someone had to take care of those residents. The LPN stated it wasn't safe for the residents to be on the hall without staff being present. The LPN was asked if she had told anyone about how she felt regarding staffing on the 200 hall. The LPN stated she had told the ADM. The LPN stated she was told he was working on it. On 10/06/16 at 8:50 p.m., the director of nurses (DON) stated prior to Monday, 10/03/16 she was not aware of any dedicated staff to the 200 hall. The DON stated as of monday staff would be assigned to the 200 hall during the day shift only. On 10/10/16 at 9:53 a.m., the DON was asked about the facilities QA process. The DON stated there had not been a QA meeting since she had started at the facility. The DON stated she took care of nursing concerns and the ADM would handle quality measures. The DON was asked if there had been and concerns brought to her attention about staffing on the 200 hall. The DON stated staff had brought concerns to her regarding the staffing on the 200 hall. The DON stated she had taken it to the ADM and he had told her the facility was above state standards for staffing. On 10/10/16 at 11:00 a.m., the ADM was interviewed regarding the quality assurance committee (QA). The ADM stated the QA committee consisted of the ADM, the medical director, the DON, the assistant director of nurses (ADON), and other department managers as needed related to concerns. The ADM stated the QA committee would meet quarterly and more often as needed. The ADM stated no concerns had been identified concerning staffing for the 200 hall. The ADM stated he had an open door policy and a daily stand up meeting with department heads. On 10/10/16 at 11:27 a.m., the DON was asked if it was safe for residents to be left unsupervised for up to 2 hours at a time on the 200 hall. The DON stated she had concerns. The DON stated staffing had not changed when residents were admitted to the 200 hall. The DON stated the ADM had told her the facility staffing was above the state standard. On 10/10/16 at 2:55 p.m., the ADM was asked if staff had brought any concerns to him related to the staffing on the 200 hall. The ADM stated, Not to my memory, nothing specific. The ADM stated he did not go to the Q2 meetings because that was the responsibility of the DON. On 10/10/16 at 3:00 p.m., the DON was asked how she handled grievances. The DON stated she would go to the resident or staff and handle the grievances. The DON stated she would then follow up to see if the problem had been corrected. The DON stated if she couldn't handle the grievance she would take it to the ADM. On 10/10/16 at 3:50 p.m., the administrator (ADM) stated the facility did not have a policy/job description for the administration of the facility.
F 0520 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to have an effective quality assurance program (QA) program to identify and implement interventions for quality of care issues for six (#1, #2, #3, #4, #5, and #6) of six sampled residents reviewed for quality assurance. The facility failed to identify the supervision and safety concerns for residents on the 200 hall. The facility identified six residents who had resided on the 200 hall. Findings: 1. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The initial care plan, dated 10/01/16, documented the resident was a full code, independent with transfers, staff would encourage the resident to use the call light for assistance with activities of daily living (ADLs), and would be assessed/treated for [REDACTED]. A nurse note, dated 10/02/16, documented the resident used a wheelchair for distance ambulation, could stand for short periods of time, and was unsteady of gait. On 10/06/16 at 5:17 p.m., resident #1 was observed in her room. The resident was asked if she was comfortable with staff not being on the 200 hall at all times. The resident stated she came to live in the facility the previous week. The resident stated staff was pretty good but did not always answer the call light. The resident stated she had complained to the ADM and staff were better. The resident stated it made her feel scared to be on the hall without staff present because she was concerned she could fall or have to throw up. The resident stated it was dangerous. The resident stated she had to be careful in the bathroom to keep from falling. The resident stated she was nauseated at 2 a.m. and was already in the bathroom before help came. The resident stated she would go to the dining room to get her own ice and rarely saw staff. The resident stated she felt alone.

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	375159	A. BUILDING _____ B. WING _____	10/10/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SPRINGS, A GRACE LIVING CENTER COMMUNITY	5800 WEST OKMULGEE MUSKOGEE, OK 74401

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 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) 2. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The order documented the resident was on a nothing by mouth (NPO) diet and was receiving enteral feedings. A physician's orders [REDACTED]., nutritional intake, or skin integrity. The admission assessment, dated 09/30/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident needed total assistance with activities of daily living (ADLs). The assessment documented the resident was always incontinent of bowel and bladder. The assessment documented the resident received oxygen therapy via a nasal cannula, was on an anticoagulant, and had a limb restraint which was used daily. The care plan, dated 10/04/16, documented the resident had impaired cognitive function, dementia or impaired thought processes related to difficulty making decisions and multiple disease processes. The care plan documented the resident had a swallowing problem related to a [MEDICAL CONDITION] and was dependent on a feeding tube for nutrition. The care plan documented the resident used padded mittens for safety of the peg tube. The care plan documented the resident was at risk for pain related to decreased mobility, left sided [MEDICAL CONDITION] , and a new peg tube placement. The care plan documented the resident was dependent on staff for activities, cognitive stimulation, and social interactions related to cognitive deficits. The care plan documented the resident had a communication problem related to aphagia. The care plan documented the resident was at risk for falls related to confusion, poor communication/comprehension, was unaware of safety needs, and had vision and hearing problems. The care plan documented the resident had an ADL self care performance deficit related to left sided [MEDICAL CONDITION], decreased mobility and weakness. The care plan documented the resident had a psychosocial well being problem related to distractibility and inability to concentrate. The care plan documented the resident was on oxygen therapy. 3. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The initial plan of care, dated 10/04/16, documented the resident was a full code, a fall risk, had pain, and needed ADL assistance. A nurse note, dated 10/04/16, documented the resident was a smoker, on 3 liters (L) of oxygen, and was able to ambulate short distances but did get short of breath (SOB). On 10/06/16 at 4:55 p.m., resident #3 was observed in her room. The resident was asked if she felt comfortable with staff not being present on the 200 hall at all times. The resident stated she came to live in the facility 2 days ago. The resident stated she had lung disease and was oxygen dependent. The resident stated staff was not on the hall at all times. 4. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The five day assessment, dated 09/22/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident needed extensive assistance with ADLs and was always incontinent of bowel and bladder. The admission nurse note, dated 09/22/16, documented the resident was alert and oriented to self only. The note documented the resident would require the assistance of two staff members for ADL care. The note documented the residents speech was unclear. The note documented the resident wore a brace on his right leg, was a high fall risk, and required a wheel chair for mobility with assistance of one staff member. The care plan, dated 10/04/16, documented the resident was at risk for falls due to decreased mobility and dementia. The care plan documented the resident was NPO and had a nutritional problem. The care plan documented the resident was at risk for pressure ulcers related to decreased mobility and incontinence. The care plan documented the resident was at risk for fractures. The care plan documented the resident had impaired cognitive function related to dementia or impaired thought processes related to dementia. The care plan documented the resident had an ADL self care performance deficit related to right femur fracture, difficulty walking, lack of coordination, muscle wasting/atrophy and decreased mobility. The care plan documented the resident had oxygen therapy related to sleep apnea. The care plan documented the resident was on intravenous therapy (IV) of normal saline related to fluid deficit. The care plan documented the resident was at risk for adverse reactions related to polypharmacy. The care plan documented the resident was on anticoagulant therapy related to [MEDICAL CONDITIONS] of lower extremity. 5. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The initial plan of care, dated 10/01/16, documented the resident was a full code, was at risk for falls, was bedfast, and needed assistance with ADLs. The admission nurse note, dated 10/01/16, documented the resident was admitted to room [ROOM NUMBER]. On 10/06/16 at 6 p.m., resident #5 was observed in her room. The resident was asked why she had requested to be moved from the 200 hall. The resident stated she had to wait a long time for assistance. The resident stated it was too quiet on the hall. The resident stated she saw staff during the day but less on evenings and nights. The resident stated she had to use the bed pan and was incontinent of stool because staff took to long to provide assistance. 6. Resident #6 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission assessment, dated 09/29/16, documented the resident was severly impaired for daily decision making. The assessment documented the resident did not ambulate. The assessment documented the resident needed limited assistance of 2 staff members for toileting, extensive assistance dressing, and total assistance for bathing. The assessment documented the resident had a lower extremity impairment and used a wheelchair for mobility. The assessment documented the resident was always incontinent of bowel and frequently incontinent of urine. The assessment documented the resident was receiving IV therapy. On 10/06/16 at 7:50 p.m., resident #6 was observed in his room. The resident was asked why he had asked to be moved from the 200 hall. The resident stated he had been on the 200 hall but didn't like it because he was alone. The resident stated he ate in the dining room alone and didn't like that. The resident stated he had asked to move to another hall because he wanted to be around other people. On 10/06/16 at 6:55 p.m., certified nurse aide (CNA) #1 was asked about the staffing on the 200 hall. The CNA stated she worked the 100 and 200 hall and was assigned to provide supervision most nights. The CNA stated she couldn't just sit over there on the 200 hall. The CNA stated she made rounds on the 200 hall every 2 hours and answered the call lights as soon as she could. The CNA was asked if she would be able to hear a resident if the called out for help. The CNA stated she would not be able to hear a resident if they called out for help. The CNA was asked how she would know if a resident had a fall. The CNA stated she would find them when she made rounds. The CNA was asked if she was able to meet the residents needs on the 200 hall. The CNA stated there may be things they don't get on the 200 hall. The CNA was asked if any residents had complained about staffing on the 200 hall. The CNA stated only one resident had complained about being on the 200 hall by herself. The CNA stated staffing was not increased when the residents were admitted to the 200 hall. On 10/06/16 at 7:10 p.m., CNA #2 was asked how staff were assigned to the 200 hall. The CNA stated shed rotated between the 100 and 200 halls. The CNA was asked how she would know if a resident had a fall on the 200 hall. The CNA stated she would probably find them when she made rounds on the hall. The CNA stated there was a person assigned to the 200 hall now on the 6 to 2 shift. The CNA stated they could use another CNA when having to cover both halls. The CNA stated they were not always able to meet the residents needs in a timely manner. On 10/06/16 at 7:20 p.m., LPN #1 was interviewed regarding the staffing for the 200 hall. The LPN stated she covered the short 100 hall and covered the residents on the 200 hall. The LPN stated she passed medications to the residents and had 12 to 16 residents to which she provided care. The LPN stated rounds were made frequently. The LPN was asked if she was comfortable covering residents on the 200 hall with staff not being on the hall at all times. The LPN stated she was not comfortable with the situation and had originally refused to care for residents on the 200 hall but was now covering the hall because someone had to take care of those residents. The LPN stated it wasn't safe for the residents to be on the hall without staff being present. The LPN was asked if she had told anyone about how she felt regarding staffing on the 200 hall. The LPN stated she had told the ADM. The LPN stated she was told he was working on it. On 10/06/16 at 8:50 p.m., the director of nurses (DON) stated prior to Monday, 10/03/16 she was not aware of any dedicated staff to the 200 hall. The DON stated as of monday staff would be assigned to the 200 hall during the day shift only. On 10/10/16 at 9:53 a.m., the DON was asked about the facilities QA process. The DON stated there had not been a QA meeting since she had started at the facility. The DON stated she took care of nursing concerns and the ADM would handle quality measures. The DON was asked if there had been and concerns brought to her attention about staffing on the 200 hall. The DON stated staff had brought concerns to her regarding the staffing on the 200 hall. The DON stated she had taken it to the ADM and he had told her the facility was above state standards for staffing.

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F 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) On 10/10/16 at 11:00 a.m., the ADM was interviewed regarding the quality assurance committee (QA). The ADM stated the QA committee consisted of the ADM, the medical director, the DON, the assistant director of nurses (ADON), and other department managers as needed related to concerns. The ADM stated the QA committee would meet quarterly and more often as needed. The ADM stated no concerns had been identified concerning staffing for the 200 hall. The ADM stated he had an open door policy, and a daily stand up meeting with department heads. On 10/10/16 at 11:27 a.m., the DON was asked if it was safe for residents to be left unsupervised for up to 2 hours at a time on the 200 hall. The DON stated she had concerns. The DON stated staffing had not changed when residents were admitted to the 200 hall. The DON stated the ADM had told her the facility staffing was above the state standard. On 10/10/16 at 2:55 p.m., the ADM was asked if staff had brought any concerns to him related to the staffing on the 200 hall. The ADM stated, Not to my memory, nothing specific. The ADM stated he did not go to the Q2 meetings because that was the responsibility of the DON. On 10/10/16 at 3:00 p.m., the DON was asked how she handled grievances. The DON stated she would go to the resident or staff and handle the grievances. The DON stated she would then follow up to see if the problem had been corrected. The DON stated if she couldn't handle the grievance she would take it to the ADM.