CENTERS FOR MEDICARE & MEDICAID SERVICES FORM AP				PRINTED:3/3/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 10/10/2016
NAME OF PROVIDER OF SU	375159 PPI IER		STREET ADDRESS, CITY, ST	
	IVING CENTER COMMUNITY	,	5800 WEST OKMULGEE MUSKOGEE, OK 74401	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing hon	ne or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF L OR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0323	Make sure that the nursing hom supervision to prevent avoidabl		ards and risks and provides	
Level of harm - Immediate jeopardy	**NOTE- TERMS IN BRACKET On 10/06/16, an Immediate Jeopa	rdy (IJ) was determined to exist d	ue to the facility's failure to provi	
	On 10/06/16, an Immediate Jeopa supervision to prevent accidents f Residents #1, #2, #3, #4, #5, and # supervision or staff present at all On 10/06/16 at 8:350 p.m., the dire assigned to the 200 hall. The DOI the day shift only. On 10/06/16 at 9:07 p.m., the adm failure to provide supervision to p On 10/06/16 at 10:52 p.m., the pla accepted. The Plan of Removal for the Imm As of 10-6-16 at 10:00pm, we wil All existing residents currently on Facility staff currently in the facilit times as long as any residents were con The staff stated an inservice was inservice pertaining to the plan of On 10/06/16 at 11:59 p.m., the IJ remained at a pattern level of no a Based on observation, interview, a faccility identified six residents ha Findings: 1. Resident #1 was admitted to the admitted to room 216 on the 200 The initial care plan, dated 10/01/ encourage the resident to use the bases/treated for [REDACT A nurse note, dated 10/02/16, doc periods of time, and was unsteady A nurse note, dated 10/03/16, doc unsteady. The note documented the 10:00 p.m. to 6:00 a.m. shift. The shift or the 2:00 p.m. to 10:00 p.m. the staffing sheet provided by the 10:00 p.m. to 6:00 a.m. shift. The shift or the 2:00 p.m. to 10:00 p.m. the staffing sheet provided by the 10:00 p.m. to 6:00 a.m. shift. The shift or the 2:00 p.m. to 10:00 p.m. the staffing sheet provided by the 10:00 p.m. to 6:00 a.m. shift. The shift or the 2:00 p.m. to 10:00 p.m. the staffing sheet provided by the 10:00 p.m. to 6:00 a.m. shift. The shift or the 2:00 p.m. to 10:00 p.m. the staffing sheet provided by the 10:00 p.m. to 6:00 a.m. shift. The shift or the 2:00 p.m. to 10:00 p.m. the staffing sheet provided by the 2:00 p.m. shift. The sheet did not 10:00 fi at 5:17 p.m., resident and antistrator and staff. The resid or become ill without saveneene ka tesident stated she had to be caref one morning and was already in t from the dining room and rarely s A nurse note, dated 10/06/16, doc careform the dining room and rarely s A nurse note, dated 10/06/16, doc careform	rdy (U) was determined to exist d for residents #1, #2, #3, #4, #5, an % had resided in the facility on th times. Ituation was verified with the Oklic ctor of nurses (DON) stated prior N stated as of 10/03/16 a certified inistrator and the director of nurse prevent accidents on the 200 hall. In of removal for the Immediate Ja ediate Jeopardy documented: I keep a staff member assigned to ity will be inserviced regarding a : re housed there by 10:30pm on 10 aff will not be allowed to work un ducted with staff regarding inserv provided the evening of 10/06/16. f removal. was removed when all component actual harm with potential for mor and record review, it was determit f5, and #6) of six sampled residen nt supervision to prevent accidents d resided on the 200 hall since the e facility on [DATE] with [DIAGI hall. 16, documented the resident that ver answer the call light. The log doct we understanding of her concerns fracility documented on 10/02/16 if. The sheet did not document st o 10:00 p.m. shift. facility documented on 10/02/16 sheet did not document st o 10:00 p.m. shift. facility documented on 10/02/16 sheet did not document st o 10:00 p.m. shift. facility documented on 10/02/16 sheet did not document st o 10:00 p.m. shift. facility documented on 10/02/16 sheet did not document st o 10:00 p.m. shift. facility documented on 10/02/16 sheet did not document st o 10:00 p.m. shift. facility documented on 10/02/16 ented no staff was assigned to th dent was observed in her room on II. t #1 stated she was fearful to be on onwing. The resident stated no staff fur the bathroom to keep from fi he bathroom before staff arrived t umented the resident stated no staff fur the bathroom to keep from fa he bathroom to keep from fa he bathroom before staff arrived t umented the resident was moved i	ue to the facility's failure to provid d#6. e 200 hall behind two locked doc ahoma State Department of Healt to 10/03/16 she was not aware of nurse aide (CNA) was assigned of es (DON) were notified of the IJ eopardy pertaining to supervision the 200 hall as long as residents her areas of the facility as of 10:0. Staff member being assigned to th -6-16. All other staff members w till they have been inserviced. ices pertaining to content for Imr The staff verbalized information ts of the plan of removal had beer re than minimal harm. ed the facility failed to provide s to reviewed for supervision to pr s for the residents who resided or e opening of the hall for resident of NOSES REDACTED]. The facilit a full code, was independent with ities of daily living (ADLs), and lchair for distance ambulation, co istances in a wheelchair and the re of one person with activities of a signed to the 200 hall for the 200 hall a licensed nurse was assigned to a seigned to the 200 hall for the 6 net on ostaff was assigned to the a 200 hall for the 2:00 p.m. to 10:00 the hall without staff present bec of present on the hall was a dango aling. The resident stated she way to shep.	de adequate) rs and without rs and without rs and without rs dedicated staff to the 200 hall during situation related to rt o prevent accidents was are housed on the hall. Opm on 10-6-16. the 200 hall at all rould be inserviced by mediate Jeopardy removal. provided in the the completed. The deficiency upervision to prevent event accidents. The the 200 hall. The care on 09/22/16. ty identified the resident was transfers, staff would the resident would build stand for short resident's gait was daily living. mented the grievance was vance was the DON sassigned to the 200 hall or the 6:00 a.m. to the 200 hall for the for an. to 2:00 p.m. 200 hall for any shift. tall for the 6:00 a.m. to 100 p.m. shift or the ean and odor-free. No sident stated staff e concern to the cause she might fall prous situation. The still at 2:00 a.m. to privision for her safety. the 200 hall. The DON
	the hall at all times. The DON stat were taken to the administrator. T On 10/10/16 at 11:27 a.m., the DO hall. The DON stated she had cor hall.	ated all staff assigned to the 200 has the DON stated the administrator DN was asked if residents were sat	all had voiced concerns. The DOI had no response. fe when left unsupervised for up t	N stated the concerns to two hours on the 200
LABORATORY DIRECTOR'S REPRESENTATIVE'S SIGNA	G OR PROVIDER/SUPPLIER	TITLE	(X6) I	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.

 FORM CMS-2567(02-99)
 Event ID: YL1011
 Facility ID: 375159
 If continuation sheet

 Previous Versions Obsolete
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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:3/3/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 375159	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/10/2016
NAME OF PROVIDER OF SU		STREET ADDR	RESS, CITY, STATE, ZIP
THE SPRINGS, A GRACE L	IVING CENTER COMMUNITY	5800 WEST OF MUSKOGEE,	
		cy, please contact the nursing home or the state sur	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST BE MATION)	3 PRECEDED BY FULL REGULATORY
F 0323	(continued from page 1) 2. Resident #2 was admitted to the	e facility on [DATE] with [DIAGNOSES REDAC	TED] The facility identified the resident was
Level of harm - Immediate jeopardy Residents Affected - Some	admitted to room 215 on the 200 The staffing sheet provided by the The staffing sheet provided by the		s assigned to the 200 hall for any shift. gned to the 200 hall for the 6:00 a.m. to
Kestucits Anceu - Some	the 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the 2:00 p.m. shift and the 2:00 p.m.	facility documented on 09/25/16 a CNA was assigned to 10:00 p.m. shift. The sheet did not document state	gned to the 200 hall for the 6:00 a.m. to
	care for the residents who resided A physician's orders [REDACTEI enteral feedings. The facility identified the resident A pradmission assessment, dated (assessment documented the resident documented the resident was alw therapy via a nasal cannula, was of The care plan, dated 10/04/16, doo processes related to difficulty mai a swallowing problem related to a plan documented the resident use risk for pain related to decreased documented the resident was dep cognitive deficits. The care plan of documented the resident was atri needs, and had vision and hearing related to left sided [DIAGNOSE]	facility documented on 09/26/16 the staff assigne on the 200 hall. D]. The order documented the resident was on a no was moved to the 400 hall on 09/27/16. D]., nutritional intake, or skin integrity. 19/30/16, documented the resident was severly imp ent needed total assistance with activities of daily J ays incontinent of bowel and bladder. The assessm on an anticoagulant, and had a limb restraint which umented the resident had impaired cognitive func king decisions and multiple disease processes. The cerebral vascular accident and was dependent on d padded mittens for safety of the peg tube. The ca mobility, left sided [DIAGNOSES REDACTED] endent on staff for activities, cognitive stimulation locumented the resident had a communication prol sk for falls related to confusion, poor communicat problems. The care plan documented the resident S REDACTED], decreased mobility and weakness related to distractibility and inability to concentrat	paired for daily decision making. The living (ADLs). The assessment nent documented the resident received oxygen n was used daily. tion, dementia or impaired thought e care plan documented the resident had a feeding tube for nutrition. The care are plan documented the resident was at , and a new peg tube placement. The care plan belm related to aphagia. The care plan ton/comprehension, was unaware of safety thad an ADL self care performance deficit s. The care plan documented the resident had a
	hall and was assigned to provide a The CNA stated she made rounds asked would she be able to hear it able to hear a resident if they call a fall. The CNA stated she would on the 200 hall. The CNA stated of 200 hall had voiced any concerns CNA stated staffing was not incre 3. Resident #3 was admitted to the	I was asked about the staffing on the 200 hall. The supervision most nights. The CNA stated she coult on the 200 hall every 2 hours and answered the cc of a resident residing on the 200 hall called out for he ed out for help on the 200 hall. The CNA was aske find them when she made rounds. The CNA was is not all resident needs may be meet on the 200 hall. The CNA stated one resident verbalized she did assed when residents were admitted to the 200 hall. facility on [DATE] with [DIAGNOSES REDAC] 4/16, documented the resident was a full code, a face a set when the state of th	dn't just sit over there on the 200 hall. all lights as soon as she could. The CNA was help. The CNA stated she would not be ed how she would know if a resident had asked if she was able to meet resident needs . The CNA was asked if residents on the not like being on the 200 hall alone. The I. .TED].
	short distances but did get short of The staffing sheet provided by the 2:00 p.m. shift and the 2:00 p.m. 1 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the 2:00 p.m. shift and the 2:00 p.m. 1 10:00 p.m. to 6:00 a.m. shift. On 10/06/16 at 4:55 p.m., the resis staff was observed on the 200 hal A nurse note, dated 10/06/16, doct On 10/06/16 at 4:55 p.m., resident lung disease and was oxygen dep 4. Resident #4 was admitted to the The five day assessment, dated 09 assessment documented the resid The admission nurse note, dated 0 resident would require the assista unclear. The note documented the for mobility with assistance of on The staffing sheet provided by the The staffing sheet provided by the The staffing sheet provided by the	facility documented on 10/04/16 a CNA was assigned to 10:00 p.m. shift. The sheet documented no staff facility documented on 10/05/16 a CNA was assigned to 10:00 p.m. shift. The sheet documented no staff dent was observed in her room on the 200 hall. The lumented the resident was moved to room 114 with #3 stated she came to live in the facility 2 days be endent. The resident stated staff was not on the hal facility on [DATE] with [DIAGNOSES REDAC] (22/16, documented the resident was alert and or ince of two staff members for ADL care. The note - resident wore a brace on his right leg, was a high	gned to the 200 hall for the 6:00 a.m. to f was assigned to the 200 hall for the gned to the 200 hall for the 6:00 a.m. to f was assigned to the 200 hall for the e resident was clean and odor free. No a permanent supervision for her safety. efore. The resident stated she had ll at all times. TED]. irred for daily decision making. The as always incontinent of bowel and bladder. iented times one. The note documented the documented the resident's speech was i fall risk, and required a wheel chair s assigned to the 200 hall for any shift. ecreased mobility and dementia. The
	for pressure ulcers related to decr fractures. The care plan documen processes related to dementia. Th right femur fracture, difficulty wa plan documented the resident had intravenous therapy (IV) of norm adverse reactions related to polyp deep vein thrombosis (DVT) of th 5. Resident #5 was admitted to the The initial plan of care, dated 10/0 needed assistance with ADLs. The admission nurse note, dated 1 The staffing sheet provided by the The staffing sheets provided by the Staffing sheet provided by the the staffing sheet provided by the 2:00 p.m. to 6:00 a.m. shift. The shift or the 2:00 p.m. to 10:00 p.n The staffing sheet provided by the 2:00 p.m. shift. The sheet docume 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the 2:00 p.m. shift. The sheet docume 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the 2:00 p.m. shift. The sheet docume 10:00 p.m. to 6:00 a.m. shift.	eased mobility and incontinence. The care plan do ted the resident had impaired cognitive function re e care plan documented the resident had an ADL s ilking, lack of coordination, muscle wasting/atropf oxygen therapy related to sleep apnea. The care p al saline related to fluid deficit. The care plan docu- harmacy. The care plan documented the resident v the lower extremity. facility on [DATE] with [DIAGNOSES REDACC 01/16, documented the resident was a full code, wa 0/01/16, documented the resident was admitted to facility, dated 10/01/16, documented no staff was sheet documented no staff was assigned to the 20	we mented the resident was at risk for elated to dementia or impaired thought self care performance deficit related to a hy and decreased mobility. The care olan documented the resident was on umented the resident was at risk for was on anticoagulant therapy related to TED]. as at risk for falls, was bedfast, and room 215. assigned to the 200 hall for any shift. e was assigned to the 200 hall for the 00 hall for the 6:00 a.m. to 2:00 p.m. s assigned to the 200 hall for any shift. gned to the 200 hall for the 6:00 a.m. to 2:00 p.m. to 10:00 p.m. shift or the gned to the 200 hall for the 6:00 a.m. to 2:00 p.m. to 10:00 p.m. shift or the sted to be moved. The resident stated on the hall. The resident stated she

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:3/3/2017 FORM APPROVED OMP NO. 0038 0301
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	375159		
IAME OF PROVIDER OF SU THE SPRINGS, A GRACE L	PPLIER IVING CENTER COMMUNITY		RESS, CITY, STATE, ZIP KMULGEE
,		MUSKOGEE,	OK 74401
(X4) ID PREFIX TAG	1	cy, please contact the nursing home or the state su DEFICIENCIES (EACH DEFICIENCY MUST B	
-	OR LSC IDENTIFYING INFORM		
F 0323 Level of harm - Immediate jeopardy	100 and 200 hall. The CNA was a	2 was asked how staff were assigned to the 200 ha asked how she would know if a resident had a fall de rounds on the hall. The CNA stated there was a	en on the 200 hall. The CNA stated she would
Residents Affected - Some	6:00 a.m. to 2:00 p.m. shift. The 6 they were not always able to mee 6. Resident #6 was readmitted to t The staffing sheet provided by the 2:00 p.m. shift and the 2:00 p.m. 10:00 p.m. to 6:00 a.m. shift. The staffing sheet provided by the 2:00 p.m. shift and the 2:00 p.m.	CNA stated they could use another CNA to provid t resident needs in a timely manner. he facility on [DATE] with [DIAGNOSES REDA facility, dated 09/23/16, documented no staff was facility documented on 09/24/16 a CNA was assi to 10:00 p.m. shift. The sheet documented no staff cfacility documented on 09/25/16 a CNA was assi to 10:00 p.m. shift. The sheet documented no staff	The coverage to both halls. The CNA stated ACTED]. Is assigned to the 200 hall for any shift. Is assigned to the 200 hall for the 6:00 a.m. to f was assigned to the 200 hall for the igned to the 200 hall for the 6:00 a.m. to
	assessment documented the reside two staff members for toileting, e the resident had a lower extremity was always incontinent of bowel IV therapy. On 10/06/16 at 7:50 p.m., the resid	09/29/16, documented the resident was severly im ent did not ambulate. The assessment documented xtensive assistance dressing, and total assistance t y impairment and used a wheelchair for mobility. and frequently incontinent of urine. The assessme dent stated he had resided on the 200 hall. The resident ited he ate in the dining room alone. The resident is	the resident needed limited assistance of for bathing. The assessment documented The assessment documented the resident int documented the resident was receiving ident stated he did not like being
	another hall because he wanted to On 10/10/16 at 11:00 a.m., the AE the 200 hall. The ADM stated he On 10/10/16 at 2:55 p.m., the ADI hall. The ADM stated, Not to my the responsibility of the DON.	be around other people. M was interviewed. The ADM stated no concern had an open door policy and a daily stand up mee M was asked if staff had brought any concerns to memory, nothing specific. The ADM stated he di	s had been identified concerning staffing for ting with department heads. him related to the staffing on the 200 d not go to the Q2 meetings because that was
F 0490	**NOTE- TERMS IN BRACKET	le way that maintains the well-being of each res	IDENTIALITY**
Level of harm - Minimal harm or potential for actual	effectively used their resources in	and record review, it was determined the facility fa a manner to promote the residents' highest levels	of well being for six (#1, #2, #3,
harm Residents Affected - Some		sidents reviewed for highest level of well being. T were present on the 200 hall. The facility identified	
	The initial care plan, dated 10/01/ encourage the resident to use the ' be assessed/treated for [REDACT A nurse note, dated 10/02/16, doct periods of time, and was unsteady On 10/06/16 at 5:17 p.m., resident being on the 200 hall at all times, stated staff was pretty good but di and staff were better. The residen concerned she could fall or have t careful in the bathroom to keep fr bathroom before help came. The staff. The resident stated she felt a 2. Resident #2 was admitted to the A physician's orders [REDACTEI enteral feedings. A physician's orders [REDACTEI The admission assessment, dated (assessment documented the residen documented the resident was alwy therapy via a nasal cannula, was of The care plan, dated 10/04/16, doo processes related to difficulty mal a swallowing problem related to a documented the resident was dep cognitive deficits. The care plan c	umented the resident used a wheelchair for distance y of gait. #1 was observed in her room. The resident was a The resident stated she came to live in the facility id not always answer the call light. The resident st it stated it made her feel scared to be on the hall w to throw up. The resident stated it was dangerous. com falling. The resident stated it was dangerous. com falling. The resident stated she was nauseated easident stated she would go to the dining room to alone. a facility on [DATE] with [DIAGNOSES REDAC D]. The order documented the resident was on a no D]., nutritional intake, or skin integrity. 09/30/16, documented the resident was severly im ent needed total assistance with activities of daily ays incontinent of bowel and bladder. The assessm on an anticoagulant, and had a limb restraint which cumented the resident had impaired cognitive func- king decisions and multiple disease processes. Th a [MEDICAL CONDITION] and was dependent of dled mittens for safety of the peg tube. The care p ility, left sided [MEDICAL CONDITION], and a endent on staff for activities, cognitive stimulation locumented the resident had a communication pro-	independent with transfers, staff would ing (ADLs), and the resident would ce ambulation, could stand for short sked if she was comfortable with staff not y the previous week. The resident tated she had complained to the ADM ithout staff present because she was The resident stated she had to be at 2 a.m. and was already in the o get her own ice and rarely saw TTED]. othing by mouth (NPO) diet and was receiving "paired for daily decision making. The living (ADLs). The assessment nent documented the resident received oxygen h was used daily." tion, dementia or impaired thought e care plan documented the resident had on a feeding tube for nutrition. The care plan lan documented the resident was at risk n we yeg tube placement. The care plan h, and social interactions related to blem related to aphagia. The care plan
	needs, and had vision and hearing related to left sided [MEDICAL O psychosocial well being problem resident was on oxygen therapy. 3. Resident #3 was admitted to the The initial plan of care, dated 10/0 assistance. A nurse note, dated 10/04/16, doct short distances but did get short o On 10/06/16 at 4:55 p.m., resident not being present on the 200 hall resident stated she had lung disea 4. Resident #4 was admitted to the The five day assessment, dated 09 assessment documented the resid The admission nurse note, dated 0 the resident would require the ass unclear. The note documented the for mobility with assistance of on The care plan, dated 10/04/16, doc care plan documented the residen for pressure ulcers related to decr fractures. The care plan documen processes related to dementia. Th right femur fracture, difficulty wa	t #3 was observed in her room. The resident was a at all times. The resident stated she came to live i se and was oxygen dependent. The resident stated 6 facility on [DATE] with [DIAGNOSES REDAC //22/16, documented the resident was severly impa ent needed extensive assistance with ADLs and w 09/22/16, documented the resident was alert and o sistance of two staff members for ADL care. The r e resident wore a brace on his right leg, was a high	t had an ADL self care performance deficit The care plan documented the resident had a te. The care plan documented the TTED]. fall risk, had pain, and needed ADL of oxygen, and was able to ambulate usked if she felt comfortable with staff n the facility 2 days ago. The staff was not on the hall at all times. TTED]. aired for daily decision making. The as always incontinent of bowel and bladder. riented to self only. The note documented to documented the residents speech was n fall risk, and required a wheel chair lecreased mobility and dementia. The re plan documented the resident was at risk coumented the resident was at risk for elated to dementia or impaired thought self care performance deficit related to hy and decreased mobility. The care

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NAME OF PROVIDER OF SU		STREET ADDR	RESS, CITY, STATE, ZIP
THE SPRINGS, A GRACE L	IVING CENTER COMMUNITY	5800 WEST OF MUSKOGEE,	
		cy, please contact the nursing home or the state sur DEFICIENCIES (EACH DEFICIENCY MUST BE	
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR		PRECEDED BI FULL REGULATORI
F 0490 Level of harm - Minimal harm or potential for actual harm	adverse reactions related to polyr [MEDICAL CONDITIONS] of I	al saline related to fluid deficit. The care plan docu harmacy. The care plan documented the resident v ower extremity. e facility on [DATE] with [DIAGNOSES REDAC]	was on anticoagulant therapy related to
Residents Affected - Some	needed assistance with ADLs. The admission nurse note, dated 1 On 10/06/16 at 6 p.m., resident #5 the 200 hall. The resident stated shall. The resident stated she saw the bed pan and was incontinent of 6. Resident #6 was readmitted to The admission assessment, dated assessment documented the resid staff members for toileting, exten resident had a lower extremity in always incontinent of bowel and therapy. On 10/06/16 at 7:50 p.m., residen 200 hall. The resident stated he h ate in the dining room alone and wanted to be around other people On 10/06/16 at 6:55 p.m., certifie worked the 100 and 200 hall and there on the 200 hall. The CNA ss she could. The CNA was asked it not be able to hear a resident if th The CNA stated she would find the complained about staffing on the herself. The CNA stated staffing On 10/06/16 at 7:10 p.m., CNA # 100 and 200 halls. The CNA was probably find them when she ma 6 to 2 shift. The CNA stated the palways able to meet the residents On 10/06/16 at 7:20 p.m., LPN # short 100 hall and covered the resi to 16 residents to which she prov comfortable covering residents of comfortable to facility wo on 10/10/16 at 11:00 a.m., the Alf staff to the 200 hall. The DON stated of the consisted of the ADM department managers as needed I needed. The ADM stated on cond door policy and a daily stand up 1 needed. The ADM stated no cond door policy and a daily staff up was aff to the 200 hall. The DON stated staffing to 10/10/16 at 11:27 a.m., the AD hall. The ADM stated, Not to my the responsibility of the DON. On 10/10/16/16 at 3:00 p.m., the AD	d nurse aide (CNA) #1 was asked about the staffing was assigned to provide supervision most nights. Tated she made rounds on the 200 hall every 2 hou she would be able to hear a resident if the called of ey called out for help. The CNA was asked how si free may be things they don't get on the 200 hall. The 200 hall. The CNA stated only one resident had or was not increased when the residents were admitte 2 was asked how staff were assigned to the 200 hall asked how she would know if a resident had or de rounds on the hall. The CNA stated there was a could use another CNA when having to cover bott needs in a timely manner. was interviewed regarding the staffing for the 200 sidents on the ball. The LPN stated she passed ided care. The LPN statef rounds were made frequ the 200 hall with staff not being on the hall at all d had originally refused to care for residents on the care of those residents. The LPN stated it wasn't s the ADM. The LPN stated prior to Monday, 100 at eas asked about the facilities QA process. The I y. The DON stated she took care of nursing concer there had been and concerns brought to her attent to her regarding the staffing. DM was interviewed regarding the quality assurand , the medical director, the DON, the assistant direce elated to concerns. The ADM stated the QA comm rems had been identified concerning staffing for th 200 was asked if such the staffing. DM was interviewed regarding the quality assurand , the medical director, the DON, the assistant direce elated to concerns. The ADM stated the QA comm rems had been identified concerning staffing for th neeting with department heads. DN was asked if staff had brought any concerns to F memory, nothing specific. The ADM stated the dia Nawa asked if staff had brought any concerns to F memory, nothing specific. The ADM stated he dia N was asked if staff had brought any concerns to F memory, nothing specific. The ADM stated he dia N was asked how she handled grievances. The DO ON stated she would then follow up to see if the p	room [ROOM NUMBER]. d why she had requested to be moved from dent stated it was too quiet on the s. The resident stated she had to use ance. .CTED]. paired for daily decision making. The the resident needed limited assistance of 2 athing. The assessment documented the assessment documented the resident was ocumented the resident was receiving IV sked why he had asked to be moved from the e was alone. The resident stated he move to another hall because he g on the 200 hall. The CNA stated she The CNA stated she couldn't just sit over rs and answered the call lights as soon as out for help. The CNA stated she would he would know if a resident had a fall. if she was able to meet the residents made omplained about being on the 200 hall by d to the 200 hall. The CNA stated between the l on the 200 hall. The CNA stated between the l on the 200 hall. The CNA stated between the l on the 200 hall. The CNA stated between the l on the 200 hall. The CNA stated between the l on the 200 hall. The CNA stated between the h and the could hall. The CNA stated between the h and the could hall. The CNA stated she would person assigned to the 200 hall now on the h halls. The CNA stated she voyered the medications to the residents and had 12 tently. The LPN stated she was not e 200 hall but was now covering the safe for the residents to be on the hall he felt regarding staffing on the 200 orking on it. 3716 she was not aware of any dedicated 00 hall during the day shift only. DON stated there had not been a QA meeting mis and the ADM would handle quality ion about staffing on the 200 hall. The DON DON stated she had taken it to the ADM ec committee (QA). The ADM stated the QA tor of nurses (ADON), and other nittee would meet quarterly and more often as ie 200 hall. The DON stated she had on the 200 hall. The DON stated the ADM had him related to the staffing on the 200 d not go to the Q2 meetings because that was DN stated she would go to the resident or staff
F 0520 Level of harm - Minimal harm or potential for actual harm	administration of the facility. Set up an ongoing quality assess quarterly, and develop correcti **NOTE- TERMS IN BRACKET Based on observation, interview, assurance program (QA) program #5, and #6) of six sampled reside	If AVE BEEN EDITED TO PROTECT CONFL and record review, it was determined the facility fa to identify and implement interventions for qualit nts reviewed for quality assurance. The facility fail	ficiencies DENTIALITY** illed to have an effective quality ty of care issues for six (#1, #2, #3, #4, led to identify the supervision and
Residents Affected - Some	safety concerns for residents on t Findings: 1. Resident #1 was admitted to th The initial care plan, dated 10/01/ encourage the resident to use the assessed/treated for [REDACTEI A nurse note, dated 10/02/16, doc periods of time, and was unstead On 10/06/16 at 5:17 p.m., residen being on the 200 hall at all times. stated staff was pretty good but d and staff were better. The residen concerned she could fall or have careful in the bathroom to keep fi	he 200 hall. The facility identified six residents wh e facility on [DATE] with [DIAGNOSES REDAC 16, documented the resident was a full code, indep call light for assistance with activities of daily livin D]. umented the resident used a wheelchair for distanc	no had resided on the 200 hall. TED]. bendent with transfers, staff would ng (ADLs), and would be er ambulation, could stand for short sked if she was comfortable with staff not the previous week. The resident ated she had complained to the ADM thout staff present because she was The resident stated she had to be at 2 a.m. and was already in the
EOPM CMS 2567(02.00)	Event ID: VI 1011	Essility ID: 275150	If continuation sheat

EPARTMENT OF HEALTH ENTERS FOR MEDICARE			PRINTED:3/3/2017 FORM APPROVED OMB NO. 0938-0391
FATEMENT OF EFICIENCIES ND PLAN OF ORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/10/2016
JKREC HON	375159		
ME OF PROVIDER OF SU		STREET ADD	RESS, CITY, STATE, ZIP
E SPRINGS, A GRACE L	IVING CENTER COMMUNITY	5800 WEST O MUSKOGEE,	
r information on the nursing	home's plan to correct this deficient	cy, please contact the nursing home or the state su	
X4) ID PREFIX TAG	SUMMARY STATEMENT OF D	DEFICIENCIES (EACH DEFICIENCY MUST B	E PRECEDED BY FULL REGULATORY
F 0520	(continued from page 4)	MATION)	
harm or potential for actual	A physician's orders [REDACTEI enteral feedings.	e facility on [DATE] with [DIAGNOSES REDAC D]. The order documented the resident was on a no D] nutritional intake, or skin integrity	
F 0520 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	enteral feedings. A physician's orders [REDACTEI The admission assessment, dated (assessment documented the resided documented the resident was alwi therapy via a nasal cannula, was of The care plan, dated 10/04/16, door processes related to difficulty mail a swallowing problem related to a documented the resident used pad for pain related to decreased mob documented the resident was depi cognitive deficits. The care plan of documented the resident was depi cognitive deficits. The care plan of documented the resident was depi related to left sided [MEDICAL O psychosocial well being problem resident was on oxygen therapy. 3. Resident #3 was admitted to the The initial plan of care, dated 10/0 assistance. 4. Rurse note, dated 10/04/16, doct short distances but did get short o On 10/06/16 at 4:55 p.m., resident to being present on the 200 hall resident stated she had lung disea 4. Resident #4 was admitted to the The five day assessment, dated 09 assessment documented the reside The fave day assessment, dated 09 assessment documented the reside for mobility with assistance of on The care plan, dated 10/04/16, docc are plan documented the resident for mobility with assistance of The admission nurse note, dated 0 for pressure ulcers related to decre- fractures. The care plan documented the for mobility with assistance of on The care plan, dated 10/04/16, doc care plan documented the resident for pressure ulcers related to document for the admission nurse note, dated 10 for an the admission nurse note, dated 10 for an the admission nurse note, dated 10 for a fast the documented the resident fast for 10/06/16 at 6 p.m., resident #5 the 200 hall. The resident stated she saw the bed pan and was incontinent of assessment documented the resident fast intravenous therapy (IV) of norm adverse reactions related to polyp (MEDICAL CONDITIONS) of fu- fue Admission nurse note, dated 10/0 needed assistance with ADLs. The admission nurse note, dated 10/0 needed assistance with ADLs. The admission nurse note, dated 10/0 needed assi	D), nutritional intake, or skin integrity. Dy/30/16, documented the resident was severly im ent needed total assistance with activities of daily ays incontinent of bowel and bladder. The assess on an anticoagulant, and had a limb restraint which cumented the resident had impaired cognitive func- king decisions and multiple disease processes. Th (MEDICAL CONDITION] and was dependent of lded mittens for safety of the peg tube. The care p ility, left sided [MEDICAL CONDITION] , and a endent on staff for activities, cognitive stimulation locumented the resident had a communication pro- sk for falls related to confusion, poor communica problems. The care plan documented the residen CONDITION], decreased mobility and weakness. related to distractibility and inability to concentra e facility on [DATE] with [DIAGNOSES REDAC 4/16, documented the resident was a full code, a fa umented the resident was a smoker, on 3 liters (L) of breath (SOB). #3 was observed in her room. The resident was a tall times. The resident stated she came to live in se and was oxygen dependent. The resident stated e facility on [DATE] with [DIAGNOSES REDAC 1/2/16, documented the resident was alert and o w/2/2/16, documented the resident was alert and o w/2/2/16, documented the resident was alert and o w/2/2/16, documented the resident was alert and o sitance of two staff members for ADL care. The re- re resident wore a brace on his right leg, was a high e staff member. umented the resident was at risk for falls due to d t was NPO and had a nutritional problem. The care ased mobility and incontinence. The care plan doc where any related to sleep apnea. The care is alsaline related to fluid deficit. The care plan doc wharmacy. The care plan documented the resident was admitted to was observed in her room. The resident was asked he had to wait a long time for assistance. The resi- der the resident tha impaired cognitive function re- e care plan documented the resident was a full code, was 0/01/16, documented the resident was a full code, was 0/02/1	paired for daily decision making. The living (ADLs). The assessment nent documented the resident received oxygen h was used daily. ction, dementia or impaired thought e care plan documented the resident had on a feeding tube for nutrition. The care plan lan documented the resident was at risk new peg tube placement. The care plan ton/comprehension, was unaware of safety t had an ADL self care performance deficit The care plan documented the resident had a te. The care plan documented the TTED]. fall risk, had pain, and needed ADL of oxygen, and was able to ambulate sked if she felt comfortable with staff n the facility 2 days ago. The staff was not on the hall at all times. TTED]. irierd for daily decision making. The as always incontinent of bowel and bladder. rriented to self only. The note documented tote documented the resident speech was n fall risk, and required a wheel chair lecreased mobility and dementia. The re plan documented the resident was at risk coumented the resident was at risk for elated to dementia or impaired thought self care performance deficit related to hy and decreased mobility. The care plan documented the resident was on umented the resident was at risk for was on anticoagulant therapy related to CTED]. as at risk for falls, was bedfast, and proom [ROOM NUMBER]. d why she had requested to be moved from dent stated it was too quiet on the s. The resident stated she had to use tance. NCTED]. paired for daily decision making. The 1 the resident needed limited assistance of 2 athing. The assessment documented the existent documented the resident was ocumented the resident was receiving IV sked why he had asked to be moved from the is was alone. The resident stated he o move to another hall because he ag on the 200 hall. The CNA stated she
	there on the 200 hall. The CNA si she could. The CNA was asked if not be able to hear a resident if th The CNA stated she would find th the 200 hall. The CNA stated ther complained about staffing on the	was assigned to provide supervision most nights, tated she made rounds on the 200 hall every 2 hou she would be able to hear a resident if the called ey called out for help. The CNA was asked how s hem when she made rounds. The CNA was asked re may be things they don't get on the 200 hall. Th 200 hall. The CNA stated only one resident had c	ITS and answered the call lights as soon as out for help. The CNA stated she would he would know if a resident had a fall. if she was able to meet the residents needs on the CNA was asked if any residents had omplained about being on the 200 hall by
	On 10/06/16 at 7:10 p.m., CNA #2 100 and 200 halls. The CNA was probably find them when she man 6 to 2 shift. The CNA stated they always able to meet the residents 0n 10/06/16 at 7:20 p.m., LPN #1 short 100 hall and covered the res to 16 residents to which she provi comfortable covering residents or comfortable with the situation and hall because someone had to take without staff being present. The I hall. The LPN stated she had told	was interviewed regarding the staffing for the 20 idents on the 200 hall. The LPN stated she passec ided care. The LPN stated rounds were made freq the 200 hall with staff not being on the hall at all d had originally refused to care for residents on th care of those residents. The LPN stated it wasn't .PN was asked if she had told anyone about how s the ADM. The LPN stated she was told he was w	II. The CNA stated shed rotated between the I on the 200 hall. The CNA stated she would person assigned to the 200 hall now on the th halls. The CNA stated they were not 0 hall. The LPN stated she covered the 1 medications to the residents and had 12 uently. The LPN was asked if she was 1 times. The LPN stated she was not e 200 hall but was now covering the safe for the residents to be on the hall she felt regarding staffing on the 200 rorking on it.
	On 10/06/16 at 8:50 p.m., the dire staff to the 200 hall. The DON str On 10/10/16 at 9:53 a.m., the DOI since she had started at the facility measures. The DON was asked if stated staff had brought concerns	ctor of nurses (DON) stated prior to Monday, 10// tated as of monday staff would be assigned to the 2 N was asked about the facilities QA process. The 1 y, The DON stated she took care of nursing conce there had been and concerns brought to her attent to her regarding the staffing on the 200 hall. The as above state standards for staffing.	03/16 she was not aware of any dedicated 200 hall during the day shift only. DON stated there had not been a QA meeting rns and the ADM would handle quality tion about staffing on the 200 hall. The DON

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:3/3/2017 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CODDECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 10/10/2016
CORRECTION	NUMBER 375159		
NAME OF PROVIDER OF SU			ADDRESS, CITY, STATE, ZIP
THE SPRINGS, A GRACE L	IVING CENTER COMMUNITY		ST OKMULGEE GEE, OK 74401
-		cy, please contact the nursing home or the	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		JST BE PRECEDED BY FULL REGULATORY
F 0520 Level of harm - Minimal harm or potential for actual harm	committee consisted of the ADM department managers as needed r	, the medical director, the DON, the assista elated to concerns. The ADM stated the Qa erns had been identified concerning staffin	ssurance committee (QA). The ADM stated the QA at director of nurses (ADON), and other a committee would meet quarterly and more often as g for the 200 hall. The ADM stated he had an open
Residents Affected - Some	On 10/10/16 at 11:27 a.m., the DC time on the 200 hall. The DON st to the 200 hall. The DON stated t On 10/10/16 at 2:55 p.m., the AD hall. The ADM stated, Not to my the responsibility of the DON. On 10/10/16 at 3:00 p.m., the DOI	DN was asked if it was safe for residents to ated she had concerns. The DON stated sta he ADM had told her the facility staffing v M was asked if staff had brought any concc memory, nothing specific. The ADM state N was asked how she handled grievances. ' ON stated she would then follow up to see	ffing had not changed when residents were admitted