| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375335 | A. BUILDING _____ B. WING _____ | 06/09/2016 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **WINDRIDGE NURSING AND REHABILITATION CENTER** | **2530 NORTH ELM STREET MIAMI, OK 74354** |

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) |
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| F 0157<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, it was determined the facility failed to notify the physcian in a timely manner when a resident expressed a desire to die and later attempted suicide for one (#2) of one sampled resident who had expressed a desire to die. The DON stated there had been no other residents who had attempted suicide. Findings:<br>Resident #2 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>An admission assessment, dated 05/06/16, documented the resident was cognitively intact and required limited to total assistance with ADLs.<br>A nurse's note, dated 05/10/16 at 1:41 a.m., documented the resident had stated she did not want to go to [MEDICAL TREATMENT] anymore and she wanted to die because she was ready to die. The note documented she kept asking for help from the nursing staff to help her to die. The note documented the resident asked how long after she stopped going to [MEDICAL TREATMENT] would it take for her to die.<br>A medicare note, dated 05/11/16, documented the resident had not wanted to go to [MEDICAL TREATMENT] and the resident's daughter had been there that morning and talked to the resident. The note documented the resident had agreed to go to [MEDICAL TREATMENT] after her daughter had talked to her.<br>A nurse's note, dated 05/12/16 at 5:57 p.m., documented the resident's physician had been there earlier that day and new orders had been received.<br>A physician's progress note, dated 05/12/16, documented an order for [REDACTED].<br>The clinical record did not contain any documentation the physician had been notified of the resident's verbalization of wanting to die prior to the visit on 05/12/16.<br>A nurse's note, dated 05/13/16 at 6:37 p.m., documented at 4:00 p.m. the resident had been found by staff with the call light wire wrapped around her neck and was pulling it tightly. The note documented the resident stated she was sick of being sick. The note documented the SS director and DON had been notified and the resident's family was at the bedside.<br>A nurse's note, dated 05/13/16 at 7:00 p.m., documented the resident had been sent to the hospital for an evaluation.<br>On 06/07/16 at 11:45 a.m., the resident was observed in bed with the head of the bed up. The resident was feeding herself lunch.<br>On 06/09/16 at 4:40 p.m., the DON was asked when should you call the physician for a resident who is talking about wanting to die. She stated the physician should be called if a resident is threatening to kill themselves. The DON was asked if she thought the physician should have been notified when the resident expressed a desire to die and was asking the staff to help her die. She stated yes, the staff should have called the physician. The DON was asked if the staff had notified the physician. She stated she would have to check.<br>At 5:16 p.m., the DON stated she could not find any documentation the physician had been notified. |
| F 0248<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide activities to meet the interests and needs of each resident.**<br><br>Based on observation, record review and resident and staff interviews, it was determined the facility failed to provide an activity program which met the needs of five residents in a confidential group interview.<br>The resident census and condition report, dated<br>06/07/16, documented 50 residents resided in the facility.<br>Findings:<br>A facility activities and social service policy, revised on November 2010, documented activities would be scheduled periodically during the day, as well as, during evenings, weekends, and holidays.<br>The activity calendar for 06/07/16 documented exercise was scheduled for 10:30 a.m. and yahtzee was scheduled for 2:00 p.m.<br>On 06/07/16 at 11:00 a.m., during the confidential resident group interview, the five residents who attended were asked if they participated in the facility's activities program. They all stated they attended at least some of the activities.<br>Two residents stated the activity director had left three or four days ago and they had not been having all of the scheduled events. Two residents stated they were supposed to have had an exercise activity that morning at 10:30 a.m., and the activity did not happen. Five residents stated they had not been having weekend activities except an occasional movie. Five residents stated they only had church occasionally on Sundays.<br>The activity calendar for 06/08/16 documented exercise was scheduled for 9 a.m., parachute at 10:00 a.m., and bingo was scheduled for 2:00 p.m.<br>On 06/08/16 at 9:00 a.m., no exercise activity was observed.<br>At 10:00 a.m., no parachute activity was observed.<br>At 2:00 p.m., three residents were observed playing yahtzee.<br>At 4:00 p.m., the social service/activity director was asked about the scheduled activities. The social service/activity director stated she had been filling in for activities since the former activity director had left several days ago. She stated she was using the activity calendar the former activity director had put together. The social service/activity director was asked about the exercise and parachute activities that were on the calendar. She stated restorative had taken over the exercise activities and she did not know if they had been doing it. She stated the parachute activity had not been done today. The social service/activity director was asked about activities on the weekends. She stated she did not think they did a lot on the weekends. She stated there was not a weekend activities person. |
| F 0280<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Allow the resident the right to participate in the planning or revision of the resident's care plan.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, it was determined the facility failed to update a care plan for three (#2, #7, and #12) of 13 sampled residents whose care plans were reviewed. The Resident Census and Condition documented 50 residents resided in the facility.<br>Findings: |

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

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

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| F 0280<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>A facility policy, dated 08/18/15, documented the resident's care plan would identify those at risk for elopement and would include interventions to reduce the risk of elopement.<br>1. Resident #12 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>A quarterly care plan meeting document, dated 01/12/16, documented the resident wandered the facility and occasionally pulled the alarm at the exit doors.<br>An elopement risk assessment, dated 02/12/16 documented the resident had been identified as being at risk for elopement and a wander guard bracelet had been placed for elopement precautions.<br>A nurse's progress note dated, 03/06/16, documented resident #12 was outside the front entrance attempting to re-enter the facility. The record documented the resident had been returned to the facility and placed on every 15 minute checks. The progress note documented all other doors to the facility were locked and intact.<br>An incident report, dated 03/06/16, documented resident #12 was discovered at the front entrance of the facility attempting to return to the facility after his wander guard sounded. The incident report documented the resident had been placed on elopement precautions with a wander guard in place prior to the incident. The incident report documented an investigation had been initiated and it had been determined the resident had exited from the 100 hall after pulling the emergency exit release unlocking the door. The incident report documented a plastic, spring loaded guard had been placed over all emergency exit releases as a protective measure to prevent residents from accessing the pull alarms.<br>A quarterly assessment, dated 03/31/16, documented the resident was severely impaired cognitively and required extensive assistance with ADLs. The assessment documented the resident exhibited wandering behavior four to six days of the seven day look back period.<br>On 06/08/16 at 1:30 p.m., resident #12 was observed resting in bed. A wander guard bracelet was observed to be on the resident's left wrist.<br>A care plan, dated 07/09/15, had not be undated to reflect the residents elopement attempt.<br><br>2. Resident #7 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>A care plan, dated 10/05/15, documented the resident was at risk for alteration in nutrition related to receiving tube feedings and being NPO. The care plan documented the resident would maintain his current weight with plus or minus three pounds. The care plan interventions included; the family and MD would be notified with any changes, the resident would be positioned to promote adequate swallowing patterns during meals and would remain upright for 30 minutes after meals, the resident would receive his diet as ordered, the resident's meal percentage and fluid intake would be recorded, the resident would be weighed weekly, the resident would be evaluated by the PT/OT as needed, and the resident would receive his medication and labs as ordered.<br>A physician's progress note, dated 02/17/16, documented the resident had pulled out his feeding tube. The note documented the resident had been unhappy about the initial insertion of the feeding tube. The note documented the resident refused to have the feeding tube re-inserted and understood the consequences of the decision. The note documented the resident's POA had declined to have the feeding tube re-inserted.<br>A facility nutritional data set and progress note, dated 02/17/16, documented the resident was at risk for weight loss due to the resident pulling out his PEG tube. The progress note documented the resident was started on a pureed diet. The progress note documented the resident ate 20% to 25% of his lunch and if the resident continued to eat less than 50% of his meals she would recommend a supplement.<br>A quarterly assessment, dated 03/26/16, documented the resident was moderately impaired cognitively, required extensive assistance with most activities of daily living, was frequently incontinent of bowel and bladder, and had experienced no weight loss.<br>A facility nutritional data set and progress note, dated 03/28/16, documented the resident had pulled out his feeding tube and had refused for it to be replaced. The progress note documented the resident was on hospice. The progress note documented a recommendation for the resident to receive Ensure Plus TID as tolerated.<br>On 06/07/16 at 12:00 p.m., resident #7 was observed sitting up in bed with his lunch tray in front of him on the over bed table. The resident was feeding himself without difficulty.<br>On 06/08/16 at 7:40 a.m., the resident was observed sitting up in bed. A CNA was observed feeding the resident breakfast.<br>On 06/09/16 at 11:12 a.m., the MDS coordinator was asked about resident #7's care plan. The MDS coordinator stated the resident's care plan should have been updated to reflect the following interventions: The resident no longer had a PEG tube, the resident's food and fluid intake should be monitored and documented, the resident should be offered an alternative if he did not eat his meal, if the resident did not eat his meal he should be offered a supplement, the resident should be assisted to eat, and the resident should be properly positioned for meals. The MDS coordinator stated the resident often refused to eat and that should also be on his care plan. The MDS coordinator stated it had been an oversight on her part the resident's care plan had not been updated.<br><br>3. Resident #2 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>An admission assessment, dated 05/06/16, documented the resident was cognitively intact and required limited to total assistance with ADLs.<br>A nurse's note, dated 05/10/16 at 1:41 a.m., documented the resident had stated she did not want to go to [MEDICAL TREATMENT] anymore and she wanted to die because she was ready to die. The note documented she kept asking for help from the nursing staff to help her to die. The note documented the resident asked how long after she stopped going to [MEDICAL TREATMENT] would it take for her to die.<br>A medicare note, dated 05/11/16, documented the resident had not wanted to go to [MEDICAL TREATMENT] and the resident's daughter had been there that morning and talked to the resident. The noted documented the resident had agreed to go to [MEDICAL TREATMENT] after her daughter had talked to her.<br>A nurse's note, dated 05/12/16 at 5:57 p.m., documented the resident's physician had been there earlier that day and new orders had been received.<br>A physician's progress note, dated 05/12/16, documented an order for [REDACTED].<br>The clinical record did not contain any documentation the physician had been notified of the resident's verbalization of wanting to die prior to the visit on 05/12/16.<br>On 06/07/16 at 11:45 a.m., the resident was observed in bed with the head of the bed up. The resident was feeding herself lunch.<br>On 06/09/16 at 4:40 p.m., the DON was asked if the resident's care plan had been updated to reflect the resident's desire to die and the resident's suicide attempt. The DON stated yes. |
| F 0309<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Provide necessary care and services to maintain the highest well being of each resident**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, it was determined the facility failed to:<br>~ intervene and continue to monitor and assess a resident after the resident verbalized a desire to die and who attempted suicide for one (#2) of one sampled resident who was observed for suicidal tendencies. The DON stated there had been no other residents who had attempted suicide; and<br>~ manage an indwelling urinary catheter based on standards of practice, including infection control for one (#5) of three sampled residents who were observed for an indwelling urinary catheter.<br>The census and condition identified 50 residents who resided in the facility and four of the residents had an indwelling urinary catheter.<br>Findings:<br>A change in a resident's condition or status policy, revised February 2014, documented, .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition .<br>A suicide threats policy, revised November 2010, documented, .Resident suicide threats shall be taken seriously and addressed appropriately .Staff shall report any resident threats of suicide immediately to the Nurse Supervisor/Charge Nurse .After assessing the resident in more detail, the Nurse Supervisor/Charge Nurse shall notify the resident's Attending |

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| F 0309<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>Physician and responsible party, and shall seek further direction from the physician .All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately .If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present .<br>1. Resident #2 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>An admission assessment, dated 05/06/16, documented the resident was cognitively intact, required limited to extensive assistance with ADLs, and received [MEDICAL TREATMENT].<br>A nurse's note, dated 05/10/16 at 1:41 a.m., documented the resident had stated she did not want to go to [MEDICAL TREATMENT] anymore and she wanted to die because she was ready to die. The note documented she kept asking for help from the nursing staff to help her to die. The note documented the resident asked how long after she stopped going to [MEDICAL TREATMENT] would it take for her to die.<br>A medicare note, dated 05/11/16, documented the resident had not wanted to go to [MEDICAL TREATMENT] and the resident's daughter had been there that morning and talked to the resident. The noted documented the resident had agreed to go to [MEDICAL TREATMENT] after her daughter had talked to her.<br>A nurse's note, dated 05/12/16 at 5:57 p.m., documented the resident's physician had been there earlier that day and new orders had been received.<br>A physician's progress note, dated 05/12/16, documented an order for [REDACTED].<br>The clinical record did not contain any documentation the physician had been notified of the resident's verbalization of wanting to die prior to the visit on 05/12/16.<br>A nurse's note, dated 05/13/16 at 6:37 p.m., documented at 4:00 p.m. the resident had been found by staff with the call light wire wrapped around her neck and was pulling it tightly. The note documented the resident stated she was sick of being sick. The note documented the SS director and DON had been notified and the resident's family was at the bedside.<br>A nurse's note, dated 05/13/16 at 7:00 p.m., documented the resident had been sent to the hospital for an evaluation.<br>On 06/07/16 at 11:45 a.m., the resident was observed in bed with the head of the bed up. The resident was feeding herself lunch.<br>On 06/09/16 at 5:16 p.m., the DON was asked what had been done for the resident to ensure her safety after she had verbalized she wanted to die. She stated the staff had taken turns sitting with her the rest of that shift. She stated the resident's sister had also been notified and had come to the facility and talked with the resident. The DON stated the resident's sister had stated the resident was just mad at her since she had told the resident she would be staying at the facility instead of going home. The DON was asked what should have been done for a resident who talked about wanting to die. She stated if the resident had said they were going to try and kill themselves they would have monitored the resident more closely. The DON was asked if expressing a desire to die would be considered suicidal ideation. The DON stated they did not feel at the time the resident's intention was to attempt suicide. The DON was asked if the physician should have been notified regarding the resident expressing a desire to die. She stated yes. The DON was asked if the psychiatric consult should have been done more timely. She stated yes. The DON was asked if the medications the physician had ordered on [DATE] had been administered to the resident. She stated she would check.<br>At 5:28 p.m., the DON stated the resident had not received the medications because the medications had not been delivered to the facility at the time the resident had attempted suicide.<br>A urinary catheter care policy, revised September 2005, documented, .Be sure the catheter tubing and drainage bag are kept off the floor .<br>2. Resident #5 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>A laboratory urinalysis result, dated 12/11/15, documented the urine had cultured out gram negative rods, escherichia coli, and proteus mirabilis.<br>A laboratory urinalysis result, dated 02/13/16, documented the urine had cultured out gram negative rods, escherichia coli, and proteus mirabilis.<br>A laboratory urinalysis result, dated 04/07/16, documented the urine had cultured out gram negative rods, escherichia coli, and proteus mirabilis.<br>A laboratory urinalysis result, dated 05/10/16, documented the urine had cultured out gram negative rods.<br>A quarterly assessment, dated 05/18/16, documented the resident was moderately impaired cognitively, required supervision to extensive assistance with ADLs, and had an indwelling urinary catheter.<br>A monthly physician's orders [REDACTED].<br>On 06/07/16 at 5:50 p.m., the resident was observed in her room sitting in a recliner with her feet elevated. An indwelling urinary catheter bag was observed hanging on the side of the trash can. The bag was uncovered and the bottom of the bag was touching the floor. The resident's urine was observed in the tubing. The urine was yellow in color and contained sediment.<br>06/08/16 at 11:05 a.m., CNA #3 was observed providing catheter care for the resident. Upon entering the room the resident was observed lying in bed. The resident's catheter bag was observed lying on the floor beside her bed.<br>At 12:15 p.m., the resident was observed sitting in her recliner with her feet elevated. An indwelling urinary catheter bag was observed hanging on the side of the trash can. The bag was uncovered and the bottom of the bag was touching the floor.<br>At 5:35 p.m., the resident was observed sitting in her recliner with her feet elevated. An indwelling urinary catheter bag was observed hanging on the side of the trash can. The bag was uncovered and the bottom of the bag was touching the floor.<br>On 06/09/16 at 2:00 p.m., CNA #2 was asked how staff was supposed to care for a resident's indwelling urinary catheter. She stated the bag would usually have a blue dignity bag covering the urine bag. She stated the bag should never be above the resident's bladder and never touch the floor.<br>At 2:20 p.m., the DON was asked how she would expect staff to care for a resident's indwelling urinary catheter. She stated the bag should be positioned where it will be able to drain and the bag should not be touching the floor. |
| F 0314<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, it was determined the facility failed to provide care and treatment to promote healing of a pressure ulcer for one (#2) of three sampled residents who were observed for pressure ulcers. The Resident Census and Condition identified 2 residents who resided in the facility and had a pressure ulcer. Findings:<br>Resident #2 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>An admission assessment, dated 05/06/16, documented the resident was cognitively intact, required limited to total assistance with ADLs, and had two stage IV pressure ulcers.<br>A physician's telephone order, dated 06/02/16, documented an order to clean the resident's coccyx wound with wound cleanser, to apply [MEDICATION NAME], to pack with Calcium Alginate, and to cover with 4x4 gauze and tape, twice a day.<br>On 06/07/16 at 11:45 a.m., the resident was observed in bed with the head of the bed up. The resident was feeding herself lunch.<br>On 06/08/16 at 8:12 a.m., LPN #2 was observed providing wound care for the resident. LPN #2 cleaned the wound with wound cleanser, applied [MEDICATION NAME], and cover the wound with gauze and tape. LPN #2 did not apply any Calcium Alginate.<br>At 2:30 p.m., LPN #2 was asked about the wound treatment order to apply Calcium Alginate She stated she knew the Calcium Alginate was supposed to go on the wound. She stated she just forgot it. |
| F 0325<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** |

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| F 0325<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>Based on observation, interview, and record review, it was determined the facility failed to ensure a dietary recommendation was given to the physician for consideration for one (#7) of four sampled residents reviewed for nutrition and/or weight loss. The Resident Census and Condition Report documented there were three residents with unplanned significant weight loss. Findings:<br>Resident #7 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>A facility six month weight change report, with a beginning date of December 2015, documented the resident's weight as 131.2 lbs in December 2015, 130.0 lbs in January 2016, 137.0 lbs in February 2016, 135.0 lbs in March 2016, 125.2 lbs in April 2016, 120.6 lbs in May 2016, and 118.3 lbs in June 2016. These weights represented a weight loss of 9.8% in six months, 12.3% in three months, and 1.9% in one month.<br>A physician's progress note, dated 02/17/16, documented the resident had pulled out his feeding tube. The note documented the resident had been unhappy about the initial insertion of the feeding tube. The note documented the resident refused to have the feeding tube re-inserted and understood the consequences of the decision. The note documented the resident's POA had declined to have the feeding tube re-inserted.<br>A facility nutritional data set and progress note, dated 02/17/16, documented the resident was at risk for weight loss due to the resident pulling out his PEG tube. The progress note documented the resident was started on a pureed diet. The progress note documented the resident ate 20% to 25% of his lunch and if the resident continued to eat less than 50% of his meals she would recommend a supplement.<br>A quarterly assessment, dated 03/26/16, documented the resident was moderately impaired cognitively, required extensive assistance with most activities of daily living, was frequently incontinent of bowel and bladder, and had experienced no weight loss.<br>A facility nutritional data set and progress note, dated 03/28/16, documented the resident had pulled out his feeding tube and had refused for it to be replaced. The progress note documented the resident was on hospice. The progress note documented a recommendation for the resident to receive Ensure Plus TID as tolerated.<br>A facility nutritional data set and progress note, dated 04/25/16, documented the resident's meal intake had improved with feeding assistance. The progress note documented the resident had been stable at 130-137 lbs times six months but had recently lost weight. The progress note documented a recommendation for the resident to receive Ensure Plus TID as tolerated. The progress note documented there was no note the Ensure had been started from the previous recommendation. The progress note documented they might consider changing to a 2.0 cal supplement if the resident was unable to drink 237 mls in one setting.<br>A facility nutritional data set and progress note, dated 05/06/16, documented the previous recommendation to start Ensure Plus TID as tolerated. The progress note documented the resident was to be fed for pleasure and as tolerated and the diet texture was upgraded for improved pleasure of foods. The progress note documented the resident's meal intake was inadequate as evidenced by his continued weight loss and food and fluids should be offered as tolerated. The progress note documented no new recommendations at this time.<br>On 06/07/16 at 12:00 p.m., resident #7 was observed sitting up in bed with his lunch tray in front of him on the over bed table. The resident was feeding himself without difficulty. There were two glasses of white liquid on the tray. The resident was asked if he liked his lunch. The resident shook his head yes.<br>On 06/08/16 at 7:40 a.m., the resident was observed sitting up in bed. A CNA was observed feeding the resident breakfast.<br>On 06/08/16 at 4:50 p.m., LPN #1 was asked what the facility procedure was if the dietitian made a recommendation. The LPN stated the dietary recommendation would be sent to the physician and if the physician agreed the order would be put in the computer. The LPN was asked if the resident had an order for [REDACTED].<br>On 06/08/16 at 4:55 p.m., the DON was asked what the facility procedure was when the dietitian made a recommendation for a resident. The DON stated the recommendation would be faxed to the physician and if the recommendation was approved the order would be implemented. The DON stated she would check on it.<br>On 06/09/16 at 11:30 a.m., CNA #2 was asked what she would do if the resident refused to eat his meal. She stated the resident liked milk so she would offer him more milk. The CNA was asked if the resident was offered or given a supplement. She stated no.<br>On 06/09/16 at 12:34 p.m., RA #1 was asked about the resident's eating. The RA stated sometimes the resident would allow staff to assist him to eat and sometimes he would not. She stated today he refused his lunch but he drank two glasses's of milk.<br>On 06/09/16 at 2:25 p.m., the DON stated the dietary recommendation did not get sent to the physician. She stated it just got missed. The DON was asked if she thought the resident's weight loss had been impacted by him not receiving the supplement. The DON stated it could have impacted his weight but he refused everything. She stated they had recently had a care plan meeting with the resident's POA and the decision was made to give the resident only the things he liked to eat and drink. |
| F 0329<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, it was determined the facility failed to ensure a resident was free from unnecessary medications for four (#2, #5, #8 and #9) of six sampled residents who were receiving a psychoactive medication without adequate monitoring. The Resident Census and Condition identiifed 27 residents recieved psychoactive medications.<br>Findings:<br>A facility behavior assessment and monitoring policy, updated in February 2014, documented when medications were prescribed for behavioral symptoms the residents' plan of care would include specific target behaviors and expected outcomes and would monitor for efficacy and adverse consequences. The policy documented the nursing staff and physician would monitor for side effects and complications related to psychoactive medications such as abnormal involuntary movements.<br>1. Resident #9 was admitted on [DATE] and had [DIAGNOSES REDACTED].<br>A care plan, dated 10/05/15 and updated on 01/05/16, documented the resident was at risk for complications related to [MEDICAL CONDITION] medications. The care plan documented the resident should receive the lowest therapeutic dose of the [MEDICAL CONDITION] medications and would be free from undesired side effects of the [MEDICAL CONDITION] medications. The<br>care plan interventions included the resident would be observed for side effects.<br>An AIMS assessment, dated 11/05/15, documented the resident had no side effects. There was no other side effect monitoring assessments in the resident's clinical record.<br>A quarterly assessment, dated 03/26/16, documented the resident was moderately impaired cognitively, required supervision to limited assistance with activities of daily living, had no behaviors, was continent of bowel and bladder, and had received an antipsychotic seven days out of the seven day look back period.<br>A psychiatrist note, dated 04/01/16, documented the resident was admitted on [MEDICATION NAME] due to depression associated with a [MEDICAL CONDITION] and [MEDICAL CONDITION].<br>A monthly physician's orders [REDACTED].<br>On 06/07/16 at 7:54 a.m., the resident was observed sitting up in bed leaning against the head board. A staff member brought in the resident's breakfast tray and placed it on an overbed table next to a chair at the foot of the resident's bed. The resident transferred himself independently to the chair and began eating his breakfast. No antipsychotic side effects were observed.<br>On 06/08/16 at 4:30 p.m., the DON was asked how often side effect monitoring was done for a resident who was receiving an antipsychotic medication. The DON stated she did side effect monitoring assessments quarterly. The DON stated she was a little behind in completing the assessments.<br><br>2. Resident #2 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>An admission assessment, dated 05/06/16, documented the resident was cognitively intact and required limited to total assistance with ADLs. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375335 | A. BUILDING _____ B. WING _____ | 06/09/2016 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| WINDRIDGE NURSING AND REHABILITATION CENTER | 2530 NORTH ELM STREET MIAMI, OK 74354 |

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 0329<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>A Medication Administration Record, [REDACTED].<br>On 06/07/16 at 11:45 a.m., the resident was observed lying in bed with the head of her bed up. The resident was feeding herself lunch.<br>On 06/09/16 at 4:40 p.m., the DON was asked for the behavior monitoring and side effect monitoring sheets for the resident for the use of [MEDICATION NAME]. After checking the DON stated there were no monitoring sheets for the resident.<br>3. Resident #5 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>A quarterly assessment, dated 02/18/16, documented the resident was moderately impaired cognitively, required supervision to total assistance with ADLs, and had received an antipsychotic medication seven days of the seven day look back period.<br>A behavior/intervention monthly flow record, dated April 2016, documented the targeted behavior for the use of [MEDICATION NAME] as anxiety.<br>An annual assessment, dated 05/18/16, documented the resident was moderately impaired cognitively, required supervision to extensive assistance with ADLs, had rejected care one to three days of the seven day look back period, and had received an antipsychotic medication seven days of the seven day look back period.<br>A behavior/intervention monthly flow record, dated May 2016, documented the targeted behavior for the use of [MEDICATION NAME] as anxiety.<br>A behavior/intervention monthly flow record, dated June 2016, documented the targeted behavior for the use of [MEDICATION NAME] as anxiety.<br>A monthly physician's orders [REDACTED].<br>On 06/07/16 at 12:10 p.m., the resident was observed sitting in a recliner in her room feeding herself lunch.<br>On 06/09/16 at 2:20 p.m., the DON was asked what behaviors the resident exhibited for the use of [MEDICATION NAME]. She stated she had not noticed any behaviors and she had not had the staff report any behaviors. The DON was asked if anxiety was a supported target behavior for the use of [MEDICATION NAME]. She stated no.<br>4. Resident #8 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].<br>An admission assessment, dated 10/02/15, documented the resident was moderately impaired convexly, required supervision to extensive assistance with ADLs, had no behaviors, and had received an antipsychotic medication seven days of the seven day look back period.<br>A quarterly assessment, dated 03/30/16, documented the resident was cognitively intact, required supervision to extensive assistance with ADLs, and had received an antipsychotic medication seven days of the seven day look back period.<br>A psychiatric physician's progress note, dated 04/18/16, documented an order to discontinue [MEDICATION NAME] and to start [MEDICATION NAME] 15 mg one by mouth daily.<br>On 06/07/16 at 12:00 p.m., the resident was observed sitting on a couch in the TV area.<br>On 06/09/16 at 2:20 p.m., the DON was asked for the behavior/side effect monitoring sheets for the resident. After checking the DON stated there were no behavior/side effect monitoring sheets. |