STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375252	A. BUILDING _____ B. WING _____	12/09/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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 0157 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to notify the physician and/or family of falls and/or changes in condition following a fall for two (#85 and #131) of two sampled residents who had falls and received [MEDICATION NAME], an anticoagulant medication. The facility identified three residents as receiving [MEDICATION NAME] and 26 residents as having falls in the last three months. Findings: 1. Resident #85 was admitted to the facility on [DATE] for skilled services related to [DIAGNOSES REDACTED]. admission orders [REDACTED]. It was documented the resident was to be monitored for signs and symptoms of bleeding every shift. An admission assessment, dated 10/30/15, documented the resident was cognitively impaired and had no behaviors or [MEDICAL CONDITION]. It was documented the resident required extensive assistance of two people for bed mobility; transfers; locomotion on and off the unit; and dressing, eating, toileting, and personal hygiene. It was documented the resident was not steady when moving from a sitting to standing position or with surface to surface transfers. It was also documented the resident had an indwelling urinary catheter and was always incontinent of bowel. It was documented the resident had received an anticoagulant medication on seven of the previous seven days. It was also documented it could not be determined whether the resident had falls prior to admission to the facility. The resident's care plan, dated 11/02/15, documented a problem related to the resident being at risk for falls due to [DIAGNOSES REDACTED]. The goal was the resident would have no falls, with or without injury, through the next review date. Approaches included to assist with transfers and bed mobility; keep the call light within reach; use proper footwear; observe for side effects from medications; remind to utilize assistive devices; provide adequate lighting; keep pathways free and clear of any objects; monitor for wet/slippery floors; therapy to evaluate and treat as ordered; use a wheelchair for mobility; and medications as ordered for [MEDICAL CONDITION]. Another problem was documented as the resident being at risk for bleeding and/or bruising related to the use of [MEDICATION NAME]. The goal was the resident would not have any bleeding or bruising through the next review date. Approaches included to observe effectiveness of medications; observe resident for blood blisters, bruising, blood in stool, or easy bleeding and notify MD promptly; labs as ordered, paying close attention to lab values including hematocrit, hemoglobin, and red blood cell levels; and to assess the environment for the needed changes. It was also documented to pay close attention to the resident. The medication administration records (MARs), dated 10/2015, documented the resident received Aspirin 325 mg one tab daily from 10/24/15 through 10/31/15. It was also documented the resident received [MEDICATION NAME] 40 mg subcutaneous daily from 10/24/15 through 10/31/15. It was documented the resident was monitored for signs and symptoms of bleeding from 10/24/15 through 10/31/15. Physician's monthly orders, dated 11/2015, documented the resident was to receive [MEDICATION NAME] 40 mg subcutaneous every day for blood thinning and Aspirin 325 mg every day. The MARs, dated 11/2015, documented the resident received Aspirin 325 mg one tab daily from 11/01/15 through 11/13/15. It was also documented the resident received [MEDICATION NAME] 40 mg subcutaneous from 11/01/15 through 11/07/15 and from 11/09/15 through 11/12/15. An incident report, dated 11/12/15 at 5:50 a.m., documented a family member and physician #1 were notified. It was documented a head to toe assessment was completed. A departmental note, dated 11/12/15 at 6:24 a.m., documented, .Patient observed this am on floor at his bedside, bed in low position, awake and alert, ROM (range of motion) done to all extremities, all WNL (within normal limits) at this time, no S/S (signs or symptoms) of pain or discomfort, patient assisted to bed x (times) 2 assist, call light in reach and operable. Family and doctor aware . An incident report, dated 11/13/15 at 9:45 p.m., documented, .staff reported patient on the floor, went to room patient laying on left side propped up by left elbow, alert oriented to person, skin tear to left elbow patient denies pain or discomfort assisted to bed cleansed skin tear with normal saline, covered with island dressing neuros started, range of motion within normal limits grasp equal, pupils equal and reactive to light . It was documented physician #1 was notified immediately. It was documented the family was not notified until 3:45 a.m. on 11/14/15. A post-incident actions sheet, dated 11/13/15 at 9:45 p.m., documented the immediate post-incident action was to start neurological checks and hourly monitoring. A neurological assessment flowsheet, dated 11/13/15 at 9:45 p.m. through 11/14/15 at 3:30 a.m., documented the resident's blood pressure increased from 112/64 at 9:45 p.m. on 11/13/15 to 141/72 at 2:30 a.m. on 11/14/15. It was documented the resident's pulse rate increased from 69 beats per minutes (bpm) to 103 bpm. Review of the clinical record revealed no documentation the resident's physician was notified of the increasing blood pressure or pulse rate. A departmental note, dated 11/14/15 at 3:15 a.m., documented, .Patient observed at this time on nursing rounds unresponsive, no pulse palpable, observed no rise or fall of chest, Unit manager notified, family .notified .(physician #2) notified. N/O (new order) received (sic) to release body to funeral home . On 12/03/15 at 8:22 a.m., licensed practical nurse (LPN) #6 was asked who physician #1 was. She stated he was the physician for long term care residents. She was asked who physician #2 was. She stated he was one of the doctors for residents on skilled services. She was asked if a resident was on skilled services, which physician was to be notified if needed. She stated one of the skilled service physicians, including physician #2. She was asked if it would be okay to call physician #1 instead. She stated, No, you shouldn't. At 8:26 a.m., LPN #7 was asked which physician had been notified regarding the fall on 11/12/15. He stated he would be the physician noted on the incident report. LPN #7 was informed physician #1 was identified on the incident report. He was asked if the resident was on skilled services or long term care services. He stated he believed he was on skilled services. LPN #7 was asked if physician #1 was the physician for skilled services. He stated no, but he was the medical director and would be the physician to call if another could not be reached. LPN #7 was asked if he had informed physician #1 the resident was receiving aspirin and [MEDICATION NAME], which put him at increased risk of bleeding. LPN #7 stated he did not recall notifying the doctor of that. He stated, I don't believe so.

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

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F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) At 9:18 a.m., the director of nursing (DON) was asked who the nurse was when the resident experienced his second fall. She stated the nurse was no longer employed at the facility. At 10:09 a.m., the DON was asked which physician had been notified of the first fall, according to the documentation. She stated physician #1 was notified. She was asked who he was. She stated he was a physician for the long term care residents. The DON was asked if physician #1 had knowledge of the residents receiving skilled services. She stated, I do not believe so. She was asked if resident #85 was receiving skilled services. She stated, Yes. She was asked who the resident's physician was. She stated it was physician #2. The DON was asked why physician #2 was not notified. She stated, I cannot tell you that. She was asked who should have been contacted. She stated, (Physician #2) or the doctor on call for him. She was asked if physician #1 covered for physician #2. She stated, No. The DON was asked if physician #1 had been notified the resident was receiving [MEDICATION NAME] and aspirin. She stated, It does not say that in the documentation. The DON was asked which physician had been notified of the second fall, according to the documentation. She stated, (Physician #1). She was asked if physician #1 had ever seen the resident. She stated, Not to my knowledge. The DON was asked what the neurological checks following the second fall showed. She stated they showed the resident's vital signs were changing. She was asked if the physician had been notified of these changes. She stated, It does not appear that way. She was asked if the family member had been notified of the second fall. She stated, It doesn't appear that she was. The DON stated the family should have been notified of the second fall. The DON was asked how she expected her staff to react to changing vital signs, including an increasing blood pressure and pulse, for a resident who had experienced two unwitnessed falls. She made no comment. She was asked how the staff intervened with the resident's changing vital signs. She stated, They should have notified the physician. The DON was asked what the staff could have done differently. She stated, Initiated neuros on the first fall, notified the right physician, notified him of the meds, and notified with changes on the neuro checks. At 11:45 a.m., the resident's family member was asked if the resident could walk or reposition himself in bed. She stated, No. She was asked how many falls the resident experienced while at the facility. She stated he had one fall. At 11:53 a.m., physician #2 was asked if he was aware the resident had experienced two falls while at the facility. He stated he did not remember being informed of the falls, but that it had been awhile since the resident was at the facility. He stated he had visited with the resident on 11/11/15. Physician #2 asked who was notified of the falls, according to the documentation. He was informed it was physician #1. He stated he did not know why they called physician #1 as he was the resident's physician. 2. Resident #131 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. admission orders [REDACTED]. A nurse's note, dated 8/15/15 at 2:00 a.m., documented, .Resident noted on floor mat next to bed. Incont (incontinent) of loose BM (bowel movement). Cleaned (and) assisted back to bed. No c/o (complaint of) pain It was documented the resident's vital signs were obtained, and they were within normal limits for the resident. It was documented that frequent checks would be completed. There was no documentation neurological checks were started for the unwitnessed fall; that the facility assessed and monitored for bleeding; or that the physician was notified of the fall. There was no documentation of frequent checks. There was no incident report of the fall. A nurse's note, dated 08/15/15 at 5:00 a.m., documented frequent rounds were made after the resident fell . There was no documentation of the resident's condition during these rounds. An admission assessment, dated 08/18/15, documented the resident had long and short term memory problems and was moderately impaired in cognitive skills for daily decision making. It was documented the resident required extensive assistance for bed mobility, transfers, and dressing. It was documented she was totally dependent for locomotion, eating, personal hygiene, and bathing. It was documented the resident was always incontinent of bowel and bladder, and had one fall without major injury since admission. The resident's care plan, dated 08/19/15, documented a problem related to being at risk for falls. The goal was the resident would have no falls with or without injury through the next review date. Approaches included to place on fall program, assist with transfers, ambulation, and bed mobility; to keep the call light within reach; assure proper footwear was used; and to observe for side effects from medications. The care plan was updated on 08/20/15 with an intervention to use a low bed and fall mats. Another problem documented was the resident was at risk for bleeding and/or bruising related to the use of anti-coagulant medications. The goal was the resident would not have any bleeding or bruising through the next review date. Approaches included to observe for medication effectiveness; to observe the resident for blood blisters, bruising, blood in the stool, and easy bleeding; to obtain labs as ordered; and to assess the environment for any needed changes. A nurse's note, dated 08/23/15 at 6:25 a.m., documented, .Pt (patient) found on mat left side of bedside. Pt awake, resp (respirations) even (and) unlabored .No new bruise seen or skin tears on pt. Incont care given . It was documented the resident's vital signs were obtained, and they were within normal limits for the resident. There was no documentation neurological checks were started for the unwitnessed fall; that the facility assessed and monitored for bleeding; or that the physician was notified of the fall. There was no incident report of the fall. A nurse's note, dated 08/29/15 at 10:30 a.m., documented, .this nurse was notified by CNA (certified nurse aide) stating resident was lying bedside bed on floor mats. Upon entering room nurse notes resident lying on left side of bed into floor mat c (with) head handing (sic) off lying on pedals of the peg tube pole. Nurse and CNA assisted resident on to back. Notes discoloration to middle of forehead. (No) skin openings, swelling or any other discolorations noted @ this time. Resident alert c some confusion noted .Resident c/o pain unable to describe locations and rate pain .Noted resident was dirty (large) BM noted in brief .Nurse educated staff that resident needs to changed (sic) (every) 2 (hours) . It was documented physician #3 was notified of the fall. A progress note, dated 08/29/15 and untimed, documented, .Nurse notes discoloration to middle of forehead. Resident c/o general pain moaning when assisting c care of getting back into bed . An incident report, dated 08/29/15, documented, .nurse was notified by staff regarding resident on floor. Upon entering nurse noted resident lying on (left) side of bed on floor mats c head hanging off mats on to pedals of peg tube pole. Alert c some confusion . On 12/07/15 at 1:56 p.m., LPN #3, who was the nurse for the resident on 08/29/15, was asked if the resident could walk. She stated she could help with assistance. She was asked if the resident could reposition herself in bed. She stated the resident moved around a lot in bed. She was asked if the resident was at risk for falls. She stated, Yes. LPN #3 was asked what happened when the resident fell on [DATE]. She stated, They told me she was on the floor. She was asked what caused the resident's fall. She stated, I couldn't say exactly what caused the fall. LPN #3 was asked if the resident was being monitored for any thing in particular. She stated the resident was at risk for bleeding, so they would have been monitoring for signs and symptoms of bleeding. She was asked if she had monitored the resident for bleeding after the fall on 08/29/15. She stated, No. She was asked which physician she notified. She stated she notified physician #3 because he was on call for physician #1. She was asked if she informed physician #3 the resident was receiving [MEDICATION NAME]. She stated, I can't remember if I said that or not. She was asked if she documented that she informed the physician. She stated, No, I didn't. At 2:11 p.m., the DON was asked which physician was notified of the falls on 08/15/15 and 08/23/15. She stated, It doesn't appear there was a physician notified if this is all the documentation I have. She was asked where other documentation would be. She stated on the incident reports. She was asked where the incident reports were. She stated they did not have one for the falls. She was asked how she expected staff to assess, monitor, and intervene for a resident who was receiving an anti-coagulant medication and experienced an unwitnessed fall. She stated they should complete neurological checks, observe for differences in vital sign, and look for bruising and bleeding. She stated the physician should be contacted and informed the resident was receiving an anti-coagulant. She stated the resident would most likely be sent out for further evaluation. The DON was asked if the resident was receiving an anti-coagulant medication. She stated yes, [MEDICATION NAME]. The DON was asked how she ensured the staff assess, monitored, and intervened for residents with falls and those experiencing a change in condition and if the physician was notified as necessary. She stated incident reports were reviewed and the charts were monitored to ensure everything was done. She was asked who monitored to ensure incident

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F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) reports were completed. She stated on weekends, it was the supervisor's responsibility to ensure the DON was notified and then nursing would follow up on them.
F 0170 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Send and promptly deliver unopened mail to residents.** Based on observation, staff and resident interview, it was determined the facility failed to promptly deliver resident mail on Saturdays. The Resident Census and Conditions report, dated 12/01/15, documented 75 residents resided in the facility. Findings: On 11/30/15 at 10:00 a.m., the activities director (AD) office was located. In the activities office on a card table were observed two pieces of mail with names of residents in the facility. The AD was asked if this mail was delivered from the postal service today. The AD stated,That was mail from the weekend that needs to go to the residents. On 12/03/15 at 2:34 p.m., during an interview with the resident council president, the president was asked about mail delivery on Saturdays. The council president stated the residents have never received mail on Saturdays. She did not know what the staff did with the mail. On 12/08/15 at 4:30 p.m., the AD was asked what happed with the resident mail delivered on Saturdays. The AD stated, Honestly, it is sitting on my desk or the office manager has it sorted for me so I can pass it out to residents on Mondays. The AD was asked if he had ever asked if staff would deliver the mail on Saturdays. The AD stated, No, I have not asked anyone to deliver it. On 12/08/15 at 5:10 p.m., the administrator (ADM) was interviewed regarding Saturday mail delivery. The ADM stated the facility has a weekend receptionist who is supposed to deliver the mail on Saturdays. She was informed of the report of no mail delivered on Saturdays. The ADM stated, I was unaware it was not being delivered until Monday. The ADM was asked if the mail should be delivered to residents when it arrives in the facility. She stated, Yes, it should.
F 0221 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep each resident free from physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #13 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The care plan, last updated 10/23/15, failed to address the resident's use of upper and lower half side rails. A significant change in status assessment, dated 10/29/15, documented the resident was cognitively intact, required extensive assist for bed mobility and did not use a restraint. On 12/01/2015 8:50 a.m., the resident was observed in bed with the top and bottom half side rails in the up position. On 12/07/2015 9:55 a.m., the resident was observed in bed with the top and bottom half side rails in the up position. At 11:19 a.m., the ADON was asked to locate the side rail assessment for resident #13. She looked under assessment tab in the clinical record and stated it was not there. The ADON then stated the resident had been out of the facility for surgery and would look in medical records for it. At 11:30 a.m., the ADON stated she could not find a side rail assessment for the resident #13. She stated the resident used the side rails for positioning. At 1:41 p.m., the resident was asked about the side rails and if she liked for them to be in the up position when she was in bed. She stated yes so she can move around in the bed as needed. At 2:17 p.m., the MDS (minimum data set)/care plan nurse #1 was asked to review the resident's care plan for side rail usage. After reviewing the care plan, she stated the side rails were not on the care plan. She was asked if side rails were something she would address on the care plan. The nurse stated the residents were not supposed to have full side rails or two half rails. She stated normally the residents were given U bars to use for positioning. She stated they were not supposed to have or use the side rails. Based on observation, record review and staff interview, it was determined the facility failed to complete an assessment for the use of side rails for two (#13 and #116) of three sampled residents reviewed for side rail use. The assistant director of nursing (ADON) identified 11 residents with half side rail use in the facility. Findings: A policy Proper Use of Side Rails, revised October 2010, documented, Purpose The purposes of these guidelines are to ensure the use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms . Side rails are only permissible if they are used to .assist with mobility and transfer of residents . An assessment will be made to determine the resident's symptoms or reason for the using the side rails. When used for mobility or transfer, an assessment will include a review of the resident's: .Bed mobility; and . Ability to change positions, transfer to and from bed or chair, and to stand and toilet . The use of side rails as an assistive device will be addressed in the resident care plan . 1. Resident #116 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A significant change comprehensive assessment, dated 07/22/15, documented the resident did not have a restraint in place. A quarterly resident assessment, dated 10/21/15, documented the resident did not have a restraint in place. Resident #116's clinical record was reviewed. No documentation of a completed assessment for side rail use could be located in the clinical record. On 11/30/15 at 3:47 p.m., resident #116 was observed lying in her bed in the supine position. Both half side rails attached to the top half of the resident's bed were observed in use. On 12/01/15 at 11:17 a.m., resident #116 was observed lying in her bed in the supine position. Both half side rails attached to the top half of the resident's bed were observed in use. On 12/03/15 at 9:46 a.m., resident #116 was observed lying supine in her bed with both side rails up. On 12/07/15 at 10:47 a.m., the director of nursing (DON) was interviewed and asked if an evaluation for side rail use had been completed for resident #116. She stated an evaluation for side rail use had not been completed for the resident. She was asked what the facility policy was for side rail use. She stated an assessment should be completed on each resident prior to side rail use. She stated the assessment had not been completed for resident #116. The DON was asked to describe the reason the side rails were used for the resident. She stated she was unsure as to why the resident had side rails. She stated the staff members might have just gotten used to pulling them up. She stated side rails were not usually on the beds. She stated resident #116 was not physically capable of using side rails for positioning assistance.
F 0226 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** SUPPLEMENTAL Based on record review and staff interviews, it was determined the facility failed to implement their abuse policy to ensure a thorough investigation of injuries of unknown origin was conducted for one (#82) of one sampled resident who had injuries of unknown origin. The facility identified 79 residents resided in the facility. Findings: An abuse investigations policy, documented, All reports of resident abuse, neglect and injuries of unknown source shall be thoroughly and promptly investigated by facility management .Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designees, will appoint a member of management to investigate the alleged incident . the results of the investigation will be recorded on approved documentation forms .The Administrator will provide a written report of the results of all abuse investigations and

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F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) appropriate action taken to the state survey and certification agency .of the reported incident . Resident #82 had [DIAGNOSES REDACTED]. A quarterly resident assessment, dated 11/01/15, documented the the resident's cognition was severely impaired. He was totally dependent on staff for transfers, dressing, hygiene, eating and bathing. Ambulation did not occur. He had lower and upper impairment on one side. A nurse's note, dated 12/25/15 at 12:30 p.m., documented, .Open Wound area (New) on pts (patients) back flank area. 2 appx (approximate) nickel size openings in skin, area surrounding not blanchable and purple in some spots. [MEDICATION NAME] applied. Communication for Wound nurse to eval (evaluate) . A nurse's note, dated 12/25/15 at 1:30 p.m., documented, .Wound measured and documented on pink skin sheet. Open area (with) scant serosanguinous to (no) drainage (with) shiny pink appearance 3.5 cm (centimeters) x (by) 4 cm at longest points (with) 0.1 cm depth. Non blanchable purple area surrounding 14 cm x 6 cm at longest points . A physician telephone order, dated 12/2515, .Clean Wound R (right) flank area (with) normal saline, pat dry, apply [MEDICATION NAME] and border gauze daily until resolved . A physician progress notes [REDACTED].patient has abrasion of right lower back since 12/25/15. his wound is mildly painful . A physician telephone order, dated 01/05/16, documented, .DC (discontinue) wound care to upper Right Flank .Resolved . There was no documentation located in the resident's clinical record that indicated how the resident acquired the wound to his right flank area. On 02/01/16 at 9:30 a.m., the administrator (ADM) was asked to locate documentation in regard to the new wound resident #82 acquired on 12/25/15. At 11:35 a.m., the ADM and director of nursing (DON) were asked if they had located any documentation in regard to the new wound resident #82 acquired on 12/25/15. The DON stated, No. They were asked if they knew how the resident acquired the new wound. The DON stated, No. The DON stated the physician progress notes [REDACTED]. They were asked if there should have been an investigation conducted since it was unknown how resident's injury occurred. The DON stated, Yes. The DON was asked if an investigation was done. She stated not that she was aware of. She was asked if the incident should have been reported to the appropriate agencies. She stated, Yes.
F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** Based on observations and staff interview, it was determined the facility failed to ensure residents were treated in a dignified manner during the dining process for three (#1, 27 and #74) of 26 residents observed during the dinner meal service. The Resident Census and Conditions report, dated 12/01/15, documented 75 residents resided in the facility. Findings: On 12/02/15 at 5:47 p.m., administration #1 was observed standing over resident #74 assisting her with her meal. At 5:50 p.m., certified nurse aid (CNA) #2 and CNA #3 were observed seated at the round assisted dining room table furthest from the kitchen serving window. CNA #8 and licensed practical nurse (LPN) #1 were observed seated at the round assisted dining table closest to the kitchen serving window. All four staff members were observed conversing over resident #27 and #74 seated at the round table closest to the kitchen serving windows. LPN #1 and CNA #8 were observed laughing out loud and carrying on in conversation throughout the dinner meal service for resident #27 and resident #74. The staff failed to engage the residents seated at their table in the conversation. At 5:57 p.m., CNA #9 was observed walking over to the table where resident's #27 and #74 were seated. He squatted down to the level of the table and began conversing with LPN #1 and CNA #8. He failed to engage the residents seated at the table in conversation. CNA #2 was also observed to have left the far round assisted dining table, walked over to the same table and began conversing with the three other staff members at the table. CNA #2 failed to engage resident #27 and resident #74 in the conversation. On 12/08/15 at 5:36 p.m. the administrator and the director of nursing (DON) were informed of the dining observations made. They were asked what the facility policy was for assisting residents during dining. The DON stated it was not acceptable for staff to be speaking with other staff. She stated the staff needed to be engaged with the residents.
F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff and resident interviews, it was determined the facility failed to honor a resident's choice to eat in the dining room for one (#116) of three sampled residents reviewed for residents' choice. The Resident Census and Conditions report, dated 12/01/15, documented 75 residents resided in the facility. Findings: Resident #116 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly resident assessment, dated 10/21/15, documented the resident required two person total assist for transfers and required one person extensive assistance for eating. A care plan, last updated on 10/22/15, documented the resident required extensive to total assist for transfers, locomotion and eating. On 11/30/15 at 11:51 a.m., the lunch dining service was observed in the dining room. Resident #116 was not observed in the dining room throughout the lunch meal service. At 5:10 p.m., the dinner dining service was observed in the dining room. Resident #116 was not observed in the dining room throughout the dinner meal service. At 5:29 p.m., certified nurse aide (CNA) #5 was asked how she determined where the residents ate their meals. She stated some residents just didn't like to go to the dining room. She stated the nurses told her if residents required assistance with eating, they ate in their rooms. On 12/02/15 at 6:03 p.m., CNA #3 was asked how the facility determined where residents ate their meals. She stated the bedbound residents, residents with wounds and residents with a fever or infections all ate meals in their rooms. She stated she tried to bring the rest of the residents down to the dining room. At 6:09 p.m., certified medication aide (CMA) #1 was asked how the facility determined where a resident ate their meals. She stated staff asked the resident where they wanted to eat. She was asked how she would determine where a resident who was unable to communicate would eat. She stated she would ask the nurse. At 6:29 p.m. CNA #4 was asked how he determined where the residents ate their meals. He stated he would ask the resident each day. He was asked how he would determine where a resident who was unable to communicate their needs would eat. He stated if a resident was unable to communicate, they should be eating in the dining room. On 12/03/15 at 8:19 a.m., CNA #10 was observed assisting resident #116 with her breakfast tray in her room. At 8:24 a.m., CNA #10 was asked how the facility determined who ate in their meals in their room and who ate their meals in the dining room. She stated it was a resident's right to choose where they ate if they were of right mind. She stated residents with bed sores depending on what the wound care nurse said about their wounds and bedridden residents ate in their room. She was asked if she knew why resident #116 ate in her room. She stated she did not know why resident #116 ate in her room. She stated the resident was shy and a little depressed. At 10:22 a.m. CNA #14 was observed placing padding on the geriatric chair located in resident #116's room. She was asked where the padding was obtained from. She stated she had gotten the padding from the laundry department. She was asked to explain the purpose of the padding. She stated it was used to relieve pressure. She was asked how well she knew resident #116. She stated the resident came from hall 400. She stated she had cared for the resident for the past eight weeks. She

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MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) was asked how often the staff used the padded geriatric chair for the resident. She stated they used the chair when the resident got up for her meals. She was asked how often the resident got into the chair. She stated the resident was out of her bed and in the chair once a week either for breakfast or for lunch. On 12/08/15 at 8:09 a.m., resident #116 was interviewed and asked if she would like to eat in the dining room with other residents or if she preferred to eat in her room. She stated she would like to eat with other residents. She was asked if staff offered for her to eat in the dining room everyday. She stated they had not. On 12/08/15 at 5:36 p.m., the administrator (ADM) and the director of nursing (DON) were informed of resident #116's desire to eat with other residents in the dining room. They were informed of the resident stating she had not been offered to eat in the dining room. They were asked what the facility policy was for determining where a resident ate their meals. The ADM stated every resident should be given the option to get up for meals. The DON stated every resident, unless they had a medical reason not to, should be offered a chance to go to meals.
F 0244 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Listen to the resident or family groups or act on their complaints or suggestions.** Based on interview and record review, it was determined the facility failed to act upon grievances voiced by residents during council meetings. The Resident Census and Conditions report, dated 12/01/15, documented 75 residents resided in the facility. Findings: On 12/01/15 at 10:00 a.m., the resident council meeting minutes were reviewed from September, October and November 2015. The meeting minutes listed current problems each month. The meeting minutes documented the same repetitive follow up statements each month. On 12/02/15 at 2:00 p.m., an interview was conducted with the resident council president. The council president stated there was no follow up from complaints made from each group meeting. The council president stated, The activity director (AD) writes down our complaints, but I do not know what happens after the meeting. The council president was asked how the group would be informed of a resolution to a reported problem. She replied, the AD would inform us verbally if there was a resolution. The council president stated, There is an on-going problem in several areas in the facility. The council president was asked what problems were not addressed. The council president stated the problem with the over head paging not being used to announce activities. She stated that had affected many of the residents who can not remember when the activities were scheduled. The council president stated, I was informed I would have to write an official grievance. She stated she did write a letter with the assistance of one of the community volunteers. The letter was sent back to the facility with a note saying it was not sent to the correct corporate person. The letter was then sent out again to another person, a lady and she has never heard anything back from anyone. The administrator (ADM) knew all about the letters and has not contacted anyone to see if there has been a decision. The council president stated, This was months ago, we the residents are all frustrated. The council president stated she felt the other staff were not aware of the problems the council were complaining about. She stated the ADM does not write any thing down and said we (the residents) had to file an official grievance. The council president stated the AD had written things down, but she was not sure who received the information after it was written. On 12/08/15 at 4:23:p.m., the AD was interviewed regarding resident grievances. The AD reported he would get a social services grievance form and fill it out after the meeting. He would then turn the form into the appropriate department. The AD was asked how he would receive feed back or follow-up of a reported problem. He reported most of the time he would verbally hear back from the person who was responsible to follow up on the grievance. The AD was asked if the residents were made aware of any resolutions. He reported the council was verbally told. He stated he kept the same follow up on each months meetings to keep it fresh in his mind. At 4:58 p.m., the ADM was interviewed regarding how are resident grievances were followed up on. The ADM stated, There is a pink form filled out and reviewed at the morning meeting. The department it pertains to would receive the grievance. The ADM stated the grievance must be resolved within 24 hours and brought back to morning meeting. The ADM was asked what happened after the form was brought back to the morning meeting. The ADM stated, I then sign the form and it goes into a social services binder. The ADM was asked how the residents were informed of the resolution. The ADM stated, The department head who had the grievance was responsible for speaking with the resident or the council group and inform them of the outcome. The ADM was asked how she ensured the residents or council members were given the grievance resolution information. The ADM stated she depended on the department heads for this. The ADM was asked if the follow up information was given to the residents. The ADM stated, I do not know. The ADM was asked about the resolution from the over head paging grievance. She stated, There really is not a resolution for the over head paging problem. The ADM stated she had spoken with the council president, this was part of our focus on excellence program. The ADM stated it was not home like, that is why our company has chosen to follow this focus on excellence program. The ADM was asked how the residents knew about the daily activities. The ADM stated, I have instructed the activity person and CNAs (certified nurse aides) to go to each resident before the activity was scheduled. The ADM was asked how did she ensure the staff were going to the residents and informing them of each activity. The ADM stated she had depended on her staff for that. The ADM was asked if she had observed the staff going to residents' rooms prior to activities occurring. The ADM stated, I was unaware the staff were not going to the residents to inform them of the activities occurring each day. I will correct the problem.
F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On 12/02/15 at 2:10 p.m., the resident council president was interviewed. The council president stated activities were being missed because the overhead system can no longer be used to announce when any activity occurs. The council president reported this problem began several months ago, and was still on-going. The council president stated there were people who could not read and miss out on the activities because the facility staff do not remind the residents or offer to take them to activities. On 12/03/2015 10:43 a.m., a facility volunteer was interviewed. The volunteer along with a group of ladies has volunteered at the facility for ten years. The volunteer stated they sang songs with the residents, gave the residents snacks and did a devotional once a month. The volunteer stated once a week the group was in the facility and painted the residents nails. The volunteer stated, Once this new rule came into effect our group kept getting smaller and smaller. The volunteer stated, As you can see we do not have hardly anyone here because the residents do not know about any activities. The majority of the residents can not remember when the activities occur in the facility. The volunteer stated, It bothers me because all of us ladies take our time to volunteer and help the residents. She stated she felt they were not helping a lot of the residents anymore. The volunteer stated, Before the staff were informed they could not make the over head announcements we would have half of the dining room full of residents. The volunteer was asked if the staff go to the rooms to announce the activity on the days they are in the building. The volunteer stated, No one has time to do that, the activity man is busy and the social services lady is busy too. On 12/08/15 4:58 p.m., the administrator (ADM) was interviewed and stated, The activity person and certified nurse aides should be going to go to each resident and informing them of the activity. The ADM stated she was unaware the staff were not going to the residents to inform them of the activities occurring each day. The ADM was asked how did she ensure the staff were going to residents and informing them of the activity. The ADM stated, I am changing the activities director on Monday.

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F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) Based on observation, staff and resident interview and record review, it was determined the facility failed to: ~ ensure staff offered and transported the resident to and from daily activities for one (#116) of three sampled residents reviewed for activities and ~ establish an effective means of communicating daily activities to the residents residing in the facility. The Resident Census and Conditions report, dated 12/01/15, documented 75 residents resided in the facility. Findings: An activity evaluation policy, last revised on May 2015, documented, .In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident .The resident's activity evaluation is to be conducted by Activity Department personnel, in conjunction with other staff who will evaluate related factors such as functional level, cognition, and medical conditions that may affect activities participation. The resident's lifelong interests, spirituality, life roles, goals, strengths, needs and activity pursuit patterns and preferences will be included in the evaluation .The activity evaluation is used to develop an individual activities care plan (separate from or as a part of the comprehensive care plan) that will allow the resident to participate in activities of his/her choice and interest .The activity evaluation and activities care plan will identify if a resident is capable of pursuing activities without intervention form the facility . 1. Resident #116 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An activities care plan, last updated 10/22/15, documented the resident can establish their own leisure time due to physical ability and cognitive deficits. It documented, .Goal .Resident will participate in group activities with assistance to and from activity from staff also staff will assist during when needed . Resident will social gatherings and social events with assistance to (and) from socials from staff .Approach .Post calendar of activities in room .Encourage resident to plan their leisure time watching TV .Praise and encourage efforts to pursue leisure/scheduled groups .Visit resident in room if needed .Transport to and from activities .Encourage participation .Praise and thank resident for attending events (and) social gathering . A physician's orders [REDACTED].[MEDICATION NAME] HCL 20 MG (MILLIGRAM) CAPSULE -IE (that is) [MEDICATION NAME] I CAP (CAPSULE) PER PEG TUBE EVERY DAY (DX (DIAGNOSIS): DEPRESSION) . An activities notes, dated 09/16/15, documented, .Resident enjoys watching TV in her room and conversating with people. She needs assistance to and from activities . An activities note, dated 10/14/15, documented, .Resident enjoys watching tv, family visits, and observing other residents. She needs help to and from activities due to limited physical functioning . An activities note, dated 11/25/15, documented, .Resident enjoys socializing, watching tv, and family visits. She needs assistance with activities due to her limited physical function . On 12/01/15 at 11:20 a.m., the hot chocolate activity was observed taking place in the dining room. At this same time resident #116 was observed lying in her bed in her room. No hot chocolate was observed in the resident's room. At 3:27 p.m. the bingo activity was observed taking place in the main dining room. At this same time, resident #116 was observed lying in her bed in her room. On 12/02/15 at 3:26 p.m. a Christmas movie social was observed in process in the main living room. Resident #116 was observed lying in her bed with both eyes open with her television on. On 12/03/15 at 8:09 a.m., resident #116 was interviewed and asked if she would like to participate in the activities in the facility. She stated, Yes. She was asked if staff invited her to daily activities. She stated no. She was asked if she enjoyed watching television. She stated yes. She was asked if she enjoyed socializing with others. She stated she did. She was asked if she enjoyed going outside. She stated she did. She was asked if she would like to be up and out of her room. She stated she would. At 9:41 a.m., the glitzy nails activity was observed in process in the main dining room. At 9:46 a.m., resident #116 was observed lying supine in her bed with both siderails up. She was asked if she enjoyed having her nails painted. She stated, Yes. She was asked if any staff had offered for her to participate and get her nails painted today. She stated no. At 9:55 a.m. the social services director (SSD) was interviewed and asked if resident #116 had a [DIAGNOSES REDACTED]. The SSD was asked what role she played in determining the resident's activity preferences and participation. She stated the activity director (AD) would be the person to ask. She stated she knew resident #116 liked to watch television in her room and enjoyed coming out to the main living area to watch television with others. She was asked what role she played in obtaining any adaptive equipment the resident would need in order to participate in the activities program. She stated the AD would notify her of any items resident #116 needed. She stated she would then determine if family could provide the item of if the facility needed to obtain the item for the resident depending on what the item was. The SSD was asked what services she provided to address resident #116's depression. She stated one time the resident mentioned missing her husband. She stated she called the husband for the resident and he came for a visit. She stated the facility would also try and keep the resident involved in other activities to aid in her depression. The SSD stated she made daily visits Monday through Friday with the resident which lasted approximately four to five minutes in length to check in on her, make sure her tube feeding is dated and to place a cover on her if she is cold. She stated she had also bought a comforter set with her own money for the resident. At 10:42 a.m., the AD was interviewed and asked how long he had been the AD. He stated he had been in the position for two months. He was asked if resident #116 had a [DIAGNOSES REDACTED]. He was asked to describe the resident's activity program. He stated the resident participated in one on one activities. He stated he met with the resident in her room three times a week for thirty minutes. He stated he socialized with her, made sure the television was on the channel she liked and see if she would like music on. The AD was asked if resident #116 ever participated in activities outside of her room. He stated the staff tried to get her up every now and then for lunch. He stated he was unsure if the resident was on a restorative program anymore. He was asked if there was any reason the resident was not able to participate in activities outside of her room. He stated the resident did have wounds. He stated he had been told previously by the wound care nurse that the resident could not be up in her chair for too long because of her wound. He was asked how resident #116 was informed of the planned daily activities. He stated each resident room had an activity calendar in it. He stated the staff were also responsible for going room to room and offering activity participation on a daily basis. The AD was asked how he monitored whether or not resident #116 was offered to participate in daily activities. He stated he could not say that he went to the resident every day and offered her to participate in the activity provided. He was asked if the resident was physically dependent on staff in order to attend activities. He stated yes, staff placed her in her geriatric chair. He was asked if resident #116 would be able to answer whether or not she wanted to attend daily activities. He stated he believed yes she could. He stated the resident did require more encouragement at times. He was asked who was responsible for ensuring the resident was transported to activities. He stated he would tell the nurse 30 minutes prior to the activity that it was about to start. He stated the certified nurse aides (CNAs) as well as the therapy department all helped transport the residents to activities. He was asked how he evaluated the resident's individual activity interests. He stated he completed an assessment to determine what they liked to do and tried to order supplies or buy the items needed to meet their interests. He was asked if he had completed an assessment on resident #116. He stated he had not. He stated he had not interviewed the resident and did not know whether or not she desired to be out of her room for activities. He was asked to review the resident's care plan for activities. He was asked how he monitored whether staff offered the resident to participate in activities. He stated there was no documentation of the resident being offered daily activities. He stated he monitored whether the resident was offered to attend by word of mouth. He was asked if he was aware of how many activities resident #116 had participated in since he had become the activity director. He stated the resident had attended one social, one party and the Thanksgiving dinner. He stated those were the only events he could recall the resident attending in the past eight weeks. On 12/07/15 at 10:49 a.m., the director of nursing (DON) was asked to review resident #116's care plan for activities. She

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F 0248 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) was asked what interventions were in place to meet the resident's activity needs/interests. She stated a calendar was posted in the resident's room. She stated the resident enjoyed watching tv. She stated staff were to encourage the resident to attend activities and provide transportation to and from activities. She stated activities were also supposed to be provided in the resident's room. The DON was asked how the facility monitored whether or not staff were offering the resident to go to daily activities. She stated she did not know. She was asked if staff should offer the resident to attend daily activities. She stated they should. She was asked if resident #116 was physically capable of attending the activities without assistance from staff. She stated, No.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #13 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The care plan, last updated 10/23/15, failed to address the resident's use of upper and lower half side rails. A significant change in status assessment, dated 10/29/15, documented the resident was cognitively intact, required extensive assist for bed mobility and did not use a restraint. On 12/01/2015 8:50 a.m., the resident was observed in bed with the top and bottom half side rails in the up position. On 12/07/2015 9:55 a.m., the resident was observed in bed with the top and bottom half side rails in the up position. At 1:41 p.m., the resident was asked about the side rails and if she liked for them to be in the up position when she was in bed. She stated yes so she can move around in the bed as needed. At 2:17 p.m., the MDS (minimum data set)/care plan nurse #1 was asked to review the resident's care plan for side rail usage. After reviewing the care plan, she stated the side rails were not on the care plan. She was asked if side rails were something she would address on the care plan. The nurse stated the residents were not supposed to have full side rails or two half rails. She stated normally the residents were given U bars to use for positioning. She stated they were not supposed to have or use the side rails. 3. www.drugs.com/pro/[MEDICATION NAME].html (12/09/15) documented, .Warnings and precautions .Increased Mortality, [MEDICAL CONDITION] Infarction, Stroke, and [MEDICAL CONDITION] .In controlled clinical trials of patients with CKD ([MEDICAL CONDITION]) .[MEDICATION NAME] (an alpha drug used to treat [MEDICAL CONDITION]) .increased the risk of death, [MEDICAL CONDITION] infarction, [MEDICAL CONDITIONS] of [MEDICAL TREATMENT] vascular access Resident #150 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. admission orders [REDACTED]. The resident's care plan, dated 10/16/15, documented a problem related to [MEDICAL CONDITION] with [MEDICAL TREATMENT]. It was documented the resident was at risk for shortness of breath, chest pain, itchy skin, [MEDICAL CONDITION], elevated blood pressure, and infections. The goal was the resident would have no complications from the disease process or [MEDICAL TREATMENT] through the next review date. Approaches included to observe for signs and symptoms of complications; monitor access site for redness, bleeding, or pain; observe for effectiveness of medications; and to check the bruit and thrill of the right arm fistula. The care plan did not address the potential side effects or adverse consequences of [MEDICATION NAME] to monitor for or how care would be coordinated between the [MEDICAL TREATMENT] center and the facility. Medication administration records (MARs), dated 11/2015, documented, .Medication has a boxed warning . On 12/07/15 at 4:20 p.m., the DON was asked if the resident received an alpha drug when at [MEDICAL TREATMENT]. She reviewed the clinical record and stated yes. She was asked what side effects and adverse consequences the staff should be monitoring for. She stated she would have to look that information up. She was asked where the potential side effects and adverse consequences be documented. She stated, I guess on the MAR indicated [REDACTED]. She was asked if they should be documented on the resident's care plan. She stated, Yes, they should be. She was asked if they were documented there. She stated, No. Just complications related to [MEDICAL TREATMENT]. On 12/08/15 at 12:43 p.m., MDS/care Plan nurse #1 was asked how the care plan addressed communicating and coordinating care with the [MEDICAL TREATMENT] center. She reviewed the care plan and stated, It does not. She was asked how the care plan addressed the use of an alpha drug and the adverse consequences and side effects to be monitoring for. She stated, It does not. 4. Resident #64 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. admission orders [REDACTED]. The resident's care plan, dated 09/21/15, documented a problem related to the use of [MEDICAL CONDITION] drug use. It was documented the medication was used for dementia with behaviors. The goal was the resident would have controlled behavior or less than three episodes of behaviors per week on the lowest possible dosage of medication. Approaches included to monitor behaviors to assist and assure the lowest possible dose of medication was given; to monitor for side effects, including sedation, weight gain, shuffling gait, dry mouth, constipation, loss of appetite, ataxia, and rigidity; Social Services as needed; providing a calm environment; and psychiatric consultation as needed. The care plan did not address the specific antipsychotic the resident was given, side effects specific to the medication, nonpharmalogical interventions to attempt with the resident in an effort to reduce her medication, or when gradual dose reductions would be attempted. A physician's orders [REDACTED]. The care plan updated 10/26/15 documented emerald hospice added to care plan for terminal illness. The care plan did not address the interventions, approaches or goals for hospice services. A significant change assessment, dated 10/28/15, documented the resident was receiving hospice care while a resident. On 12/08/15 at 11:49 a.m., the DON was asked how the resident's care plan addressed nonpharmalogical interventions to attempt with the resident. She stated it did not other than a calm environment, activities of choice, and family involvement. She was asked where it was documented the staff had attempted those interventions. She stated if they were not in the nurses' notes, she did not know where it would be. She was asked if the care plan address gradual dose reductions. She stated, It says to make sure lowest therapeutic dose is given. It doesn't say we are going to do a gradual dose reduction. On 12/08/15 at 12:36 p.m., MDS/Care Plan nurse #1 was asked how the care plan addressed gradual dose reductions. She stated the care plan documented to monitor behaviors to assist and assure the lowest possible dose was given. She was asked if the care plan addressed when the gradual dose reductions would occur. She stated, No, it does not. She was asked if the care plan addressed the specific drug the resident was taking. She stated, No specific drug. She was asked if the side effects listed were specific for [MEDICATION NAME]. She stated, No. At 5:33 p.m., the assistant director of nurses (ADON) was asked how the care plan addressed the care hospice would provide for the resident. The ADON stated, there was no documentation in the care plan, I do not know what care the hospice staff would provide. The ADON was asked if the care plan should include care hospice services were providing. the ADON stated yes it should. Based on observation, staff interviews and record review, it was determined the facility failed to fully develop care plans for four (#13, 64, 150 and #161) of 47 sampled residents whose clinical records were reviewed for care plans. The Resident Census and Conditions report, dated 12/01/15, documented 75 residents resided in the facility. Findings: 1. Resident #161 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED].[MEDICATION NAME] 125mcg (micrograms) TABLET -IE (that is) [MEDICATION NAME] 1 TAB BY MOUTH EVERY DAY . A physician's orders [REDACTED].LABORATORY ORDERS .CBC (complete blood count), CMP (complete metabolic panel), MAG (magnesium) LEVEL ONCE A WEEK ON MONDAY . A physician's orders [REDACTED].[MEDICATION NAME] HCL 0.1MG (milligram) TABLET -IE [MEDICATION NAME] 1 TABLET BY MOUTH AS

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	375252	A. BUILDING _____ B. WING _____	12/09/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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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 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) NEEDED FOR SYSTOLIC BLOOD PRESSURE < (SIC) 170, RECHECK B/P (blood pressure) AT 1 HOUR AFTER DOSE, IF SYSTOLIC BLOOD PRESSURE REMAINS GREATER THAN 170 MMHG (millimeters of mercury) CALL MD (medical doctor) - NOT TO EXCEED 1 DOSE Q (every) 6H (hour) . A care plan, dated 11/20/15, documented, .PROBLEM .CARDIOVASCULAR PROBLEMS .Dx (diagnosis): CAD ([MEDICAL CONDITION]) .HTN (hypertension) .Other: Afib ([MEDICAL CONDITION]) .GOALS .will not experience any signs and symptoms of cardiovascular problems through next review date .APPROACHES .Observe effectiveness of medication .Monitor vital signs per protocol .Monitor labs when available .(Dig ([MEDICATION NAME]) level) .Administer medications as ordered .notify MD as needed . The November 2015 Medication Administration Record [REDACTED]. The December 2015 MAR indicated [REDACTED]. On 12/08/15 at 10:27 a.m., the director of nursing (DON)was asked how they monitored when to give resident #161's blood pressure medication. She stated, They should be taking his blood pressure. She was asked how often the resident's blood pressure was required to be monitored. She stated, How ever often his [MEDICATION NAME] is able to be given. It should be taken every six hours. She was asked if she could locate where the blood pressure values had been documented. She stated, No. It should be on his nursing notes and it should be on his medication sheet every six hours. They weren't doing it. She was asked if the resident's blood pressure should have been re-checked after the [MEDICATION NAME] was given. She stated, Absolutely. She was asked if the physician had been notified when the medication was not effective. She stated, No. She was asked to locate the section of the care plan that identified blood pressure. She stated, It just says hypertension, give blood pressure medication and notify physician. She was asked if the care plan had been followed. She stated no. At 11:35 a.m., the DON was asked when resident #161 was started on [MEDICATION NAME]. She stated the resident started the medication on 11/12/15. She was asked when the [MEDICATION NAME] levels were monitored. She stated she could not tell. She was asked the signs and symptoms of [MEDICATION NAME] toxicity. She stated she would have to look it up. She was asked how the staff had monitored for toxicity and where it had been documented. She stated it's not documented. She was shown the November 2015 MAR indicated [REDACTED]. She was asked what the policy was for notifying the physician when a medication was not given. She stated if the medication was held three times the physician would be notified. She was asked if the physician had been notified. She stated no. She was asked to locate the [MEDICATION NAME] monitoring on the care plan. She stated it wasn't on the care plan. At 12:00 p.m., licensed practical nurse (LPN) #4 was asked what the policy was for notifying the physician when a medication was held. She stated the physician should be notified when a medication was held three times.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, it was determined the facility failed to revise a care plan to reflect the resident's status for one (#69) of 30 sampled residents whose care plans were reviewed. The Resident Census and Condition Report documented 75 residents resided in the facility. Findings: Resident #69 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The INDIVIDUAL RESIDENT CARE PLAN-A, dated 09/21/15, documented the resident was alert and oriented and required assistance with repositioning every two hours. A care plan, dated 09/22/15, documented the resident had altered skin integrity on both glutes, superior and inferior trochanter, right ischium and right hip. The goal was to have no complications related to (r/t) skin alteration. Approaches included: provide treatment as ordered. Provide turning and repositioning frequently. Keep clean and dry. The care plan did not include the open wound on the resident's right buttock. The SKIN GRID - OTHER SKIN PROBLEMS sheet, dated 09/22/15, did not include weekly documentation of observation of the resident's buttocks. The sheet documented observations of the left lower medial thigh, the right shin and the left hip. The last day observation of the wounds were documented on 09/28/15. The sheet documented skin observations for the month of October were made on 10/02/15, 10/09/15, 10/14/15, 10/29/15 and 10/29/15. An admission assessment, dated 09/28/15, documented the resident was cognitively intact and did not exhibit rejection of care. The assessment documented the resident required two person extensive assistance with bed mobility, dressing and bathing and required one person extensive assistance with toilet use and personal hygiene. The assessment documented the resident had lower extremity impairment on both sides. The assessment documented the resident had an ostomy and was not on a toileting program. The assessment documented the resident had one unhealed stage II pressure ulcer. The assessment documented the resident had moisture associated skin damage, received pressure ulcer care and had application of non surgical dressings. The October 2015 treatment sheet documented the resident did not receive magic butt paste as ordered or wound care as ordered on [DATE]. The October 2015 functional performance sheet documented the resident received incontinent care two times on the day shift for a total of 11 times and no incontinent care one time during the day shift. The evening shift documented the resident received incontinent care three times during the shift on six days. The sheet documented the resident received incontinent care two times during the shift for a total of six days. The night shift documented 11 times incontinent care was performed, three times during the shift for 11 days, and performed two times during the shift for two of the days. The other days did not include incontinent care had been performed. Incontinent care was provided three times a shift for 14 of the 16 days, and performed two times on one day, there was no documentation of incontinent care for 10/31/15. Bathing was documented to have occurred five times on the 7th, 9th,16th, 23rd and 26th of October 2015. There was no November 2015 documentation of a SKIN GRID-OTHER SKIN PROBLEMS sheet in the clinical record. The November 2015 treatment sheet documented the resident did not receive wound care as ordered on the 11/12/15, 11/ 23/15, 11/ 25/15, 11/ 27/15 and 11/30/15. November 2015 functional performance sheet documented the resident received incontinent care three times during the day shift all days except on the 28th, 29th and 31st. The functional performance sheet documented incontinent care occurred two - three times during the evening shift, and two - three times during the night shift. Bathing was documented to have occurred seven times in November. The December 2015 SKIN GRID - OTHER SKIN PROBLEMS sheet documented a skin tear on the resident's left upper thigh on 12/03/15. The sheet documented measurements for a surgical wound at the left lower medial thigh, the right shin and the left hip on 12/04/15. There was no documentation of observation of the resident's buttocks for December 2015. The December 2015 treatment sheet documented the resident did not receive wound care as ordered on [DATE], and the magic butt paste was not applied as ordered on [DATE]. December 2015 functional performance sheet documented the resident received incontinent care three times on the day shift. Two days had no documentation of incontinent care provided. The evening shift documented the resident received incontinent care two times during the shift for a total of four days. The night shift documented the resident received incontinent care three times during the shift for a total of six times. The December 2015 physician's orders did not include an order for [REDACTED]. Apply xeroform cover with foam, change on Monday, Wednesday and Friday. Additional orders: follow facility pressure ulcer prevention policy/protocol, offload heels per policy, pressure relief/off loading. A wound progress note, dated 11/24/15, documented the resident's right lower leg stage IV pressure ulcer was not healed. The measurements were 3 centimeter (cm) x 2 cm x 0.1 cm. The Left superior trochanter stage III pressure ulcer was not healed and measured 9 cm x 3 cm x 0.1 cm.

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F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) There was no documentation of an assessment of the resident's buttocks in the progress note. On 12/02/2015 at 1:01 p.m., the resident was asked how many times each shift the staff assist her with incontinent care. The resident stated she often had to wait to be changed because the staff would say they need two people. The resident she was able to roll herself over and they could do it with out the other person. The resident stated the staff told her it was the policy. On 12/07/15 at 10:05 a.m., the resident's buttocks were observed with licensed practical nurse (LPN) #3 and certified nurse aide (CNA) #12. The resident was rolled over to the left side. The resident was observed to have three pads under her which were saturated with dark yellow urine. The incontinent pads were noted to have a very strong urine odor. The resident was observed to have an open area at her right buttock. The open area was observed to be bleeding. LPN #3 was asked what the area was. She stated it looked like an abrasion to her. The LPN stated there was currently an order for [REDACTED]. She stated there was a wound care nurse who is no longer at the facility who provided all wound care. She stated each charge nurse started performing wound care on their residents a week ago because the wound care nurse was no longer working for the facility. The skin around the open area on the right buttock was observed to be bright pink. The surrounding skin on the buttock was white in color and macerated. When the LPN left the room to obtain a measuring tape, CNA #12 stated the open area on her buttock had been there for a couple of weeks. The CNA stated, I reported this area to the wound care nurse when I had first observed the open area. The resident stated, That is right, she told the wound care nurse the day she found the area. The resident stated, The wound care nurse (Name deleted) came to see me that day and put some kind of gauze dressing on the open area, but it would not stay on my skin. The LPN came back into the room and measured the open area. She stated the open area was 4 cm x 2 cm. The CNA was asked about in-services on how to turn and reposition a resident or in-services about incontinent care and how often they should be done. The CNA stated, We always get in-services on those things. At 10:34 a.m., the director of nurses (DON) was interviewed regarding who was responsible for wound care. The DON stated, We had a wound care nurse up until last Monday, 11/30/15, when she skipped out on us. At 1:43 p.m., LPN #3 was interviewed regarding what was ordered for the resident's buttocks. She stated the wound care order was initially for the resident's bottom, it was magic butt paste. The LPN stated the nurses were to apply as ordered. She was asked if the care plan documented the resident had an open area on her right buttock. The LPN stated it was not included on the resident's care plan. At 2:08 p.m., the DON was asked how long the resident had the open area on the right buttock. She stated there was no documentation in the record regarding how long the wound was there. The DON was asked if the resident's care plan was updated to reflect the open area on the resident's right buttock. She stated the open area was not included in the care plan. The DON stated there was an order written [REDACTED]. She was asked if there was any other treatment ordered for this open area prior to today. The DON stated, No, I can not say there were any other wound care orders. On 12/08/15 at 10:00 a.m., the DON was asked what the policy was for staff to report open areas. She stated, Anytime an area is observed, it would be reported to any nurse. The DON was asked when CNA # 12 reported the open area to the wound care nurse. She stated, I do not know if the CNA informed anyone, I have not talked to her. The DON was asked where the nurse would document the new open areas. She stated, In the nurse notes.
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #131 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. admission orders [REDACTED]. An incident report, dated 08/11/15, documented, .was admitted on [DATE] from .next door. She was non responsive to stimuli including a sternal rub on admission. A rapid response was called and she was administered [MEDICATION NAME]. She then became somewhat responsive. After a few minutes the nurse left the room. A few minutes later (resident #131) was noted to be on the floor. She had a knot forming on the top of her forehead. After assessment, the physician was notified and ordered (resident #131) to be sent to (hospital name deleted) to have a computed tomography (CT) of the head .The CT of the head was negative and (resident #131) was sent back to us. Her assessments were completed. Interventions put in place are bed in lowest position and fall mats to the side of bed .She was evaluated by and picked up on PT, OT and ST (physical, occupational, and speech therapies) . An individual resident care plan, dated 08/11/15 documented the resident was at risk for falling due to a history of falls, altered mental status, and medications. It was documented a low bed with fall mats was in place. An update to the individual care plan, dated 08/12/15, documented the resident received [MEDICATION NAME]. The goal was there would be no signs or symptoms of bleeding. The intervention was to observe for signs and symptoms of bleeding. A nurse's note, dated 8/15/15 at 2:00 a.m., documented, .Resident noted on floor mat next to bed. Incont (incontinent) of loose BM (bowel movement). Cleaned (and) assisted back to bed. No (complaint of) pain It was documented the resident's vital signs were obtained, and they were within normal limits for the resident. It was documented that frequent checks would be completed. There was no documentation neurological checks were started for the unwitnessed fall; that the facility assessed and monitored for bleeding; or that the physician was notified of the fall. There was no documentation of frequent checks. There was no documentation any new interventions had been identified or implemented to aid in the prevention of falls or that the facility had attempted to identify the root cause of the fall. A nurse's note, dated 08/15/15 at 5:00 a.m., documented frequent rounds were made after the resident fell , but there was no documentation of the rounds. An admission assessment, dated 08/18/15, documented the resident had long and short term memory problems and was moderately impaired in cognitive skills for daily decision making. It was documented the resident required extensive assistance for bed mobility, transfers, and dressing. It was documented she was totally dependent for locomotion, eating, personal hygiene, and bathing. It was documented the resident was always incontinent of bowel and bladder, and had one fall without major injury since admission. The resident's care plan, dated 08/19/15, documented a problem related to being at risk for falls. The goal was the resident would have no falls with or without injury through the next review date. Approaches included to place on fall program, assist with transfers, ambulation, and bed mobility; to keep the call light within reach; assure proper footwear was used; and to observe for side effects from medications. The care plan was updated on 08/20/15 with an intervention to use a low bed and fall mats. Another problem was the resident was at risk for bleeding and/or bruising related to the use of anti-coagulant medications. The goal was the resident would not have any bleeding or bruising through the next review date. Approaches included to observe for medication effectiveness; to observe the resident for blood blisters, bruising, blood in the stool, and easily bleeding; to obtain labs as ordered; and to assess the environment for any needed changes. A nurse's note, dated 08/23/15 at 6:25 a.m., documented, .Pt (patient) found on mat left side of bedside. Pt awake, resp (respirations) even (and) unlabored .No new bruise seen or skin tears on pt. Incont care given . It was documented the resident's vital signs were obtained, and they were within normal limits for the resident. There was no documentation neurological checks were started for the unwitnessed fall; that the facility assessed and monitored for bleeding; or that the physician was notified of the fall. There was no documentation any new interventions had been identified or implemented to aid in the prevention of falls or that the facility had attempted to identify the root cause of the fall. A nurse's note, dated 08/29/15 at 10:30 a.m., documented, .this nurse was notified by CNA stating resident was lying bedside bed on floor mats. Upon entering room nurse notes resident lying on left side of bed into floor mat c (with) head handing (sic) off lying on pedals of the peg tube pole. Nurse and CNA assisted resident on to back. Notes discoloration to middle of forehead. (No) skin openings, swelling or any other discolorations noted @ this time. Resident alert c some confusion noted .Resident c/o pain unable to describe locations and rate pain .Noted resident was dirty (large) BM noted in brief

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F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) .Nurse educated staff that resident needs to changed (sic) (every) 2 (hours) . A progress note, dated 08/29/15 and untimed, documented, .Nurse notes discoloration to middle of forehead. Resident c/o general pain moaning when assisting c care of getting back into bed . An incident report, dated 08/29/15, documented, .nurse was notified by staff regarding resident on floor. Upon entering nurse noted resident lying on (left) side of bed on floor mats c head hanging off mats unto pedals of peg tube pole. Alert c some confusion . On 12/07/15 at 1:56 p.m., LPN #3, who was the nurse for the resident on 08/29/15, was asked if the resident could walk. She stated she could help with assistance. She was asked if the resident could reposition herself in bed. She stated the resident moved around a lot in bed. She was asked if the resident was at risk for falls. She stated, Yes. LPN #3 was asked what happened when the resident fell on [DATE]. She stated, They told me she was on the floor. She was asked what caused the resident's fall. She stated, I couldn't say exactly what caused the fall. LPN #3 was asked who identified interventions to aid in the prevention of falls. She stated, We try to do something right then and there, and then the DON follows up. She was asked how staff was made aware of any interventions identified by the DON. She stated, They come back and tell us or you can go back and look at the care plan. She was asked how the aides were informed of the interventions. She stated they tried to get the aides right at the time of the incident. LPN #3 was asked if the resident was being monitored for any thing in particular. She stated the resident was at risk for bleeding, so they would have been monitoring for signs and symptoms of bleeding. She was asked if she had monitored the resident for bleeding after the fall on 08/29/15. She stated, No. She was asked which physician she notified. She stated she notified physician #3 because he was on call for physician #1. She was asked if she informed physician #3 the resident was receiving [MEDICATION NAME]. She stated, I can't remember if I said that or not. She was asked if she documented that she informed the physician. She stated, No, I didn't. On 12/07/15 at 2:11 p.m., the DON was asked if the resident was at risk for falls. She stated, Yes. She was asked if the resident had falls while at the facility. She stated, Yes. She stated the resident had experienced a fall within the first few minutes of being at the facility. The DON was asked what interventions were implemented at that time. She stated a fall mat and low bed were implemented. The DON was asked what the root cause of the fall was. She stated the resident had received emergency care and she woke up and tried to get up and fell . The DON was asked how many falls the resident had at the facility. She reviewed the clinical record and stated the resident had three falls. She was asked when the resident fell . She reviewed the record and stated 08/11/15, 08/15/15, 08/23/15, and 08/29/15. The DON was asked where the incident reports were for the falls on 08/15/15 and 08/23/15. She reviewed the incident reports and stated she could not find one for those falls. The DON was asked what the root cause was for the resident's falls. She stated, I don't know right off. I knew about the first fall. That's the only one that sticks in my head. She stated, As far as the others, I don't know. The DON was asked what the facility's policy was on determining root causes of falls. She stated falls were reviewed in clinical meetings and they tried to figure out what happened and why. She was asked if the resident's falls were reviewed. She stated, The first one, yes. The DON was asked when the fall mat and low bed were implemented. She stated it was when the resident returned to the facility after the first fall. She was asked what interventions were identified and implemented after the fall on 08/15/15. She stated, I didn't know about that. That wasn't told to me. She stated the nurse had documented she implemented frequent checks but there was no documentation of the checks. She was asked which physician was notified of the falls on 08/15/15 and 08/23/15. She stated, It doesn't appear there was a physician notified if this is all the documentation I have. She was asked where other documentation would be. She stated on the incident reports. She was asked where the incident reports were. She stated they did not have one for the falls. The DON was asked if the resident was supposed to be monitored for signs and symptoms of bleeding. She stated, Yes. She stated it was documented on the resident's care plan. The DON was asked to show where it was documented the resident was assessed for signs and symptoms of bleeding following the falls on 08/15/15 and 08/23/15. She reviewed the clinical record and stated, I don't see they have charted anything. She was asked if there was documentation of neurological checks following those falls. She stated, No. She stated she was not aware of those falls. The DON was asked what the facility's policy was for completing neurological checks. She stated they should be completed with any unwitnessed fall or fall with a head injury. She was asked how she expected staff to assess, monitor, and intervene for a resident who was receiving an anti-coagulant medication and experienced an unwitnessed fall. She stated they should complete neurological checks, observe for differences in vital sign, and look for bruising and bleeding. She stated the physician should be contacted and informed the resident was receiving an anti-coagulant. She stated the resident would most likely be sent out for further evaluation. The DON was asked if the resident was receiving an anti-coagulant medication. She stated yes, [MEDICATION NAME]. The DON was asked how she ensured the staff assess, monitored, and intervened for residents with falls and those experiencing a change in condition and if the physician was notified as necessary. She stated incident reports were reviewed and the charts were monitored to ensure everything was done. She was asked who monitored to ensure incident reports were completed. She stated on weekends, it was the supervisor's responsibility to ensure the DON was notified and then nursing would follow up on them. The DON was asked what caused the resident's falls. She stated, I can't tell you. A lot of residents roll out of bed onto their floor mats. On 12/07/15 at 4:31 p.m., the DON was asked how the facility was implementing the care plan when they did not assess and monitor for bleeding, notify the physician of falls, determine root causes of falls, or identify and implement interventions to aid in the prevention of falls. She stated, They (staff) aren't. 3. Resident #85 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. admission orders [REDACTED]. It was documented the resident was to be monitored for signs and symptoms of bleeding every shift. An admission assessment, dated 10/30/15, documented the resident was cognitively impaired and had no behaviors or [MEDICAL CONDITION]. It was documented the resident required extensive assistance of two people for bed mobility; transfers; locomotion on and off the unit; and dressing, eating, toileting, and personal hygiene. It was documented the resident was not steady when moving from a sitting to standing position or with surface to surface transfers. It was also documented the resident had an indwelling urinary catheter and was always incontinent of bowel. It was documented the resident had received an anticoagulant medication on seven of the previous seven days. It was also documented it could not be determined whether the resident had falls prior to admission to the facility. The resident's care plan, dated 11/02/15, documented a problem related to the resident being at risk for falls due to [DIAGNOSES REDACTED]. The goal was the resident would have no falls, with or without injury, through the next review date. Approaches included to assist with transfers and bed mobility; keep the call light within reach; use proper footwear; observe for side effects from medications; remind to utilize assistive devices; provide adequate lighting; keep pathways free and clear of any objects; monitor for wet/slippery floors; therapy to evaluate and treat as ordered; use a wheelchair for mobility; and medications as ordered for [MEDICAL CONDITION]. Another problem was documented as the resident being at risk for bleeding and/or bruising related to the use of [MEDICATION NAME]. The goal was the resident would not have any bleeding or bruising through the next review date. Approaches included to observe effectiveness of medications; observe resident for blood blisters, bruising, blood in stool, or easy bleeding and notify MD promptly; labs as ordered, paying close attention to lab values including hematocrit, hemoglobin, and red blood cell levels; and to assess the environment for the needed changes. It was also documented to pay close attention to the resident. The medication administration records (MARs), dated 10/2015, documented the resident received Aspirin 325 mg one tab daily from 10/24/15 through 10/31/15. It was also documented the resident received [MEDICATION NAME] 40 mg subcutaneous daily from 10/24/15 through 10/31/15. It was documented the resident was monitored for signs and symptoms of bleeding from 10/24/15 through 10/31/15.

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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 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) Physician's monthly orders, dated 11/2015, documented the resident was to receive [MEDICATION NAME] 40 mg subcutaneous every day for blood thinning and Aspirin 325 mg every day. The MARs, dated 11/2015, documented the resident received Aspirin 325 mg one tab daily from 11/01/15 through 11/13/15. It was also documented the resident received [MEDICATION NAME] 40 mg subcutaneous from 11/01/15 through 11/07/15 and from 11/09/15 through 11/12/15. An incident report, dated 11/12/15 at 5:50 a.m., documented a family member and physician #1 were notified. It was documented a head to toe assessment was completed. A departmental note, dated 11/12/15 at 6:24 a.m., documented, .Patient observed this am on floor at his bedside, bed in low position, awake and alert, ROM done to all extremities, all WNL (within normal limits) at this time, no S/S (signs or symptoms) of pain or discomfort, patient assisted to bed x 2 assist, call light in reach and operable. Family and doctor aware . Review of the clinical record revealed no documentation the facility attempted to determine the root cause of the resident's fall. There was no documentation he was assessed and monitored for signs and symptoms of bleeding after the fall. An incident report, dated 11/13/15 at 9:45 p.m., documented, .staff reported patient on the floor,went to room patient laying on left side propped up by left elbow, alert oriented to person, skin tear to left elbow patient denies pain or discomfort assisted to bed cleansed skin tear with normal saline, covered with island dressing neuros started, range of motion within normal limits grasp equal, pupils equal and reactive to light . It was documented physician #1 was notified immediately. It was documented the family was not notified until 3:45 a.m. on 11/14/15. A post-incident actions sheet, dated 11/13/15 at 9:45 p.m., documented the immediate post-incident action was to start neurological checks and hourly monitoring. A neurological assessment flowsheet, dated 11/13/15 at 9:45 p.m. through 11/14/15 at 3:30 a.m., documented the resident's blood pressure increased from 112/64 at 9:45 p.m. on 11/13/15 to 141/72 at 2:30 a.m. on 11/14/15. It was documented the resident's pulse rate increased from 69 beats per minutes (bpm) to 103 bpm. Review of the clinical record revealed no documentation the resident's physician was notified of the increasing blood pressure or pulse rate. A departmental note, dated 11/14/15 at 3:15 a.m., documented, .Patient observed at this time on nursing rounds unresponsive, no pulse palpable, observed no rise or fall of chest, Unit manager notified, family .notified .(physician #2) notified. N/O (new order) received (sic) to release body to funeral home . On 12/03/15 at 8:22 a.m., LPN #6 was asked who physician #1 was. He stated he was the physician for long term care residents. She was asked who physician #2 was. She stated he was one of the doctors for residents on skilled services. She was asked if a resident was on skilled services, which physician was to be notified if needed. She stated one of the skilled service physicians, including physician #2. She was asked if it would be okay to call physician #1 instead. She stated, No, you shouldn't. On 12/03/15 at 8:26 a.m., LPN #7 was asked if the resident could walk. He stated he did not think so. He was asked if the resident could reposition himself in bed. LPN #7 stated the resident moved around a lot and he would have to be repositioned. He stated the resident would get his legs off the bed. He was asked if the resident was at risk for falls. He stated yes, because of the [MEDICAL CONDITION] diagnosis. LPN #7 was asked what happened when the resident experienced his first fall. He stated, His bed was in the low position. I just remember him. He didn't have any open areas or hematomas like he had bumped his head or anything like that. He was asked what caused the resident's fall. He stated he thought it was because the resident was trying to get out of bed. LPN #7 was asked what medications the resident was on that put him at increased risk for bleeding. He stated he did not recall any. He was asked if the resident was being monitored for anything in particular. He stated nothing that he could recall at this time. LPN #7 was asked which physician had been notified regarding the fall. He stated he would be the physician noted on the incident report. LPN #7 was informed physician #1 was identified on the incident report. He was asked if the resident was on skilled services or long term care services. He stated he believed he was on skilled services. LPN #7- was asked if physician #1 was the physician for skilled services. He stated no, but he was the medical director and would be the physician to call in call another could not be reached. LPN #7 was asked if he had informed physician #1 the resident was receiving aspirin and [MEDICATION NAME], which put him at increased risk of bleeding. LPN #7 stated he did not recall notifying the doctor of that. He stated, I don't believe so. He was asked how he assessed and monitored for complications after a fall. LPN #7 stated any unwitnessed fall was followed with neurological checks. On 12/03/15 at 9:18 a.m., the DON was asked who the nurse was when the resident experienced his second fall. She stated the nurse was no longer employed at the facility. On 12/03/15 at 9:22 a.m., CNA #6 was asked if the resident had been at risk for falls. He stated he thought so. He was asked how he would have known. He stated when a resident arrived at the facility, he would check to see if there was a fall risk bracelet in place from the hospital, or he would ask the nurse if the resident was at risk. He stated if he thought they were at risk for falls, he would put fall mats in place and make sure the bed was in the low position. He was asked if the nurses told the CNAs that residents were at risk for falls. He stated they figured it out on their own mostly. CNA #6 stated he would get a bed alarm as well and let the nurses know so they could get an order. CNA #6 was asked if the resident had experienced any falls. He stated, I came in one it me and found him sitting in the floor by the bed. He stated he found the resident at shift change, at approximately 5:45 or 5:50 a.m. He was asked what caused the resident's fall. He stated he did not know. He was asked what he did when he found the resident. He stated he notified the nurse, they obtained vital signs, and put the resident back in bed. CNA #6 was asked if he was informed of any new interventions after the fall. He stated no. On 12/03/15 at 10:09 a.m., the DON was asked if the resident had been at risk for falls. She reviewed the clinical record and stated, Yes, I would say that he was. She stated it was not documented the resident had a previous fall, but it was documented he had confusion. She stated the family member had reported the resident was able to ambulate prior to being hospitalized . She was asked if the resident had experienced falls while at the facility. She stated she thought he had two or three falls, occurring on 11/12/15 and 11/13/15. The DON was asked what had been determined to be the root cause of the resident's falls. She stated, I am not really sure what the root cause was. I was not here. I was on vacation when this occurred. She was asked who had been responsible during her absence. She stated both ADON #1 and #2. The DON was asked what the facility's policy and procedure was for determining root causes of falls. She stated that whenever a fall occurred, the facility tried to drill down and figure how what caused the falls. She stated with resident #85, there were several reasons for the resident to fall, including confusion and the ability to walk prior to hospitalization . She was asked where the investigation into the root causes of the resident's falls was documented. She stated, There wasn't one on these forms (incident reports). She was asked if that was where root cause investigations were documented. She stated, Yes, and what interventions were put into place. The DON was asked what interventions were put into place after the resident's first fall. She stated, According to this, it doesn't show anything. She reviewed the clinical record and stated a fall mat and low bed had been initiated on admission. She was asked if any new intervention had been identified and implemented. She stated, It does not appear to (be). It says something about frequent monitoring. She stated the incident report had documented frequent monitoring would occur. The DON was asked where the documentation of frequent monitoring was. She reviewed the clinical record and stated, I don't know. I don't see it. The DON was asked which physician had been notified of the first fall, according to the documentation. She stated physician #1 was notified. She was asked who he was. She stated he was a physician for the long term care residents. The DON was asked if physician #1 had knowledge of the residents receiving skilled services. She stated, I do not believe so. She was asked if resident #85 was receiving skilled services. She stated, Yes. She was asked who the resident's physician was. She stated it was physician #2. The DON was asked why physician #2 was not notified. She stated, I cannot tell you that. She was asked who should have been contacted. She stated, (Physician #2) or the doctor on call for him. She was asked if physician #1 covered for physician #2. She stated, No. The DON was asked if physician #1 had been notified the resident was receiving [MEDICATION NAME] and aspirin. She stated, It does not say that in the documentation.

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	375252	A. BUILDING _____ B. WING _____	12/09/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) The DON was asked which physician had been notified of the second fall, according to the documentation. She stated, (Physician #1). She was asked if physician #1 had ever seen the resident. She stated, Not to my knowledge. The DON was asked how she expected staff to monitor residents for potential complications after having experiencing a fall. She stated neurological checks were to be completed after every unwitnessed fall. She was asked where the documentation was of the neurological checks following the first fall. She reviewed the clinical record and stated, It doesn't appear that he (LPN #7) started them. She was asked what the neurological checks following the second fall showed. She stated they showed the resident's vital signs were changing. She was asked if the physician had been notified of these changes. She stated, It does not appear that way. She was asked if the family member had been notified of the second fall. She stated, It doesn't appear that she was. The DON stated the family should have been notified of the second fall. The DON was asked how the resident was assessed and monitored after the falls. She stated that neurological checks had been completed after the second fall and a fall and pain evaluation had been completed after the first fall. She was asked what medication the resident took that put him at increased risk for bleeding. She stated aspirin and [MEDICATION NAME]. She was asked how the staff took into account the increased risk for bleeding in relation to the two unwitnessed falls the resident experienced. She stated, It does not appear they did. The DON was asked how she expected her staff to react to changing vital signs, including an increasing blood pressure and pulse, for a resident who had experienced two unwitnessed falls. She made no comment. She was asked how the staff intervened with the resident's changing vital signs. She stated, They should have notified the physician. The DON was asked how she monitored her staff to ensure they assessed, monitored, and intervened as necessary when residents experienced a fall or change in condition. She stated incident reports were reviewed during daily clinical morning meetings and the ADONs reviewed the charting. She was asked if a concern had been identified with the resident's falls and the lack of assessing, monitoring, and intervening as necessary to a changing condition. She stated, It does not appear we did. She was asked if the monitoring system was working. She stated, It needs some tweaking it appears. The DON was asked what the staff could have done differently. She stated, Initiated neuros on the first fall, notified the right physician, notified him of the meds, and notified with changes on the neuro checks. On 12/03/15 at 11:45 a.m., the resident's family member was asked if the resident could walk or reposition himself in bed. She stated, No. She was asked how many falls the resident experienced while at the facility. She stated he had one fall. On 12/03/15 at 11:53 a.m., physician #2 was asked if he was aware the resident had experienced two falls while at the facility. He stated he did not remember being informed of the falls, but that it had been awhile since the resident was at the facility. He stated he had visited with the resident on 11/11/15. Physician #2 asked who was notified of the falls, according to the documentation. He was informed it was physician #1. He stated he did not know why they called physician #1 as he was the resident's physician. On 12/07/15 at 4:31 p.m., the DON was asked how the facility was implementing the care plan when they did not assess and monitor for bleeding, determine root causes of falls, or identify and implement interventions to aid in the prevention of falls. She stated, They (staff) aren't. 4. Resident #150 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's care plan, dated 10/16/15, documented a problem related to [MEDICAL CONDITION] with [MEDICAL TREATMENT]. It was documented the resident was at risk for shortness of breath, chest pain, itchy skin, [MEDICAL CONDITION], elevated blood pressure, and infections. The goal was the resident would have no complications from the disease process or [MEDICAL TREATMENT] through the next review date. Approaches included to observe for signs and symptoms of complications; monitor access site for redness, bleeding, or pain; observe for effectiveness of medications; and to check the bruit and thrill of the right arm fistula. admission orders [REDACTED]. An admission assessment, dated 10/23/15, documented the resident was cognitively intact and received [MEDICAL TREATMENT] services. A care plan, dated 10/27/15, documented the resident had a potential for injury related to a [DIAGNOSES REDACTED]. Approaches included to observe the effectiveness of medications. A physician's progress note, dated 11/11/15, documented, .Protein-calorie malnutrition. Increase the protein diet . There was no documentation in the clinical record the order was noted. On 12/07/15 at 4:01 p.m., LPN #9 was asked who reviewed physician progress notes [REDACTED]. She was asked who was responsible for ensuring any orders on progress notes were noted and implemented. She stated the unit managers were. She was asked what type of diet the resident received. She stated he received a four gram sodium restricted diet. On 12/07/15 at 4:17 p.m., the assistant dietary manager was asked what type of diet did the resident receive. She stated a regular, sodium restricted diet. On 12/07/15 at 4:20 p.m., the DON was asked who was responsible for noting orders written on progress notes. She stated the nurses were. She was shown the physician progress notes [REDACTED]. She stated that particular physician did not write his progress notes when making rounds. She stated he wrote them off-site and when he returned, he brought them with him. She stated his progress notes went directly to medical records and then on to the chart. She was asked if the order had been noted and implemented. She stated, No. On 12/07/15 at 4:01 p.m., LPN #9 was asked how the facility communicated and coordinated care with the [MEDICAL TREATMENT] center. She stated there were [MEDICAL TREATMENT] books, and the [MEDICAL TREATMENT] center would call if there was something out of the ordinary. She was asked if the resident received an alpha d
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to: ~ Assess, monitor, and intervene for two (#85 and #131) of two sampled residents who received anti-coagulant medications and experienced falls. The facility identified three residents as receiving [MEDICATION NAME], an anti-coagulant; and ~ Turn and reposition and provide incontinent care for one (#69) of two sampled residents who were reviewed for care of surgical wounds; and ~ Turn and reposition and provide surgical wound care in a manner to prevent cross-contamination for one (#116) of two sampled residents reviewed for care of surgical wounds. The facility identified four residents with surgical wounds; and ~ Coordinate care with the [MEDICAL TREATMENT] center for one (#150) of one sampled resident who was reviewed for [MEDICAL TREATMENT]. The facility identified seven residents who received [MEDICAL TREATMENT] services; and ~ Coordinate care with hospice for one (#64) of one sampled resident who was reviewed for hospice services. The facility identified ten residents who received hospice services. Findings: www.drugs.com/pro/[MEDICATION NAME].html (12/09/15) documented, .Warnings and precautions .Increased Mortality, [MEDICAL CONDITION] Infarction, Stroke, and [MEDICAL CONDITION] .In controlled clinical trials of patients with CKD ([MEDICAL CONDITION]) .[MEDICATION NAME] (an alpha drug used to treat [MEDICAL CONDITION]) .increased the risk of death, [MEDICAL CONDITION] infarction, [MEDICAL CONDITIONS] of [MEDICAL TREATMENT] vascular access The facility's policy on falls, dated 09/2012, documented, .The staff will evaluate and document falls that occur while the individual is in the facility .For an individual who ha fallen, staff will attempt to define possible causes within 24 hour of the fall the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall . A repositioning policy, last revised May 2013, documented, .The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents . Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief .Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .Notify

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MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 12) the supervisor if the resident refuses the care . 1. Resident #131 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. admission orders [REDACTED]. An incident report, dated 08/11/15, documented, .was admitted on [DATE] from .next door. She was nonresponsive to stimuli including a sternal rub on admission. A rapid response was called and she was administered [MEDICATION NAME]. She then became somewhat responsive. After a few minutes the nurse left the room. A few minutes later (resident #131) was noted to be on the floor. She had a knot forming on the top of her forehead. After assessment, the physician was notified and ordered (resident #131) to be sent to (hospital name deleted) to have a computed tomography (CT) of the head .The CT of the head was negative and (resident #131) was sent back to us. Her assessments were completed. Interventions put in place are bed in lowest position and fall mats to the side of bed .She was evaluated by and picked up on PT, OT and ST (physical, occupational, and speech therapies) . An individual resident care plan, dated 08/11/15 documented the resident was at risk for falling due to a history of falls, altered mental status, and medications. It was documented a low bed with fall mats was in place. An update to the individual care plan, dated 08/12/15, documented the resident received [MEDICATION NAME]. The goal was there would be no signs or symptoms of bleeding. The intervention was to observe for signs and symptoms of bleeding. A nurse's note, dated 8/15/15 at 2:00 a.m., documented, .Resident noted on floor mat next to bed. Incont (incontinent) of loose BM (bowel movement). Cleaned (and) assisted back to bed. No c/o (complaint of) pain It was documented the resident's vital signs were obtained, and they were within normal limits for the resident. It was documented that frequent checks would be completed. There was no documentation neurological checks were started for the unwitnessed fall; that the facility assessed and monitored for bleeding; or that the physician was notified of the fall. There was no documentation of frequent checks. There was no incident report of the fall. A nurse's note, dated 08/15/15 at 5:00 a.m., documented frequent rounds were made after the resident fell . There was no documentation of the resident's condition during these rounds. An admission assessment, dated 08/18/15, documented the resident had long and short term memory problems and was moderately impaired in cognitive skills for daily decision making. It was documented the resident required extensive assistance for bed mobility, transfers, and dressing. It was documented she was totally dependent for locomotion, eating, personal hygiene, and bathing. It was documented the resident was always incontinent of bowel and bladder, and had one fall without major injury since admission. The resident's care plan, dated 08/19/15, documented a problem related to being at risk for falls. The goal was the resident would have no falls with or without injury through the next review date. Approaches included to place on fall program, assist with transfers, ambulation, and bed mobility; to keep the call light within reach; assure proper footwear was used; and to observe for side effects from medications. The care plan was updated on 08/20/15 with an intervention to use a low bed and fall mats. Another problem was the resident was at risk for bleeding and/or bruising related to the use of anti-coagulant medications. The goal was the resident would not have any bleeding or bruising through the next review date. Approaches included to observe for medication effectiveness; to observe the resident for blood blisters, bruising, blood in the stool, and easy bleeding; to obtain labs as ordered; and to assess the environment for any needed changes. A nurse's note, dated 08/23/15 at 6:25 a.m., documented, .Pt (patient) found on mat left side of bedside. Pt awake, resp (respirations) even (and) unlabored .No new bruise seen or skin tears on pt. Incont care given . It was documented the resident's vital signs were obtained, and they were within normal limits for the resident. There was no documentation neurological checks were started for the unwitnessed fall; that the facility assessed and monitored for bleeding; or that the physician was notified of the fall. There was no incident report of the fall. A nurse's note, dated 08/29/15 at 10:30 a.m., documented, .this nurse was notified by CNA stating resident was lying bedside bed on floor mats. Upon entering room nurse notes resident lying on left side of bed into floor mat c (with) head handing (sic) off lying on pedals of the peg tube pole. Nurse and CNA (certified nurse aide) assisted resident on to back. Notes discoloration to middle of forehead. (No) skin openings, swelling or any other discolorations noted @ this time. Resident alert c some confusion noted .Resident c/o pain unable to describe locations and rate pain .Noted resident was dirty (large) BM noted in brief .Nurse educated staff that resident needs to changed (sic) (every) 2 (hours) . A progress note, dated 08/29/15 and untimed, documented, .Nurse notes discoloration to middle of forehead. Resident c/o general pain moaning when assisting c care of getting back into bed . An incident report, dated 08/29/15, documented, .nurse was notified by staff regarding resident on floor. Upon entering nurse noted resident lying on (left) side of bed on floor mats c head hanging off mats unto pedals of peg tube pole. Alert c some confusion . On 12/07/15 at 1:56 p.m., licensed practical nurs (LPN) #3, who was the nurse for the resident on 08/29/15, was asked if the resident could walk. She stated she could help with assistance. She was asked if the resident could reposition herself in bed. She stated the resident moved around a lot in bed. She was asked if the resident was at risk for falls. She stated, Yes. LPN #3 was asked what happened when the resident fell on [DATE]. She stated, They told me she was on the floor. She was asked what caused the resident's fall. She stated, I couldn't say exactly what caused the fall. LPN #3 was asked if the resident was being monitored for any thing in particular. She stated the resident was at risk for bleeding, so they would have been monitoring for signs and symptoms of bleeding. She was asked if she had monitored the resident for bleeding after the fall on 08/29/15. She stated, No. She was asked which physician she notified. She stated she notified physician #3 because he was on call for physician #1. She was asked if she informed physician #3 the resident was receiving [MEDICATION NAME]. She stated, I can't remember if I said that or not. She was asked if she documented that she informed the physician. She stated, No, I didn't. On 12/07/15 at 2:11 p.m., the director of nursing (DON) was asked where the incident reports were for the falls on 08/15/15 and 08/23/15. She reviewed the incident reports and stated she could not find one for those falls. She was asked what interventions were identified and implemented after the fall on 08/15/15. She stated, I didn't know about that. That wasn't told to me. She stated the nurse had documented she implemented frequent checks but there was no documentation of the checks. She was asked which physician was notified of the falls on 08/15/15 and 08/23/15. She stated, It doesn't appear there was a physician notified if this is all the documentation I have. She was asked where other documentation would be. She stated on the incident reports. She was asked where the incident reports were. She stated they did not have one for the falls. The DON was asked if the resident was supposed to be monitored for signs and symptoms of bleeding. She stated, Yes. She stated it was documented on the resident's care plan. The DON was asked to show where it was documented the resident was assessed for signs and symptoms of bleeding following the falls on 08/15/15 and 08/23/15. She reviewed the clinical record and stated, I don't see they have charted anything. She was asked if there was documentation of neurological checks following those falls. She stated, No. She stated she was not aware of those falls. The DON was asked what the facility's policy was for completing neurological checks. She stated they should be completed with any unwitnessed fall or fall with a head injury. She was asked how she expected staff to assess, monitor, and intervene for a resident who was receiving an anti-coagulant medication and experienced an unwitnessed fall. She stated they should complete neurological checks, observe for differences in vital sign, and look for bruising and bleeding. She stated the physician should be contacted and informed the resident was receiving an anti-coagulant. She stated the resident would most likely be sent out for further evaluation. The DON was asked if the resident was receiving an anti-coagulant medication. She stated yes, [MEDICATION NAME]. The DON was asked how she ensured the staff assess, monitored, and intervened for residents with falls and those experiencing a change in condition and if the physician was notified as necessary. She stated incident reports were reviewed and the charts were monitored to ensure everything was done. She was asked who monitored to ensure incident reports were completed. She stated on weekends, it was the supervisor's responsibility to ensure the DON was notified and then nursing would follow up on them. 2. Resident #85 was admitted to the facility on [DATE] for skilled services related to [DIAGNOSES REDACTED]. admission orders [REDACTED]. It was documented the resident was to be monitored for signs and symptoms of bleeding every

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The resident's care plan, dated 11/02/15, documented a problem related to the resident being at risk for falls due to [DIAGNOSES REDACTED]. The goal was the resident would have no falls, with or without injury, through the next review date. Approaches included to assist with transfers and bed mobility; keep the call light within reach; use proper footwear; observe for side effects from medications; remind to utilize assistive devices; provide adequate lighting; keep pathways free and clear of any objects; monitor for wet/slippery floors; therapy to evaluate and treat as ordered; use a wheelchair for mobility; and medications as ordered for [MEDICAL CONDITION]. Another problem was documented as the resident being at risk for bleeding and/or bruising related to the use of [MEDICATION NAME]. The goal was the resident would not have any bleeding or bruising through the next review date. Approaches included to observe effectiveness of medications; observe resident for blood blisters, bruising, blood in stool, or easy bleeding and notify MD promptly; labs as ordered, paying close attention to lab values including hematocrit, hemoglobin, and red blood cell levels; and to assess the environment for the needed changes. It was also documented to pay close attention to the resident. Medication administration records (MARs), dated 10/2015, documented the resident received Aspirin 325 mg one tab daily from 10/24/15 through 10/31/15. It was also documented the resident received [MEDICATION NAME] 40 mg subcutaneous daily from 10/24/15 through 10/31/15. It was documented the resident was monitored for signs and symptoms of bleeding from 10/24/15 through 10/31/15. Physician's monthly orders, dated 11/2015, documented the resident was to receive [MEDICATION NAME] 40 mg subcutaneous every day for blood thinning and Aspirin 325 mg every day. MARs, dated 11/2015, documented the resident received Aspirin 325 mg one tab daily from 11/01/15 through 11/13/15. It was also documented the resident received [MEDICATION NAME] 40 mg subcutaneous from 11/01/15 through 11/07/15 and from 11/09/15 through 11/12/15. A departmental note, dated 11/12/15 at 6:24 a.m., documented, .Patient observed this am on floor at his bedside, bed in low position, awake and alert, ROM (range of motion) done to all extremities, all WNL (within normal limits) at this time, no S/S(signs or symptoms) of pain or discomfort, patient assisted to bed x 2 assist, call light in reach and operable. Family and doctor aware . An incident report, dated 11/12/15 at 5:50 a.m., documented a family member and physician #1 were notified. It was documented a head to toe assessment was completed. Review of the clinical record revealed no documentation the resident was assessed and monitored for signs and symptoms of bleeding after the fall. An incident report, dated 11/13/15 at 9:45 p.m., documented, .staff reported patient on the floor,went to room patient laying on left side propped up by left elbow, alert oriented to person, skin tear to left elbow patient denies pain or discomfort assisted to bed cleansed skin tear with normal saline, covered with island dressing neuros started, range of motion within normal limits grasp equal, pupils equal and reactive to light . It was documented physician #1 was notified immediately. It was documented the family was not notified until 3:45 a.m. on 11/14/15. A post-incident actions sheet, dated 11/13/15 at 9:45 p.m., documented the immediate post-incident action was to start neurological checks and hourly monitoring. A neurological assessment flowsheet, dated 11/13/15 at 9:45 p.m. through 11/14/15 at 3:30 a.m., documented the resident's blood pressure increased from 112/64 at 9:45 p.m. on 11/13/15 to 141/72 at 2:30 a.m. on 11/14/15. It was documented the resident's pulse rate increased from 69 beats per minutes (bpm) to 103 bpm. Review of the clinical record revealed no documentation the resident's physician was notified of the increasing blood pressure or pulse rate. A departmental note, dated 11/14/15 at 3:15 a.m., documented, .Patient observed at this time on nursing rounds unresponsive, no pulse palpable, observed no rise or fall of chest, Unit manager notified, family .notified .(physician #2) notified. N/O (new order) received (sic) to release body to funeral home . On 12/03/15 at 8:22 a.m., LPN #6 was asked who physician #1 was. He stated he was the physician for long term care residents. She was asked who physician #2 was. She stated he was one of the doctors for residents on skilled services. She was asked if a resident was on skilled services, which physician was to be notified if needed. She stated one of the skilled service physicians, including physician #2. She was asked if it would be okay to call physician #1 instead. She stated, No, you shouldn't. On 12/03/15 at 8:26 a.m., LPN #7 was asked if the resident could walk. He stated he did not think so. He was asked if the resident could reposition himself in bed. LPN #7 stated the resident moved around a lot and he would have to be repositioned. He stated the resident would get his legs off the bed. He was asked if the resident was at risk for falls. He stated yes, because of the [MEDICAL CONDITION] diagnosis. LPN #7 was asked what happened when the resident experienced his first fall. He stated, His bed was in the low position. I just remember him. He didn't have any open areas or hematomas like he had bumped his head or anything like that. He was asked what caused the resident's fall. He stated he thought it was because the resident was trying to get out of bed. LPN #7 was asked what medications the resident was on that put him at increased risk for bleeding. He stated he did not recall any. He was asked if the resident was being monitored for anything in particular. He stated nothing that he could recall at this time. LPN #7 was asked which physician had been notified regarding the fall. He stated it would be the physician noted on the incident report. LPN #7 was informed physician #1 was identified on the incident report. He was asked if the resident was on skilled services or long term care services. He stated he believed he was on skilled services. LPN #7 was asked if physician #1 was the physician for skilled services. He stated no, but he was the medical director and would be the physician to call in call another could not be reached. LPN #7 was asked if he had informed physician #1 the resident was receiving aspirin and [MEDICATION NAME], which put him at increased risk of bleeding. LPN #7 stated he did not recall notifying the doctor of that. He stated, I don't believe so. He was asked how he assessed and monitored for complications after a fall. LPN #7 stated any unwitnessed fall was followed with neurological checks. He was asked if he had completed neurological checks for the resident after the fall. He stated he could not remember. On 12/03/15 at 9:18 a.m., the DON was asked who the nurse was when the resident experienced his second fall. She stated the nurse was no longer employed at the facility. On 12/03/15 at 9:22 a.m., CNA #6 was asked if the resident had experienced any falls. He stated, I came in one it me and found him sitting in the floor by the bed. He stated he found the resident at shift change, at approximately 5:45 or 5:50 a.m. He was asked what caused the resident's fall. He stated he did not know. He was asked what he did when he found the resident. He stated he notified the nurse, they obtained vital signs, and put the resident back in bed. On 12/03/15 at 10:09 a.m., the DON was asked what interventions were put into place after the resident's first fall. She stated, According to this, it doesn't show anything. She reviewed the clinical record and stated a fall mat and low bed had been initiated on admission. She was asked if any new intervention had been identified and implemented. She stated, It does not appear to (be). It says something about frequent monitoring. She stated the incident report had documented frequent monitoring would occur. The DON was asked where the documentation of frequent monitoring was. She reviewed the clinical record and stated, I don't know. I don't see it. The DON was asked which physician had been notified of the first fall, according to the documentation. She stated physician #1 was notified. She was asked who he was. She stated he was a physician for the long term care residents. The DON was asked if physician #1 had knowledge of the residents receiving skilled services. She stated, I do not believe so. She was asked if resident #85 was receiving skilled services. She stated, Yes. She was asked who the resident's physician was. She

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) stated it was physician #2. The DON was asked why physician #2 was not notified. She stated, I cannot tell you that. She was asked who should have been contacted. She stated, (Physician #2) or the doctor on call for him. She was asked if physician #1 covered for physician #2. She stated, No. The DON was asked if physician #1 had been notified the resident was receiving [MEDICATION NAME] and aspirin. She stated, It does not say that in the documentation. The DON was asked which physician had been notified of the second fall, according to the documentation. She stated, (Physician #1). She was asked if physician #1 had ever seen the resident. She stated, Not to my knowledge. The DON was asked how she expected staff to monitor residents for potential complications after having experiencing a fall. She stated neurological checks were to be completed after every unwitnessed fall. She was asked where the documentation was of the neurological checks following the first fall. She reviewed the clinical record and stated, It doesn't appear that he (LPN #7) started them. She was asked what the neurological checks following the second fall showed. She stated they showed the resident's vital signs were changing. She was asked if the physician had been notified of these changes. She stated, It does not appear that way. She was asked if the family member had been notified of the second fall. She stated, It doesn't appear that she was. The DON stated the family should have been notified of the second fall. The DON was asked how the resident was assessed and monitored after the falls. She stated that neurological checks had been completed after the second fall and a fall and pain evaluation had been completed after the first fall. She was asked what medication the resident took that put him at increased risk for bleeding. She stated aspirin and [MEDICATION NAME]. She was asked how the staff took into account the increased risk for bleeding in relation to the two unwitnessed falls the resident experienced. She stated, It does not appear they did. The DON was asked how she expected her staff to react to changing vital signs, including an increasing blood pressure and pulse, for a resident who had experienced two unwitnessed falls. She made no comment. She was asked how the staff intervened with the resident's changing vital signs. She stated, They should have notified the physician. The DON was asked how she monitored her staff to ensure they assessed, monitored, and intervened as necessary when residents experienced a fall or change in condition. She stated incident reports were reviewed during daily clinical morning meetings and the ADONs reviewed the charting. She was asked if a concern had been identified with the resident's falls and the lack of assessing, monitoring, and intervening as necessary to a changing condition. She stated, It does not appear we did. She was asked if the monitoring system was working. She stated, It needs some tweaking it appears. The DON was asked what the staff could have done differently. She stated, Initiated neuros on the first fall, notified the right physician, notified him of the meds, and notified with changes on the neuro checks. 3. Resident #150 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. admission orders [REDACTED]. The resident's care plan, dated 10/16/15, documented a problem related to [MEDICAL CONDITION] with [MEDICAL TREATMENT]. It was documented the resident was at risk for shortness of breath, chest pain, itchy skin, [MEDICAL CONDITION], elevated blood pressure, and infections. The goal was the resident would have no complications from the disease process or [MEDICAL TREATMENT] through the next review date. Approaches included to observe for signs and symptoms of complications; monitor access site for redness, bleeding, or pain; observe for effectiveness of medications; and to check the bruit and thrill of the right arm fistula. The care plan did not address the potential side effects or adverse consequences of [MEDICATION NAME] to monitor for or how care would be coordinated between the [MEDICAL TREATMENT] center and the facility. An admission assessment, dated 10/23/15, documented the resident was cognitively intact and received [MEDICAL TREATMENT] services. A care plan, dated 10/27/15, documented the resident had a potential for injury related to a [DIAGNOSES REDACTED]. Approaches included to observe the effectiveness of medications. A physician's progress note, dated 11/11/15, documented, .Protein-calorie malnutrition. Increase the protein diet . There was no documentation in the clinical record the order was noted. Review of the resident's clinical record and [MEDICAL TREATMENT] notebook revealed no consistent communication between the [MEDICAL TREATMENT] center and the facility. The most recent documentation in the book was dated 11/10/15. There was no documentation the resident was being monitored for potential adverse consequences and side effects related to the use of [MEDICATION NAME]. On 12/03/15 at 2:46 p.m., the resident was asked if he knew what medications he received at [MEDICAL TREATMENT]. He stated, No. He was asked if the facility ever talked with him about the things that occurred while at [MEDICAL TREATMENT]. He stated, No. On 12/07/15 at 3:55 p.m., LPN #8 was asked how the facility communicated and coordinated care with the [MEDICAL TREATMENT] center. She stated the [MEDICAL TREATMENT] center usually sent a report sheet back with the resident. She was asked how lab results and physician orders [REDACTED]. She was if that was documented. She stated, No. LPN #8 was asked if the resident received an alpha drug while at [MEDICAL TREATMENT]. She stated, I couldn't tell you that. She stated, Whatever he receives at [MEDICAL TREATMENT], I am not sure what their procedure is there. She was asked what potential adverse consequences and side effects were to monitored for in relation to an alpha drug. She stated, I'm just throwing this out there. Nausea, vomiting, maybe a lower blood pressure, temperature. On 12/07/15 at 4:01 p.m., LPN #9 was asked how the facility communicated and coordinated care with the [MEDICAL TREATMENT] center. She stated there were [MEDICAL TREATMENT] books, and the [MEDICAL TREATMENT] center would call if there was something out of the ordinary. She was asked if the resident received an alpha drug while at [MEDICAL TREATMENT]. She stated she would need to look. She reviewed the record and stated, Yes, three times a week. She was asked what potential side effects and adverse consequences were monitored for in relation to the alpha drug. She stated she would have to look the information up. LPN #9 was asked who reviewed physician progress notes [REDACTED]. She was asked who was responsible for ensuring any orders on progress notes were noted and implemented. She stated the unit managers were. She was asked what type of diet the resident received. She stated he received a four gram sodium restricted diet. On 12/07/15 at 4:17 p.m., the assistant dietary manager was asked what type of diet did the resident receive. She stated a regular, sodium restricted diet. On 12/07/15 at 4:20 p.m., the DON was asked who was responsible for noting orders written on progress notes. She stated the nurses were. She was shown the physician progress notes [REDACTED]. She stated that particular physician did not write his progress notes when making rounds. She stated he wrote them off-site and when he returned, he brought them with him. She stated his progress notes went directly to medical records and then on to the chart. She was asked if the order had been noted and implemented. She stated, No. The DON was asked how the facility communicated and coordinated care with the [MEDICAL TREATMENT] center. She stated the driver took the book with the resident to [MEDICAL TREATMENT], and then sometimes, if the information did not come back, the restorative aide would call for the information. She was asked what information was communicated. She stated usually diet and medication changes, along with lab results. The DON was asked where this information was. She stated it was in the [MEDICAL TREATMENT] book. She was asked what the last date of any communication with the [MEDICAL TREATMENT] center was. She reviewed the book and stated 11/10/15. She was asked if the resident had been to [MEDICAL TREATMENT] since then. She stated, Yes. She was asked where the communication documentation was from 11/10/15 until present. She stated, I don't know. The DON was asked if the resident received an alpha drug when at [MEDICAL TREATMENT]. She reviewed the clinical record and stated yes. She was asked what side effects and adverse consequences the staff should be monitoring for. She stated she would have to look that information up. She was asked where the potential side effec
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #69 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The care plan, dated 09/29/15, documented the resident had a Self care deficit . Resident needs the following assistance with ADLs: .dressing: -extensive- two person, Eating: - supervision/set up, Toilet use: - extensive - two person, Personal Hygiene: extensive - one person, Bathing: extensive - two person . Approaches included .Give assistance to resident when

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F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 15) bathing/dressing .Provide supplies for bathing/dressing .Report and persistent changes in ADL's (sic) to medical doctor (MD)/staff nurse . The admission assessment, dated 09/28/15, documented the resident was cognitively intact. The assessment documented the resident did not exhibit rejection of care. The resident required two person extensive assistance with bed mobility, dressing and bathing and one person extensive assistance with toilet use and personal hygiene. The assessment documented the resident had lower extremity impairment on both sides. The assessment documented the resident had an ostomy and was not on a toileting program. The assessment documented the resident had pain frequently rated at a seven, the pain limited the daily activities and frequently made it hard to sleep. A nurse's note, dated 09/25/15 at 7:03 p.m., documented the resident stated she had not had a bath in a week. The INDIVIDUAL RESIDENT CARE PLAN-A, dated 09/21/15, documented .Bathing/Dressing/Grooming .bed bath assist .Requires assist with dressing .Other: Non weight bearing .Cognitive Alert, Oriented . The October 2015 functional performance sheet documented the resident received incontinent care two times on the day shift for a total of 11 times and no incontinent care one time on the day shift. The evening shift documented the resident received incontinent care three times during the shift on six days. The sheet documented the resident received incontinent care two times during the shift a total of six days. The night shift documented 11 times incontinent care was performed three times during the shift for 11 days and performed two times during the shift for two of the days. The other days did not document incontinent care had been performed. Incontinent care was provided three times a shift for 14 of the 16 days, performed two times on one day and there was no documentation of incontinent care for 10/31/15. Bathing was documented to have occurred five times during the month on the 7th, the 9th, the 16th, the 23rd and 26th of October 2015. The November 2015 functional performance sheet documented the resident received incontinent care three times during the day shift all days except on the 28th, the 29th and the 31st. The functional performance sheet documented incontinent care occurred two - three times during the evening shift, and two - three times during the night shift. Bathing was documented to have occurred seven times in November 2015. A nurse's note, dated 11/02/15, documented the resident was offered a bath on multiple occasions .the patient was yelling and crying stating, I have been trying to get a bath for 12 hours and I can't get anyone to listen to me. On 11/30/2015 at 4:58 p.m., the resident was interviewed regarding toileting. The resident stated she needed help with toileting and had no control over bladder function. The resident was observed to have incontinent pads under her with no brief on. She also had a [MEDICAL CONDITION] bag. The care plan, updated 11/17/15, documented the resident was at risk for a decline in current ADLs. A goal listed was for the resident's dignity and current level of ADLs would be maintained. An approach listed was for staff to assist with ADLs as needed. A nurse's note, dated 11/11/15, documented, CNA notified this nurse resident refused bath this shift d/t/ bath given yesterday and wants to wait until Friday for bath. The December 2015 functional performance sheet documented the resident received incontinent care three times on the day shift. Two days had no documentation of incontinent care provided. The evening shift documented the resident received incontinent care two times during the shift a total of four days. The night shift documented the resident received incontinent care three times during the shift for a total of six times. On 12/02/2015 at 1:01 p.m., the resident was asked how many times each shift the staff assist her with incontinent care. The resident stated she often had to wait to be changed because the staff would say they need two people. The resident stated she was able to roll herself over and they could do it with out the other person. The resident stated the staff tell her it is the policy. The resident stated when the staff start the incontinent care, they usually saw my gown was also wet. The staff would leave and go find a gown and come back later, sometimes an hour later, to finish the incontinent care. The resident stated at lunch time the staff would be getting residents up, then help them eat, then put them back to bed, So I am left until the end of the shift. The resident stated, I am changed one time every shift. I have just quit asking because they do not come and help. I had always been changed at the end of the shift because the oncoming staff will get mad if residents are wet when they come to work. The resident was asked if she had been assisted with incontinent care today. The resident stated, No one has been in here yet. She stated The 10-6 (10:00 p.m. to 6:00 a.m.) shift did it right before they went home. On 12/02/2015 at 1:28 p.m., CNA #7 was interviewed regarding how often the resident received incontinent care. The CNA stated the resident was provided incontinent care at least twice a shift. The CNA was asked how often a resident who required assistance with toileting were toileted. The CNA stated residents who require assistance should be toileted every two hours. At 4:08 p.m., the resident was noted to have a very strong odor of urine with no observed wetness or discoloration to the top sheet. She observed to have on the same green and tan checkered hospital gown on from earlier today. The resident was asked if staff had offered to change her pad at any time today. The resident stated, No, the CNAs did not offer to change me any time today. The resident stated, I did tell them I wanted a bath from someone today. She stated the CNA did not stay over and a CNA from the oncoming 2:00 p.m. to 10:00 p.m. shift said they did not have time to give her a bed bath today. The resident stated, A lot of the time there is only one CNA here working our hall, but today there were three aides here and you would think they could have gotten me a bed bath today. On 12/03/15 at 9:35 a.m., resident was awake and visiting with her mother. She stated she had been provided incontinent care by CNA #7. The resident stated she had not received a bed bath. On 12/07/15 at 8:34 a.m., CNA #12 was observed on hall 200. The CNA entered the resident's room, asked if she was finished eating breakfast and left the room. The CNA did not offer or provide incontinent care. At 9:10 a.m., CNA #10 and CNA #12 were observed standing at the end of the hall talking. CNA #12 told other CNA # 10 she was clocking out to take her break and will be back. CNA #10 was observed walking up and down the hall speaking to the residents but did not enter any residents' room. At 9:06 a.m., an unidentified CNA was observed entering the resident's room to offer ice to her. The CNA did not offer to assist the resident with any care. At 9:25 a.m., CNA #14 was observed walking up and down the hallway. The CNA did not offer to provide any incontinent care to the resident. At 9:40 a.m., CNA #12 reported she was back from break and walking down hallway with CNA # 14. At 9:45 a.m., CNA # 13 reported she was the bath aide today. CNA #13 entered the resident's room and asked the resident's room mate if she wanted a shower today. The CNA did not ask the resident if she wanted a bed bath or shower. At 9:54 a.m., CNA #12 was asked when incontinent care for the resident was last provided. The CNA stated this would be the first time it would be done today, since we were giving her a bed bath we will do it then. The CNA stated, The 10/6 (10:00 p.m. to 6:00 a.m.) shift changed her before they left this morning. The resident's incontinent pads were observed to have large discolored dark yellow areas where the resident's thighs were laying and at the lower area of the resident's back. The CNA was asked about the odor and color of the resident's urine. The CNA stated, It was normally that odor and color. The LPN #3 was then asked about the odor of the resident's urine. The LPN stated it was very strong and was discolored on the incontinent pad. At 10:05 a.m., the resident's buttocks were observed with LPN #3 and CNA #12. The resident was rolled over to the left side with staff assistance. The resident was observed to have three pads under her saturated with dark yellow urine. The incontinent pads were noted to have a very strong urine odor. At 10:24 a.m., the resident's feet were exposed from under the sheet. The toe nails were observed on each foot to be very long and thick. The resident was asked how often her toe nails were trimmed by staff. The resident stated, It was at least a couple of months ago. CNA #12 was asked if she had trimmed or filed the resident's toe nails. The CNA stated she have never cut or trimmed the resident's toe nails. The CNA was asked if she knew who was responsible for cutting or trimming the resident's nails. The

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F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 16) CNA stated she was not sure who was responsible for cutting the resident's toe nails. LPN #3 was asked to observe the resident's toe nails. She was asked who cuts or trims the toe nails. The LPN stated the CNAs would be the ones to cut the resident's toe nails. She stated anyone could cut or trim the toe nails since the resident was not a diabetic. The LPN stated, They are very long and need to be trimmed and filed. On 12/08/15 at 10:00 a.m., the DON was asked how often a resident should have incontinent care provided. She reported it should be provided every two hours and as needed. The DON was asked if incontinent care was provided twice for a resident during a shift would it be sufficient for a resident who was dependent with toileting. She stated, No, it would not be. The DON was asked how often dependent residents should be bathed. She reported the residents should be bathed at least every other day. The DON was asked how bathing was monitored for the residents. She reported the CNAs documented on the ADL sheets when a resident received a bath. The DON was asked if the resident was bathed every other day. She stated, No she was not. The DON was asked who was responsible for providing nail care for dependent residents. She stated, The CNAs can do the nail care, the clipping would be done by the nurses. The DON was asked how often the nurses should clip the residents nails should be checked or clipped. She stated the nails should be checked or clipped weekly or as needed. The DON was asked where would documentation that the nails were clipped or trimmed be located. She stated it was on the ADL sheets for cleaning but she did not know about clipping. The DON was asked if the staff had in-services on caring for residents who are resistive to care. She stated, Yes, there have been in-services, the staff know what to do. The DON was asked if the resident was resistive to care. She stated, She is often resistive. The nurses were supposed to document every time she refused care. At 1:38 p.m., the resident stated, I was changed by the aide a little while ago. The resident was observed to be dry and had a clean, dry pad in place. At 1:45 p.m., CNA #12 was asked what time the resident received incontinent care. The CNA reported she had changed her at 1:10 p.m. The CNA was asked how many times she had changed the resident today. The CNA stated she had changed the resident two times today, this morning and just now at 1:10 p.m. The CNA was asked how often the resident should be changed. The CNA stated she should be changed every two hours. The CNA stated, We tell the nurses she will not let us change her. The nurses would tell us it is her right to refuse to turn or be changed, so we don't do anything. The nurses told us they just document she is refusing the care. The CNA stated, The nurses told us it is a resident's right to refuse any care, we just need to tell the nurse when they refuse. The CNA was asked if the facility provided in-services on how to turn and reposition a resident,or in-services about incontinent care and assistance with bathing residents. The CNA stated We always get in-services on those things. Based on observation, record review, and staff and resident interview, it was determined the facility failed to provide turning and repositioning assistance, bathing, nail care and oral care to dependent residents for two (#69 and #116) of three sampled residents reviewed for activities of daily living (ADLs). The Resident Census and Conditions report, dated 12/01/15, documented 28 residents required assistance with ADLs. Findings: A repositioning policy, last revised May 2013, documented, .The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents . Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief .Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .Notify the supervisor if the resident refuses the care . 1. Resident #116 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 04/27/15, documented, .CONTRACTURES resident has contractures of U&L (upper and lower) EXT (extremities) Bil (bilateral) Knees- Severe had AKA (above the knee amputation) (bilateral) with potential for further contractures R/T (related to) M.S. ([MEDICAL CONDITION]) .Passive ROM (range of motion) to joints during care and as needed .Reposition at least every 2 hours .Provide activities which don't depend on dexterity: music, parties, movies . P/F (potential for) SKIN BREAKDOWN Related to .(decreased) mobility Skin Risk Assessment Score of .Contributing [DIAGNOSES REDACTED].Other contributing factors of .Contractures Bil Amputation .Approaches .Turn and reposition at least q (every) 2 hrs (hours) and as needed . .Alteration in Skin Integrity .Resident has the following skin breakdown .S/P (status [REDACTED].With potential for further skin breakdown R/T .(decreased) mobility .Other contributing factors of .MS .Severe Contractures .U&L EXT .Turn and reposition at least every 2 hrs . SELF-CARE DEFICIT .Resident needs the following assistance with ADLS .Extensive to total assist .Bed mobility .Transfers .Locomotion .Dressing .Eating .Toilet Use .Personal Hygiene .Bathing .Related to M.S .Give .assistance to resident when bathing/dressing/transferring . A care plan, dated 5/24/15, documented, .Alteration in skin integrity (left) buttock (left) ischium .provide turning and repositioning frequently .tx (treatment) as ordered . A care plan, dated 07/06/15, documented, .Resident has sheering to right and left ischiums .8-20-15- wedge use for positioning . A quarterly resident assessment, dated 10/21/15, documented the resident required extensive two person assist for bed mobility. It documented the resident required total assistance of two people for transfers, dressing, toilet use, and bathing. It documented the resident required total one person assistance for locomotion on and off the unit and for personal hygiene. On 12/01/15 at 7:34 a.m., licensed practical nurse (LPN) #6 was interviewed and asked if resident #116 currently had one or more pressure ulcers. She stated the resident had two, stage two, pressure ulcers, one to the left ischium and one to the right ischium. At 9:30 a.m., resident #116 was observed lying in her bed on her back with the only pillow observed in use was the pillow under the resident's head. At 11:20 a.m., resident #116 was observed lying in her bed in her room in the same position. At 11:21 a.m., resident #116 was observed lying in bed on her back with her eyes closed. Both side rails were observed in the up position and the only pillow observed in use was the pillow under the resident's head. At 2:21 p.m., resident #116 was observed lying in her bed on her back with her eyes closed. The only pillow support observed was the pillow observed under her head. At 3:25 p.m., resident #116 was observed lying on her back with the only pillow support observed being the pillow under her head. At 3:58 p.m., the resident remained lying on her back with her eyes open. The only pillow support observed was the pillow under her head. At 4:47 p.m., the director of nursing (DON) provided a list of residents with pressure ulcers. Resident #116 was included in the list. At 4:54 p.m. the resident was observed lying on her back with her eyes closed. The only pillow support observed was the pillow under her head. On 12/02/15 at 2:09 p.m., the resident was observed lying on her back in her bed, eyes open, with both side rails up. The only pillow observed was the pillow behind the resident's head. At 3:05 p.m., the resident was observed lying on her back in her bed. The only pillow support observed was the pillow under her head. At 3:26 p.m., the resident was observed lying in her bed with both eyes open with her television on in the same position. At 3:55 p.m., the resident was observed to be lying in the same position.

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	375252	A. BUILDING _____ B. WING _____	12/09/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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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 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 17) On 12/03/15 at 8:09 a.m., resident #116 was interviewed and asked if staff ever positioned her on different sides throughout the day. She stated, No. She was asked what positions she was placed in by staff. She stated, I stay in this position. She was asked if staff provided her oral care and cleaned her mouth. She stated they did not. The resident was observed with residue of her health shake observed on her mouth and surrounding skin. At 9:46 a.m., resident #116 was observed lying supine in her bed with both side rails up. At 2:40 p.m., certified nurse aide (CNA) #11 was interviewed and asked what oral care was provided to resident #116. She stated they used the mouth swabs dipped in mouthwash and water to clean the resident's mouth. She was asked if the staff ever brushed the residents teeth. She stated they never used a toothbrush with toothpaste to provide oral care because the resident was a choking hazard with her tube feeding. At 3:32 p.m. LPN #1 was interviewed and asked what oral care was provided to resident #116. She stated the staff used mouthwash diluted with water and swabs for oral care. She was asked if the staff ever used a toothbrush and toothpaste to clean the resident's natural teeth. She stated, Not to my knowledge. On 12/07/15 at 8:03 a.m., resident #116 was observed with a white substance on the tissue surrounding her mouth. She stated her lips were dry. At 8:20 a.m., LPN #3 was interviewed and asked the reason for resident #116's peg tube. She stated the resident did not have a great appetite so the tube was utilized for nutritional support. She was asked if the resident had a swallowing difficulty. She stated she did not. She stated resident #116 took in food and fluids by mouth. She was informed of the staff stating the resident did not get her teeth brushed with toothpaste and a toothbrush due to swallowing difficulties. She stated she did not know why staff would think that. She stated the resident ate by mouth and there was no reason for the staff not to brush her teeth. She stated she would let the staff know she could have her teeth brushed. At 10:34 a.m. the DON was interviewed and asked when resident #116's pressure ulcers developed. She stated she did not know off of the top of her head, she would have to look. She reviewed the resident's clinical record and stated the right ischium was identified on 07/06/15 and the left buttock was identified on 07/06/15. She stated the resident was not admitted with them. She stated the facility completed a significant change assessment on 07/22/15. The DON was asked what risk factors resident #116 had for pressure ulcer development. She stated the resident had mobility, nutrition, and incontinence risk factors. She was asked what interventions were in place to prevent the worsening of and aide in the healing of the resident's pressure ulcers. She stated the resident required extensive assistance for bathing, bed mobility and positioning. She stated the facility followed the standards of practice of turning the resident every two hours. She stated they utilized pillow support for positioning. She stated the facility also would periodically recheck the resident throughout the day. She was asked how the facility determined the appropriate interventions for the resident. She stated a lot of the interventions were very standard. She stated they monitored dietary and nutritional status and the wound care was provided by the wound care nurse. She stated the wound care physician would make changes as needed. She was asked how she monitored the staff to ensure the interventions were implemented. She stated, You just see it. She was informed of all the observations made of resident #116 lying on her back with the only pillow support observed behind her head. She was asked if she was aware of the reason the resident remained in the position. She stated she could not. She stated the resident should have been turned and repositioned at least every two hours. The DON was asked how the effectiveness of wound care and pressure ulcer prevention measures were evaluated. She stated the facility had a wound care nurse up until last Monday. She stated she would measure the wounds once a week. She stated the wound physician also measured the wounds weekly. She was asked what wound care protocols were used. She stated the wound care nurse would report weekly. She stated if changes occurred, they would notify the physician for new orders. She was asked who has providing wound care for the residents. She stated the nurses on the floor were provided the wound care. She stated the new wound care nurse would be starting on the 21st. At 10:52 a.m. the DON was asked to describe the oral care provided to resident #116. She stated the staff should be providing oral care every shift. She stated the staff should brush the resident's teeth with a [MEDICATION NAME] toothette. She was asked if there was any medical reason to prevent resident #166 from having her natural teeth brushed with toothpaste and a toothbrush. She stated, To my knowledge, No.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Hospital records for resident #49, dated 11/03/15, documented the resident had the following ulcers: ~ a stage four pressure ulcer to both buttocks, ~ a stage three pressure ulcer to the right heel, ~ a stage four pressure ulcer to the right medial leg, ~ a necrotic right medial knee wound base, ~ a right medial distal thigh wound base with necrotic slough, ~ a right medial proximal wound base with 100% granulation, ~ a left lateral foot wound and ~ a left lateral knee wound. The resident was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The wound physician saw the resident on Thursday, 11/12/15, and measured each wound. The progress note of the same date documented the resident had the following ulcers: ~ a stage two pressure ulcer to the left medial ankle, ~ a stage three pressure ulcer to the left lateral lower leg, ~ a stage three pressure ulcer to the left lateral knee, ~ a stage three pressure ulcer to the right heel-resolved, ~ a stage four pressure ulcer to the right medial knee, ~ an unstageable pressure ulcer to the right medial upper leg, ~ a stage four pressure ulcer to an unspecified buttock, ~ an unstageable pressure ulcer to the left distal lateral foot and ~ a chronic stage four pressure ulcer to the right heel. The wound physician saw the resident on Thursday, 11/19/15, and measured each wound. The progress note of the same date documented the resident continued with the same pressure ulcers as the previous week. There was no documentation to show the pressure ulcer measurements were completed for the week of 11/22/15 through 11/28/15. On 12/03/15 at 2:15 p.m., the ADON was asked to locate any other wound measurements for resident #49 besides the two wound physician progress notes [REDACTED]. At 3:00 p.m., the ADON was asked if she had located any other wound measurements. She stated she had asked RN #1 to look for the measurements. The ADON stated RN (registered nurse) #1 was calling the charge nurse to see where she had put the measurements. At 3:30 p.m., the ADON provided pressure ulcer measurements for resident #49, dated 12/02/15. The measurements had been completed by RN #1 for the following pressure ulcers: ~ a stage three to the right heel, ~ a stage three to the left lateral leg, ~ a stage three to the left ankle, ~ a stage three to the sacrum, ~ a stage three to the right posterior, ~ a stage three to the left knee and ~ a stage three to the right foot. On 12/08/2015 at 11:54 a.m., LPN #5 was asked how often she measured the residents pressure ulcers. She stated normally she

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 18) would measure wounds once a week but didn't know what the facility protocol was since she had only worked at the facility for about a week. She stated the wound physician was here every week on Tuesday or Wednesday and he measured all wounds. At 11:57 a.m., LPN # 4 was asked how often she measured the residents' pressure ulcers. She stated the facility had a wound physician who came on a weekly basis. The LPN stated if the wound physician was not seeing the resident then she would measure the pressure ulcers. At 12:02 p.m., the DON was asked how often did the nurses measure the pressure ulcers or wounds. She stated weekly and the wound physician measured them weekly. The DON was asked to print all nurses' notes and any wound measurements in the computer for resident #49. No other documentation of pressure ulcer measurements was provided for resident #49 prior to survey exit on 12/09/15. Based on observation, record review, staff and resident interviews, it was determined the facility failed to provide necessary care and services to prevent and/or promote healing of pressure ulcers for three (#49, 69 and #116) of five sampled residents who were reviewed for pressure ulcers. The facility failed to: ~ Identify, assess, monitor, obtain orders for and provide treatment for one resident (#69). This resulted in actual harm for resident #69 when interventions were not implemented and the resident developed a new (facility acquired) stage II pressure ulcer; and ~ Implement the intervention of turning and repositioning for one resident (#116) which resulted in actual harm when the status [REDACTED]. Both of these were facility acquired; and ~ Provide consistent measurements for one (#49) of five sampled residents who were reviewed for pressure ulcers. The assistant director of nursing (ADON) identified 11 residents with pressure ulcers. Findings: A facility policy for prevention of pressure ulcers, updated 09/2013, documented, .The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practioner, physician, and family, and addressed. Interventions and Preventive Measures: General .For a person in bed: .Change position at least every two hours or more frequently if needed .Encourage the resident to participate in active range of motion exercises to improve circulation .Routinely assess and document the condition of the resident's skin per Weekly Skin Integrity form for any signs and symptoms or irritation or breakdown .Report any signs of a developing pressure ulcer to the physician . Interventions and Preventive Measures: Residents with Risk Factors Risk factor - Moisture .Place resident on a minimum of a q (every) 2 hour check and change program. Provide personal hygiene care/bath to remove perspiration, bacteria and promote comfort .Address causes of moisture .scheduled toileting . A Pressure Ulcer Risk Assessment policy, updated 9/13, documented, .Skin Assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated . Assessment . Monitoring: staff will perform routine skin inspections (with daily care). Nurses are to be notified to inspect the skin if skin changes are identified. Nurses will conduct skin assessments at least weekly to identify changes . A repositioning policy, last revised May 2013, documented, .The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents . Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief .Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .Notify the supervisor if the resident refuses the care . 1. Resident # 69 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The INDIVIDUAL RESIDENT CARE PLAN-A, dated 09/21/15, documented the resident was alert and oriented and required assistance with repositioning every two hours. Nurses' notes, dated 09/21/15 to 12/08/15, did not document when the weekly skin assessments were completed. An admission assessment, dated 09/28/15, documented the resident was cognitively intact and did not exhibit rejection of care. The assessment documented the resident required two person extensive assistance with bed mobility, dressing and bathing and required one person extensive assistance with toilet use and personal hygiene. The assessment documented the resident had lower extremity impairment on both sides. The assessment documented the resident had an ostomy and was not on a toileting program. The assessment documented the resident had pain frequently rated at a 7, the pain limited the daily activities and frequently made it hard to sleep. The assessment documented the resident had one unhealed stage II pressure ulcer. The assessment documented the resident had moisture associated skin damage, received pressure ulcer care and had application of non surgical dressings. The care plan, dated 09/22/15, documented the resident had altered skin integrity at bilateral glutes, superior and inferior trochanter, right ischium and right hip. The care plan documented a goal for the resident would be to have no complications related to skin alteration with goal date of 12/22/15. The care plan documented the following approaches: provide treatment as ordered, notify responsible party of wound status/changes. Provide turning and repositioning frequently. Keep clean and dry. The SKIN GRID - OTHER SKIN PROBLEMS sheet, dated 09/22/15, did not include weekly documentation of observation of the resident's buttocks. The sheet documented observations of the left lower medial thigh, the right shin and the left hip. The last day observation of the wounds were documented on 09/28/15. The sheet documented skin observations for the month of October were made on 10/02/15, 10/09/15, 10/14/15, 10/29/15 and 10/29/15. The October 2015 treatment sheet documented the resident did not receive magic butt paste as ordered or wound care as ordered on [DATE]. The October 2015 functional performance sheet documented the resident received incontinent care two times on the day shift for a total of 11 times and no incontinent care one time during the day shift. The evening shift documented the resident received incontinent care three times during the shift on six days. The sheet documented the resident received incontinent care two times during the shift for a total of six days. The night shift documented 11 times incontinent care was performed three times during the shift for 11 days, and was performed two times during the shift for two of the days. The other days did not document incontinent care had been performed. Incontinent care was provided three times a shift for 14 of the 16 days, and performed two times on one day and there was no documentation of incontinent care for 10/31/15. Bathing was documented to have occurred five times on the 7th, 9th,16th, 23rd and 26th of October 2015. There was no November 2015 documentation of a SKIN GRID-OTHER SKIN PROBLEMS sheet in the clinical record. The November 2015 treatment sheet documented the resident did not receive wound care as ordered on the 11/12/15, 11/ 23/15, 11/ 25/15, 11/ 27/15 and 11/30/15. November 2015 functional performance sheet documented the resident received incontinent care three times during the day shift for all days except on the 28th, 29th and 31st. The functional performance sheet documented incontinent care occurred two - three times during the evening shift, and two - three times during the night shift. Bathing was documented to have occurred seven times in November. On 11/30/15 at 4:58 p.m., the resident stated she had no control over her bladder and had pads under her. The December 2015 SKIN GRID - OTHER SKIN PROBLEMS sheet documented a skin tear on the resident's left upper thigh on 12/03/15. The sheet documented measurements for a surgical wound at the left lower medial thigh, the right shin and the left hip on 12/04/15. There was no documentation of observation of the resident's buttocks for December 2015. The December 2015 treatment sheet documented the resident did not receive wound care as ordered on [DATE], and the magic butt paste was not applied as ordered on [DATE]. December 2015 functional performance sheet documented the resident received incontinent care three times on the day shift. Two days had no documentation of incontinent care provided. The evening shift documented the resident received incontinent

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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 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 19) care two times during the shift for a total of four days. The night shift documented the resident received incontinent care three times during the shift for a total of six times. The December 2015 physician's orders did not include an order for [REDACTED]. Additional orders: Follow facility pressure ulcer prevention policy/protocol, offload heels per policy and pressure relief/off loading. A physician wound progress note, dated 11/24/15, documented the resident's right lower leg stage IV pressure ulcer was not healed. The measurements were 3 centimeter (cm) x 2 cm x 0.1 cm. The Left superior trochanter stage III pressure ulcer was not healed and measured 9 cm x 3 cm x 0.1 cm. There was no documentation of an assessment of the resident's buttocks in the progress note. On 12/02/2015 at 1:01 p.m., the resident was asked how many times each shift the staff assist her with incontinent care. The resident stated she often had to wait to be changed because the staff would say they need two people. The resident stated, I am able to roll myself over and they can do it with out the other person. The resident stated the staff tell her it is the policy. The resident stated when the staff start the incontinent care, they usually saw my gown was also wet. The staff would leave and go find a gown and come back later, sometimes an hour later, to finish the incontinent care. The resident stated at lunch time, the staff would be getting residents up, then help them eat, then put them back to bed, So I am left until the end of the shift. The resident stated, I am changed one time every shift. I have just quit asking because they do not come and help. I had always been changed at the end of the shift because the oncoming staff will get mad if residents were wet when they come to work. The resident was asked if she had been assisted with incontinent care today. She stated, No one had been in the room to offer incontinent care yet. The 10:00 p.m. to 6:00 a.m. shift did it right before they went home. At 1:28 p.m., certified nurse aide (CNA) #7 was interviewed regarding how often the resident received incontinent care. The CNA stated the resident was provided incontinent care at least twice a shift. The CNA was asked how often a resident who required assistance with toileting was toileted. The CNA reported residents who require assistance should be toileted every two hours. At 4:08 p.m., the resident was noted to have a very strong odor of urine about her person. There was no observed discoloration on the sheet covering the resident. The resident was asked if she had received incontinent care since the change of shift. The resident stated, No, I have not been changed yet. At 5:25 p.m., the resident was observed with her dinner tray. The resident reported the staff provided incontinent care for her 15 minutes earlier. On 12/03/2015 at 9:35 a.m., the resident stated she had been provided incontinent care by CNA #7. The resident stated she had not received a bed bath. On 12/07/15 at 8:10 a.m., the resident's dressings were observed with LPN #3. The dressings on the left upper hip and left lower hip were dated 12/05/15. The dressings had not been changed in two days. The dressing on the right lower extremity was dated 12/04/15. This dressing had not been changed in three days. At 8:34 a.m., CNA #12 was observed on hall 200. The CNA entered the residents room, asked if she was finished eating breakfast, and left the resident's room. The CNA did not offer or provide incontinent care. At 9:10 a.m., two CNAs were standing at the end of the hall talking. CNA #12 told CNA #10 she was clocking out to take her break and would be back. CNA #10 was observed walking up and down the hall, speaking to the residents but did not enter any residents room. At 9:06 a.m., an unidentified CNA entered the resident's room to offer ice to her. The CNA did not offer to assist the resident with any care. At 9:25 a.m., CNA #14 was observed walking up and down the hallway. The CNA did not offer to provide any incontinent care to the resident. At 9:40 a.m., CNA #12 reported she was back from break and was walking down hallway with CNA # 14. At 9:45 a.m., CNA #13 reported she was the bath aide today. CNA #13 entered the resident's room and asked the resident's room mate if she wanted a shower today. The CNA did not ask the resident if she wanted a bed bath or shower. At 9:54 a.m., CNA #12 was asked when incontinent care for the resident was last provided. The CNA stated this would be the first time it would be done today, since we were giving her a bed bath we will do it then. The CNA stated the 10:00 p.m. to 6:00 a.m. shift changed her before they left this morning. The resident's incontinent pads were observed to have large discolored dark yellow areas where the residents thighs were laying and at the lower area of the resident's back. At 10:05 a.m., the resident's buttocks were observed with LPN #3 and CNA #12. The resident was rolled over to the left side. The resident was observed to have three pads under her which were saturated with dark yellow urine. The incontinent pads were noted to have a very strong urine odor. The resident was observed to have an open area at her right buttock. The open area was observed to be bleeding. LPN #3 was asked what the area was. The LPN stated it looked like an abrasion to her. She stated there was currently an order for [REDACTED]. The LPN reported there was a wound care nurse who is no longer at the facility who provided all wound care. The LPN reported each charge nurse started performing wound care on their residents last week because the wound care nurse was no longer working for the facility. The skin around the open area on the right buttock was observed to be bright pink. The surrounding skin on the buttock was white in color and macerated. When the LPN left the room to obtain a measuring tape, CNA #12 stated the open area on her buttock had been there for a couple of weeks. The CNA stated, I reported this area to the wound care nurse when I had first observed the open area. The resident stated, That is right, she told the wound care nurse the day she found the area. She stated, The wound care nurse (Name deleted) came to see me that day and put some kind of gauze dressing on the open area, but it would not stay on my skin. The LPN came back into the room and measured the open area. The LPN stated the open area was 4 cm x 2 cm. The CNA was asked about the odor and color of the resident's urine. The CNA stated, It was normally that odor and color. The LPN was then asked about the odor of the resident's urine. She stated it was very strong and was discolored on the incontinent pad. The LPN was asked if she was aware of the color and odor of the urine. She stated she was not aware of the odor or color. At 10:34 a.m., the DON was interviewed regarding who was responsible for providing wound care in the facility. The DON stated, We had a wound care nurse up until last Monday on 11/30/15 when she skipped out on us. At 1:38 p.m., the resident stated she was changed by the CNA. The resident was observed to be dry and had a clean, dry pad in place. CNA #12 was asked what time she changed the resident. The CNA stated she changed her at 1:10 pm. The CNA was asked how many times she had changed the resident today. The CNA stated she had changed the resident two times today, this morning and just now at 1:10 pm. The CNA was asked how often the resident should be changed. The CNA stated she should be changed every two hours. The CNA stated, We tell the nurses she will not let us change her. The nurses would tell us it is her right to refuse to turn or be changed, so we don't do anything. The nurses told us they just document she is refusing the care. The CNA was asked about inservices on how to turn and reposition a resident or about incontinent care and how often they should be done. The CNA stated, We always get inservices on those things. At 1:43 p.m., LPN #3 was asked what was ordered for the resident's right buttock. The LPN stated the wound care order was initially for the resident's bottom, it was magic butt paste. The LPN stated the nurses were to apply as ordered. At 2:08 p.m., the director of nursing (DON) was asked how long the resident had the open area on the right buttock. She stated there was no documentation in the record regarding how long the wound had been there. The DON stated there was an order written [REDACTED]. She was asked if there was any other treatment ordered for this open area prior to today. The DON stated, No, I can not say there were any other wound care orders. The DON was interviewed regarding how often a resident should have incontinent care provided. She stated it should be provided every two hours and as needed. The DON was asked if incontinent care was being provided twice on a shift would it be sufficient for a resident who was dependent with incontinent care. The DON stated No, it is not. On 12/08/15 at 7:30 a.m., the DON was asked for all skin assessment reports for the resident beginning on 09/21/15 to

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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 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 20) present. At 9:00 a.m., the DON provided copies a Wound Healing Progress report, dated 09/21/15, and copies of Wound Assessment Reports, dated 04/24/15 to 08/07/15. The DON did not provide copies of assessments for the 09/21/15 to present day. At 9:08 a.m., the MDS (minimum data set)/care plan nurse #1 was interviewed regarding where the information for a new open wound would be documented. The MDS nurse stated the previous wound care nurse did that section and the assessments. She was asked where would the information be documented. The MDS nurse stated it would be in the chart. The nurse stated the documentation should be in the wound care section. She did not know what the wound care nurse's process was for documenting new open wounds. At 10:00 a.m., the DON was interviewed regarding what the policy was for performing skin checks for residents. The DON stated the nurses would do a skin check on admission, and the wound care nurse would complete the skin assessment the next day worked. The DON was asked when the physician was notified. She stated, I can not tell you the date. The DON was asked if the physician should have been notified of the new area when it was first reported to the wound care nurse. She stated, Yes, it should have been reported. The DON was asked what the facility had been doing to care for the pressure ulcer on the resident's right buttock. She stated, Whatever is in the chart. The DON was asked what the policy was for staff to report open areas. She stated, Anytime an area is observed, it would be reported to any nurse. The DON was asked when CNA #12 reported the open area to the wound care nurse. She stated, I do not know if the CNA informed anyone, I have not talked to her. The DON was asked where a nurse would document a new open area. She stated, In the nurse notes. The DON was asked if the resident was resistive to care. The DON stated, She is often resistive, the nurses were supposed to document every time she refused care. The DON was asked if the staff had inservices on caring for residents who are resistive to care. She stated, Yes there have been inservices, the staff know what to do. 2. Resident #116 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan, dated 04/27/15, documented, .CONTRACTURES resident has contractures of U&L (upper and lower) EXT (extremities) Bil (bilateral) Knees- Severe had AKA (above the knee amputation) (bilateral) with potential for further contractures R/T (related/to) M.S. ([MEDICAL CONDITION]) .Passive ROM (range of motion) to joints during care and as needed .Reposition at least every 2 hours .Provide activities which don't depend on dexterity: music, parties, movies . P/F (potential for) SKIN BREAKDOWN Related to .(decreased) mobility Skin Risk Assessment Score of .Contributing [DIAGNOSES REDACTED].Other contributing factors of .Contractures Bil (bilateral) Amputation .Approaches .Turn and reposition at least q (every) 2 hrs (hours) and as needed . .Alteration in Skin Integrity .Resident has the following skin breakdown .S/P (status/post) muscle flap .sig(significant) (change) new pressure ulcer areas .With potential for further skin breakdown R/T .(decreased) mobility .Other contributing factors of .MS .Severe Contractures .U&L EXT .Turn and reposition at least every 2 hrs . SELF-CARE DEFICIT .Resident needs the following assistance with ADLS (activities of daily living) .Extensive to total assist .Bed mobility .Transfers .Locomotion .Dressing .Eating .Toilet Use .Personal Hygiene .Bathing .Related to M.S .Give .assistance to resident when bathing/dressing/transferring . A nurses' note, dated 04/28/15, documented, .Surgical Incision//Right Buttock .Resident admitted on ,[DATE] with multiple wounds . A wound assessment report, dated 04/27/15, documented resident #116 had a surgical incision to her right buttock; hip, a surgical incision to her right buttock; sacral, and a surgical incision to her right buttock; medial ischium. A wound assessment report, dated 05/04/15, documented the resident had a surgical incision to her right buttock; sacral and a surgical incision to her right buttock; medial ischium. It documented the surgical incision to the right buttock; ischium resolved on 05/20/15. A wound assessment report, dated 05/06/15, documented the resident had a surgical incision to her right buttock; hip. A wound assessment report, dated 05/13/15, documented resident #116 had a surgical incision to the right buttock; medial ischium, a surgical incision to the right buttock; sacral, and a surgical incision to the right buttock; hip. It documented the surgical incision to the right buttock; hip resolved on 06/04/15. A wound assessment report, dated 06/04/15, documented the resident had a surgical incision to her right buttock; sacral. It documented the wound resolved on 06/12/15. A care plan, dated 5/24/15, documented, .Alteration in skin integrity (left) buttock (left) ischium .provide turning and repositioning frequently .tx (treatment) as ordered . A care plan, dated 07/06/15, documented, .Resident has sheering to right and left ischiums .8-20-15- wedge use for positioning . A skin grid- other skin problems sheet, dated 7/6/15, documented the resident had a right ischium failed flap. A skin grid- other skin problems sheet, dated 07/06/15, documented the resident had a left ischium failed flap. A wound assessment report, dated 07/06/15 documented the resident had a stage two pressure ulcer to the right buttock, ischium and a stage two pressure ulcer to the left buttock; ischium. A nurses' note, dated 07/09/15, documented, .Focus R/T (related to) PA (physician's assistant) here to assess wounds. Residents (sic) wounds to left and right ischium that resident was admitted with have reopened . No documentation was provided to reflect resident #116 had ever had a surgical wound to the left ischium. A significant change resident assessment, dated 07/22/15, documented resident #116 required extensive one person assist for bed mobility, transfers, dressing, eating, toilet use, personal hygiene and bathing. It documented the resident required total dependence of two person assistance for locomotion on and off the unit. It documented none of the above on the dental section of the assessment. It documented the resident had three stage three pressure ulcers. It documented two of these pressure ulcers were present on admission. It documented the resident did not have any current pressure ulcers. A physician's order, dated 09/03/15, documented, .CLEANSE RIGHT ISCHIUM WITH NORMAL SALINE, PAT DRY APPLY SANTYL NICKEL THICK AND COVER WITH DRY DRESSING FOAM CHANGE DAILY AND AS NEEDED FOR SOILAGE OR LOSS OF OCCLUSION . A physician's order, dated 09/03/15, documented, .CLEANSE LEFT ISCHIUM WITH NORMAL SALINE, PAT DRY, APPLY COLLAGEN TO WOUND BED AND COVER WITH FOAM/DRY DRESSING, CHANGE EVERY MON. (MONDAY), WED. (WEDNESDAY), & FRI (FRIDAY) AND AS NEEDED FOR SOILAGE OR LOSS OF OCCLUSION . A wound assessment report, dated 09/25/15, documented the resident had a stage two pressure ulcer to her right buttock; right ischium and a stage two pressure ulcer to her left buttock; left ischium. This was the most recent wound assessment report provided to the surveyor. A weekly report for all other skin problems, dated 10-02-15, documented the resident had a non in house acquired surgical wound to the left ischium which measured 1.5 x 8.5. It documented the wound was identified on 04/27/15, and was improving. It documented the care plan for this wound was current. It documented the resident had a non in house acquired surgical wound to the right ischium which measured 6 x 5 x 0.2. It documented the wound was identified on 04/27/15, and was improving. It documented the care plan for this wound was current. A weekly report for all other skin problems, dated 10-09-15 documented the resident had a non in house acquired surgical wound to the left ischium which measured 0.7 x 11.5. It documented the wound was identified on 04/27/15, and was healing. It documented the care plan for this wound was current. It documented the resident had a non in house acquired surgical wound to the right ischium which measured 4.5 x 2.5. It documented the wound was identified on 04/27/15, and was improving. It documented the care plan for this wound was current. A weekly report for all other skin problems, dated 10/23/15, documented the resident had a non in house acquired surgical wound to right ischium buttock which measured 4 x 2 x 0.2. It documented the wound was identified on 04/27/15, and was improving. It documented the care plan for this wound was up to date. It documented the resident had a non in house acquired surgical wound to the right ischium buttock which measured 9.5x1.5x0.2. It documented the wound was improving. A quarterly resident assessment, dated 10/21/15, documented the resident required extensive two person assist for bed mobility. It documented the resident required total assistance of two people for transfers, dressing, toilet use, and

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	375252	A. BUILDING _____ B. WING _____	12/09/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 21) bathing. It documented the resident required total one person assistance for locomotion on and off the unit and for personal hygiene. The November 2015 treatment administration record (TAR) documented blanks on the 23rd, 25th, and the 30th for the left ischium wound care completion. A skin grid/pressure sheet, dated 12/02/15, documented the resident had a right ischium stage two. A skin grid/pressure sheet, dated 12/02/15, documented the resident had a left ischium stage two. On 12/01/15 at 7:34 a.m., LPN #6 was interviewed and asked if resident #116 currently had one or more pressure ulcers. She stated the resident had two stage two pressure ulcers, one to the left ischium and one to the right ischium. At 9:30 a.m
F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** SUPPLEMENTAL Based on observation, record review and staff interview, it was determined the facility failed to ensure a urinary catheter was not placed without medical justification for one (#302) of three sampled residents reviewed for urinary catheter use. The facility identified six residents with urinary catheters resided in the facility. Findings: Resident #302 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's visit report, dated 01/26/15, documented the resident had a [DIAGNOSES REDACTED]. It documented, .1/26/16: new pressure ulcers of left, right buttock and coccyx . A physician's orders [REDACTED].May insert foley catheter dx (diagnosis): wounds . On 01/31/16 at 8:52 a.m., resident #302 was observed to have an indwelling urinary catheter in place. At 9:16 a.m., the wound care nurse was asked the reason resident's urinary catheter was placed. She stated the catheter was placed on 01/27/16 due to the location of the resident's wounds as well as the staging of the wounds. The nurse stated the physician had discontinued the dressings to the resident's wounds due to the resident having loose stools. She was asked what stages the resident's wounds were. She stated the wounds were a stage two. She was asked if it was her understanding that a stage two pressure ulcer was an appropriate use for a urinary catheter. The nurse stated, Yes. She stated the catheter was used to promote healing. She stated once the wounds were healed, the catheter would be removed. On 02/01/16 at 4:22 p.m., the director of nursing (DON) was asked the reason resident #302's urinary catheter was placed. She stated the catheter was placed because of the resident's wounds. She was asked to review the resident's clinical record and identify the staging of the resident's wounds. The DON reviewed the record and stated all of the resident's wounds were a stage two. She was asked if she knew the justification for the use of a urinary catheter. She stated, Absolutely. The DON was asked what was the justification for the use of a urinary catheter in the aiding of pressure ulcer healing. She stated the pressure ulcer had to be a stage three.
F 0318 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, it was determined the facility failed to ensure one (#103) of three sampled residents continued to receive treatment and services to prevent further decrease in range of motion following a hospitalization . The assistant director of nursing (ADON) identified 19 residents who required restorative services. Findings: Resident #103 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The restorative care program sheet for November 2015 documented the resident received services for two days and was hospitalized two days. Approaches included exercise to prevent further contractures and transfer to improve balance. There was no other documentation for the month. The individual resident care plan - A, dated 11/07/15, did not document the resident would have functional activity with restorative program for range of motion (ROM). A telephone order, dated 11/10/15, documented discontinue restorative which ended 10/05/15. A clarification telephone order, dated 11/17/15, documented to continue current restorative program for 90 days, start 10/08/15. An annual resident assessment, dated 12/01/15, documented the resident was cognitively intact with daily decision making and did not reject care. The resident required one person extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene and bathing. The resident required meal set up with supervision. The resident was always incontinent of bowel and bladder. The resident had functional limitation in ROM with impairment on both sides of the upper extremities. The assessment documented the resident was not receiving restorative nursing care for active or passive range of motion. The monthly physician's orders [REDACTED].>There were was not a restorative care program sheet for the month of December 2015 in the resident's clinical record. The care plan, dated 12/02/15, documented the resident was at risk for injury related to (r/t) [MEDICAL CONDITION]. Goals included resident would be free of injury and avoidable decline r/t contractures thru next review date of 03/2/16. Approaches included monitoring resident for steadiness in the wheel chair. Educate staff on the proper technique for positioning the resident. The care plan did not include interventions for restorative care for the resident. On 12/01/15 at 07:42 a.m., licensed practical nurse (LPN) #10 was interviewed regarding the resident's functional limitations. The LPN was asked if the resident had contractures. She stated the resident did not have contractures. At 8:14 a.m., the resident was observed sitting in the dining room eating breakfast. She was using both hands to drink a supplement. The resident was observed to have contractures of both upper extremities. A telephone order, dated 12/2/15, documented to D/C the resident from restorative. On 12/07/15 at 08:10 a.m., the resident was observed sitting in a wheel chair (w/c) in the dining room eating breakfast. The resident was observed using both hands to drink from the coffee cup. At 11:12 a.m., the resident was observed in bed. She was holding a stuffed animal wrapped in a blanket. There were no splints observed on the resident's hands. On 12/08/15 at 2:51 p.m., certified nurse aide (CNA) #2 was interviewed regarding restorative therapy for the resident. The CNA reported the therapy staff worked with her for ROM. The CNA stated, I do range of motion with her when she gets her coffee and when she eats. The CNA reported the resident only uses coffee cups to drink liquids out of because of her contractures. At 3:26 p.m., occupational therapist (OT) #1 was interviewed regarding how residents were recommended for restorative therapy. The OT reported an evaluation would be completed to see what the resident needs. If the resident did not qualify for therapy, they would place the resident on a restorative program. The OT was asked who would write the restorative program. The OT reported it was written by the nursing staff. The OT reported the nursing department would determine if the resident would continue after the first 90 days of restorative therapy. At 3:52 p.m., LPN #3 was asked if the resident was currently receiving restorative therapy. She stated, No, she was not. The LPN was asked if she knew why the resident was D/C'd from restorative therapy. The LPN stated, I do not know why. At 3:58 p.m., the director of nurses (DON) was interviewed regarding restorative services for the resident. She stated, I do know what happened. On 11/17/15 there was an order written [REDACTED]. The DON stated, I am not sure what happened, I need

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F 0318 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 22) to get clarification and documentation for this. At 4:54 p.m., the DON stated she had information regarding the restorative services for the resident. She stated, There was a miscommunication, the restorative aides told me they did not restart her after she came back from the hospital. The DON stated, That is why I wrote the order to discontinue restorative. She was asked if the resident should be receiving restorative therapy. The DON stated, Yes, she does. The resident should have never been D/Cd from restorative services.
F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	**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** Based on interview and record review, it was determined the facility failed to provide supervision to prevent falls for two (#85 and #131) of two sampled residents who were reviewed for falls. This resulted in actual harm of a head injury for resident #131, who received an anticoagulant medication, when she experienced three falls and no interventions were identified or implemented to aid in the prevention of falls. The facility identified 26 residents who had experienced falls in the last three months. Findings: The facility's policy on falls, dated 09/2012, documented, .The staff will evaluate and document falls that occur while the individual is in the facility .For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall .the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall . 1. Resident #131 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. admission orders [REDACTED]. An incident report, dated 08/11/15, documented, .was admitted on [DATE] from .next door. She was nonresponsive to stimuli including a sternal rub on admission. A rapid response was called and she was administered Narcan. She then became somewhat responsive. After a few minutes the nurse left the room. A few minutes later (resident #131) was noted to be on the floor. She had a knot forming on the top of her forehead. After assessment, the physician was notified and ordered (resident #131) to be sent to (hospital name deleted) to have a computed tomography (CT) of the head .The CT of the head was negative and (resident #131) was sent back to us. Her assessments were completed. Interventions put in place are bed in lowest position and fall mats to the side of bed .She was evaluated by and picked up on PT, OT and ST (physical, occupational, and speech therapies) . An individual resident care plan, dated 08/11/15, documented the resident was at risk for falling due to a history of falls, altered mental status and medications. It was documented a low bed with fall mats was in place. A nurse's note, dated 8/15/15 at 2:00 a.m., documented, .Resident noted on floor mat next to bed. Incont (incontinent) of loose BM (bowel movement). Cleaned (and) assisted back to bed. No (complaint of) pain It was documented the resident's vital signs were obtained, and they were within normal limits for the resident. It was documented that frequent checks would be completed. There was no documentation any new interventions had been identified or implemented to aid in the prevention of falls or that the facility had attempted to identify the root cause of the fall. There was no incident report of the fall. A nurse's note, dated 08/15/15 at 5:00 a.m., documented frequent rounds were made after the resident fell . There was no documentation of the resident's condition during those rounds. An admission assessment, dated 08/18/15, documented the resident had long and short term memory problems and was moderately impaired in cognitive skills for daily decision making. It was documented the resident required extensive assistance for bed mobility, transfers, and dressing. It was documented she was totally dependent for locomotion, eating, personal hygiene, and bathing. It was documented the resident was always incontinent of bowel and bladder, and had one fall without major injury since admission. The resident's care plan, dated 08/19/15, documented a problem related to being at risk for falls. The goal was the resident would have no falls with or without injury through the next review date. Approaches included to place on fall program, assist with transfers, ambulation, and bed mobility; to keep the call light within reach; assure proper footwear was used; and to observe for side effects from medications. The care plan was updated on 08/20/15 with an intervention to use a low bed and fall mats. A nurse's note, dated 08/23/15 at 6:25 a.m., documented, .Pt (patient) found on mat left side of bedside. Pt awake, resp (respirations) even (and) unlabored .No new bruise seen or skin tears on pt. Incont care given . It was documented the resident's vital signs were obtained, and they were within normal limits for the resident. There was no documentation any new interventions had been identified or implemented to aid in the prevention of falls or that the facility had attempted to identify the root cause of the fall. There was no incident report of the fall. A nurse's note, dated 08/29/15 at 10:30 a.m., documented, .this nurse was notified by CNA (certified nurse aide) stating resident was lying bedside bed on floor mats. Upon entering room nurse notes resident lying on left side of bed into floor mat c (with) head handing (sic) off lying on pedals of the peg tube pole. Nurse and CNA assisted resident on to back. Notes discoloration to middle of forehead. (No) skin openings, swelling or any other discolorations noted @ this time. Resident alert c some confusion noted .Resident c/o pain unable to describe locations and rate pain .Noted resident was dirty (large) BM noted in brief .Nurse educated staff that resident needs to changed (sic) (every) 2 (hours) . A progress note, dated 08/29/15 and untimed, documented, .Nurse notes discoloration to middle of forehead. Resident c/o general pain moaning when assisting c care of getting back into bed . An incident report, dated 08/29/15, documented, .nurse was notified by staff regarding resident on floor. Upon entering nurse noted resident lying on (left) side of bed on floor mats c head hanging off mats on to pedals of peg tube pole. Alert c some confusion . On 12/07/15 at 1:56 p.m., LPN #3, who was the nurse for the resident on 08/29/15, was asked if the resident could walk. She stated she could help with assistance. She was asked if the resident could reposition herself in bed. She stated the resident moved around a lot in bed. She was asked if the resident was at risk for falls. She stated, Yes. LPN #3 was asked what happened when the resident fell on [DATE]. She stated, They told me she was on the floor. She was asked what caused the resident's fall. She stated, I couldn't say exactly what caused the fall. LPN #3 was asked who identified interventions to aid in the prevention of falls. She stated, We try to do something right then and there, and then the DON (director of nursing) follows up. She was asked how staff was made aware of any interventions identified by the DON. She stated, They come back and tell us or you can go back and look at the care plan. She was asked how the aides were informed of the interventions. She stated they tried to get the aides right at the time of the incident. LPN #3 was asked if the resident was being monitored for anything in particular. She stated the resident was at risk for bleeding, so they would have been monitoring for signs and symptoms of bleeding. She was asked if she had monitored the resident for bleeding after the fall on 08/29/15. She stated, No. She was asked which physician she notified. She stated she notified physician #3 because he was on call for physician #1. She was asked if she informed physician #3 the resident was receiving Lovenox. She stated, I can't remember if I said that or not. She was asked if she documented that she informed the physician. She stated, No, I didn't. On 12/07/15 at 2:11 p.m., the DON was asked if the resident was at risk for falls. She stated, Yes. She was asked if the resident had falls while at the facility. She stated, Yes. She stated the resident had experienced a fall within the first few minutes of being at the facility. The DON was asked what interventions were implemented at that time. She stated a fall mat and low bed were implemented. The DON was asked what the root cause of the fall was. She stated the resident had received emergency care and she woke up and tried to get up and fell . The DON was asked how many falls the resident had at the facility. She reviewed the clinical record and stated the resident

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F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 23) had three falls. She was asked when the resident fell . She reviewed the record and stated 08/11/15, 08/15/15, 08/23/15, and 08/29/15. The DON was asked where the incident reports were for the falls on 08/15/15 and 08/23/15. She reviewed the incident reports and stated she could not find one for those falls. The DON was asked what the root cause was for the resident's falls. She stated, I don't know right off. I knew about the first fall. That's the only one that sticks in my head. She stated, As far as the others, I don't know. The DON was asked what the facility's policy was on determining root causes of falls. She stated falls were reviewed in clinical meetings and they tried to figure out what happened and why. She was asked if the resident's falls were reviewed. She stated, The first one, yes. The DON was asked when the fall mat and low bed were implemented. She stated it was when the resident returned to the facility after the first fall. She was asked what interventions were identified and implemented after the fall on 08/15/15. She stated, I didn't know about that. That wasn't told to me. She stated the nurse had documented she implemented frequent checks but there was no documentation of the checks. The DON was asked what caused the resident's falls. She stated, I can't tell you. A lot of residents roll out of bed onto their floor mats. 2. Resident #85 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. admission orders [REDACTED]. It was documented the resident was to be monitored for signs and symptoms of bleeding every shift. An admission assessment, dated 10/30/15, documented the resident was cognitively impaired and had no behaviors or psychosis. It was documented the resident required extensive assistance of two people for bed mobility; transfers; locomotion on and off the unit; and dressing, eating, toileting, and personal hygiene. It was documented the resident was not steady when moving from a sitting to standing position or with surface to surface transfers. It was also documented the resident had an indwelling urinary catheter and was always incontinent of bowel. It was documented the resident had received an anticoagulant medication on seven of the previous seven days. It was also documented it could not be determined whether the resident had falls prior to admission to the facility. The resident's care plan, dated 11/02/15, documented a problem related to the resident being at risk for falls due to [DIAGNOSES REDACTED]. The goal was the resident would have no falls, with or without injury, through the next review date. Approaches included to assist with transfers and bed mobility; keep the call light within reach; use proper footwear; observe for side effects from medications; remind to utilize assistive devices; provide adequate lighting; keep pathways free and clear of any objects; monitor for wet/slippery floors; therapy to evaluate and treat as ordered; use a wheelchair for mobility; and medications as ordered for Parkinson's disease. A departmental note, dated 11/12/15 at 6:24 a.m., documented, .Patient observed this am on floor at his bedside, bed in low position, awake and alert, ROM (range of motion) done to all extremities, all WNL (within normal limits) at this time, no S/S (signs or symptoms) of pain or discomfort, patient assisted to bed x (times) 2 assist, call light in reach and operable. Family and doctor aware . Review of the clinical record revealed no documentation the facility attempted to determine the root cause of the resident's fall. An incident report, dated 11/13/15 at 9:45 p.m., documented, .staff reported patient on the floor, went to room patient laying on left side propped up by left elbow, alert oriented to person, skin tear to left elbow patient denies pain or discomfort assisted to bed cleansed skin tear with normal saline, covered with island dressing neuros started, range of motion within normal limits grasp equal, pupils equal and reactive to light . On 12/03/15 at 8:26 a.m., LPN #7 was asked if the resident could walk. He stated he did not think so. He was asked if the resident could reposition himself in bed. LPN #7 stated the resident moved around a lot and he would have to be repositioned. He stated the resident would get his legs off the bed. He was asked if the resident was at risk for falls. He stated yes, because of the Parkinson's diagnosis. LPN #7 was asked what happened when the resident experienced his first fall. He stated, His bed was in the low position. I just remember him. He didn't have any open areas or hematomas like he had bumped his head or anything like that. He was asked what caused the resident's fall. He stated he thought it was because the resident was trying to get out of bed. On 12/03/15 at 9:18 a.m., the DON was asked who the nurse was when the resident experienced his second fall. She stated the nurse was no longer employed at the facility. On 12/03/15 at 9:22 a.m., CNA #6 was asked if the resident had been at risk for falls. He stated he thought so. He was asked how he would have known. He stated when a resident arrived at the facility, he would check to see if there was a fall risk bracelet in place from the hospital, or he would ask the nurse if the resident was at risk. He stated if he thought they were at risk for falls, he would put fall mats in place and make sure the bed was in the low position. He was asked if the nurses told the CNAs that residents were at risk for falls. He stated they figured it out on their own mostly. CNA #6 stated he would get a bed alarm as well and let the nurses know so they could get an order. CNA #6 was asked if the resident had experienced any falls. He stated, I came in one time and found him sitting in the floor by the bed. He stated he found the resident at shift change, at approximately 5:45 or 5:50 a.m. He was asked what caused the resident's fall. He stated he did not know. He was asked what he did when he found the resident. He stated he notified the nurse, they obtained vital signs, and put the resident back in bed. CNA #6 was asked if he was informed of any new interventions after the fall. He stated, no. On 12/03/15 at 10:09 a.m., the DON was asked if the resident had been at risk for falls. She reviewed the clinical record and stated, Yes, I would say that he was. She stated it was not documented the resident had a previous fall, but it was documented he had confusion. She stated the family member had reported the resident was able to ambulate prior to being hospitalized . She was asked if the resident had experienced falls while at the facility. She stated she thought he had two or three falls, occurring on 11/12/15 and 11/13/15. The DON was asked what had been determined to be the root cause of the resident's falls. She stated, I am not really sure what the root cause was. I was not here. I was on vacation when this occurred. She was asked who had been responsible during her absence. She stated both ADON #1 and #2. The DON was asked what the facility's policy and procedure was for determining root causes of falls. She stated that whenever a fall occurred, the facility tried to drill down and figure how what caused the falls. She stated with resident #85, there were several reasons for the resident to fall, including confusion and the ability to walk prior to hospitalization . She was asked where the investigation into the root causes of the resident's falls was documented. She stated, There wasn't one on these forms (incident reports). She was asked if that was where root cause investigations were documented. She stated, Yes, and what interventions were put into place. The DON was asked what interventions were put into place after the resident's first fall. She stated, According to this, it doesn't show anything. She reviewed the clinical record and stated a fall mat and low bed had been initiated on admission. She was asked if any new intervention had been identified and implemented. She stated, It does not appear to (be). It says something about frequent monitoring. She stated the incident report had documented frequent monitoring would occur. The DON was asked where the documentation of frequent monitoring was. She reviewed the clinical record and stated, I don't know. I don't see it.
F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to implement nutritional interventions as ordered by the physician for one (#150) of one sampled resident who was reviewed for [MEDICAL TREATMENT]. The facility identified seven residents as receiving [MEDICAL TREATMENT]. Findings: Resident #150 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 24) The resident's care plan, dated 10/16/15, documented a problem related to [MEDICAL CONDITION] with [MEDICAL TREATMENT]. It was documented the resident was at risk for shortness of breath, chest pain, itchy skin, [MEDICAL CONDITION], elevated blood pressure, and infections. The goal was the resident would have no complications from the disease process or [MEDICAL TREATMENT] through the next review date. Approaches included to observe for signs and symptoms of complications; monitor access site for redness, bleeding, or pain; observe for effectiveness of medications; and to check the bruit and thrill of the right arm fistula. An admission assessment, dated 10/23/15, documented the resident was cognitively intact and received [MEDICAL TREATMENT] services. A care plan, dated 10/27/15, documented the resident had a potential for injury related to a [DIAGNOSES REDACTED]. Approaches included to observe the effectiveness of medications. A physician's progress note, dated 11/11/15, documented, .Protein-calorie malnutrition. Increase the protein diet . There was no documentation in the clinical record the order was noted or implemented. On 12/07/15 at 4:01 p.m., licensed practical nurse #9 was asked who reviewed physician progress notes [REDACTED]. She was asked who was responsible for ensuring any orders on progress notes were noted and implemented. She stated the unit managers were. She was asked what type of diet the resident received. She stated he received a four gram sodium restricted diet. On 12/07/15 at 4:17 p.m., the assistant dietary manager was asked what type of diet did the resident receive. She stated a regular, sodium restricted diet. On 12/07/15 at 4:20 p.m., the director of nursing was asked who was responsible for noting orders written on progress notes. She stated the nurses were. She was shown the physician progress notes [REDACTED]. She stated that particular physician did not write his progress notes when making rounds. She stated he wrote them off-site and when he returned, he brought them with him. She stated his progress notes went directly to medical records and then on to the chart. She was asked if the order had been noted and implemented. She stated, No.
F 0329 **Level of harm** - Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure: ~ blood pressure (b/p) had been monitored to identify the need for blood pressure medication and ~ laboratory testing had been obtained to monitor therapeutic levels of medications for one (#161) of five sampled residents whose records were reviewed for unnecessary medications. The Resident Census and Conditions report, dated 12/01/15, documented 75 residents resided in the facility. Findings: Resident #161 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED].[MEDICATION NAME] 125mcg (micrograms) TABLET -IE (that is) [MEDICATION NAME] 1 TAB (tablet) BY MOUTH EVERY DAY . A physician's orders [REDACTED].LABORATORY ORDERS .CBC (complete blood count), CMP (complete metabolic panel), MAG (magnesium) LEVEL ONCE A WEEK ON MONDAY . A physician's orders [REDACTED].[MEDICATION NAME] HCL 0.1MG (milligram) TABLET -IE [MEDICATION NAME] 1 TABLET BY MOUTH AS NEEDED FOR SYSTOLIC BLOOD PRESSURE < (SIC) 170, RECHECK B/P AT 1 HOUR AFTER DOSE, IF SYSTOLIC BLOOD PRESSURE REMAINS GREATER THAN 170 MMHG (millimeters of mercury) CALL MD (medical doctor) - NOT TO EXCEED 1 DOSE Q (every) 6H (hour) . A care plan, dated 11/20/15, documented, .PROBLEM .CARDIOVASCULAR PROBLEMS .Dx (diagnosis): CAD ([MEDICAL CONDITION]) .HTN (hypertension) .Other: Afib ([MEDICAL CONDITION]) .GOALS .will not experience any signs and symptoms of cardiovascular problems through next review date .APPROACHES .Observe effectiveness of medication .Monitor vital signs per protocol .Monitor labs when available .(Dig ([MEDICATION NAME]) level) .Administer medications as ordered .notify MD as needed . The November 2015 Medication Administration Record [REDACTED]. The December 2015 MAR indicated [REDACTED]. On 12/08/15 at 10:27 a.m., the director of nursing (DON)was asked how they monitored when to give resident #161's blood pressure medication. She stated, They should be taking his blood pressure. She was asked how often the resident's blood pressure was required to be monitored. She stated, How ever often his [MEDICATION NAME] is able to be given. It should be taken every six hours. She was asked if she could locate where the blood pressure values had been documented. She stated, No. It should be on his nursing notes and it should be on his medication sheet every six hours. They weren't doing it. She was asked if the resident's blood pressure should have been re-checked after the [MEDICATION NAME] was given. She stated, Absolutely. She was asked if the physician had been notified when the medication was not effective. She stated, No. She was asked to locate the section of the care plan that identified blood pressure. She stated, It just says hypertension, give blood pressure medication and notify physician. At 11:35 a.m., the DON was asked when resident #161 was started on [MEDICATION NAME]. She stated the resident started the medication on 11/12/15. She was asked when the [MEDICATION NAME] levels were monitored. She stated I can't tell you that. She was asked the signs and symptoms of [MEDICATION NAME] toxicity. She stated she would have to look it up. She was asked how they had monitored for toxicity and where it had been documented. She stated it's not documented. She was shown the November 2015 MAR indicated [REDACTED]. She was asked what the policy was for notifying the physician when a medication was not given. She stated if the medication was held three times the physician would be notified. She was asked if the physician had been notified. She stated no.
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined the facility failed to ensure there was sufficient staff to meet the needs of residents. The following areas were found to be deficient: the care of pressure ulcers, supervision to prevent falls, the care of surgical wounds, coordination of care for [MEDICAL TREATMENT] and hospice, care plan implementation and notification of the physician and family for changes in condition. The Resident Census and Conditions of Resident report, dated 12/01/15, documented 75 residents resided in the facility. This had the potential to affect all 75 residents. Findings: 1. The facility failed to provide necessary care and services to prevent and/or promote healing of pressure ulcers for three (#49, 69 and #116) of five sampled residents who were reviewed for pressure ulcers. This resulted in actual harm for resident #69 when interventions were not implemented and the resident developed a new stage II pressure ulcer. See F314. 2. The facility failed to provide supervision to prevent falls for two (#85 and #131) of two sampled residents who were reviewed for falls. This resulted in actual harm of a head injury for resident #131, who received an anticoagulant medication, when she experienced three falls and no interventions were identified or implemented to aid in the prevention of falls. See F323. 3. The facility failed to: ~ Assess, monitor, and intervene for two (#85 and #131) residents who received anti-coagulant medications and experienced falls; and ~ Turn and reposition and provide incontinent care for one (#69) resident who was reviewed for the care of surgical wounds;

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F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 25) and ~ Turn and reposition and provide surgical wound care in a manner to prevent cross-contamination for one (#116) of two sampled residents reviewed for the care of surgical wounds; and ~ Coordinate care with the [MEDICAL TREATMENT] center for one (#150) of one sampled resident who was reviewed for [MEDICAL TREATMENT]; and ~ Coordinate care with hospice for one (#64) of one sampled resident who was reviewed for hospice services. See F309. 4. The facility failed to ensure care plans were implemented related to: ~ failing to assess and monitor residents after falls for two (#85 and #131) sampled residents; and ~ failing to transport a dependent resident to and from activities for one (#116) sampled resident; and ~ failing to brush a resident's natural teeth with toothpaste and a toothbrush for one (#116) sampled resident; and ~ failing to turn and reposition a dependent resident at least every two hours for one (#116) resident; and ~ failing to assess and monitor for side effects and adverse consequences for the medication [MEDICATION NAME] (used to treat [MEDICAL CONDITION]) for one (#150) resident and ~ failing to increase the protein in a resident's diet for one (#150) resident. See F282. 5. The facility failed to notify the physician and/or family of falls and/or changes in condition following a fall for two (#85 and #131) residents who had falls and received [MEDICATION NAME], an anticoagulant medication. See F157. 6. On 12/08/15 at 4:02 p.m., certified nurse aide (CNA) #2 was asked how she ensured residents were turned, positioned and skin care was completed for those residents identified to be at risk for pressure ulcers. She stated checks were done on the resident every two hours or as needed to see if the resident had been repositioned or turned. She stated she would ask other staff members if the skin care had been done. She was asked how she ensured incontinence care was done as needed. She stated she would check the resident at the beginning of her shift, every two hours and as needed. She was asked if there was enough staff to meet the residents needs. She stated there was enough staff to meet the residents needs. She was asked how she would communicate a concern about a resident. She stated if she had a concern about a resident she would go to the charge nurse and go up the chain of command if needed. She was asked if she needed assistance from another aide could she get it. She stated she got help when she needed it. She was asked how she informed staff if she needed help. She stated she would turn the light on if in a resident's room, go get another aide or report to the charge nurse. At 4:18 p.m., CNA #1 was asked how she ensured residents were turned, positioned and skin care was completed for those residents identified to be at risk for pressure ulcers. She stated she would check on the resident every two hours and if she noticed a skin condition she would report the concern to the charge nurse. She was asked how she ensured incontinence care was done as needed. She stated she would check on the resident every two hours. She was asked if there was enough staff to meet the residents needs. She stated most of the time there was enough staff to meet the residents needs. She was asked to elaborate. She stated on the weekends there wasn't enough staff all of the time. She was asked how she would communicate a concern about a resident. She stated if she had a concern about a resident she would report the concern to the charge nurse. She stated if she felt it hadn't been handled she would go up the chain of command. She was asked if she needed assistance from another aide did she get it. She stated she got help when she needed it. She was asked how she informed staff if she needed help. She stated she would turn the light on if in a resident's room. At 4:31 p.m., licensed practical nurse #1 (LPN) was asked how she supervised and monitored the delivery of care by nursing assistants according to the residents' care plans. She stated by watching the nursing assistants perform care and monitor their documentation. She was asked how she ensured staff assessed resident condition changes. She stated when it is brought to her attention she would assess the residents' condition changes and through verbal communication. She was asked how she responded to nursing assistants' requests for assistance. She stated she would help if help was needed or would find another CNA to assist. She was asked how she ensured there was adequate staff to meet the needs of the residents. She stated she would go to her shift supervisor to recruit help if help was needed if there wasn't enough staff. She was asked how she ensured the staff were knowledgeable about the needs of the residents and were capable of delivering the care as planned. She stated she would let her staff know if they were not familiar with the resident, refer to the chart and educate if necessary. She was asked how she ensured staff were appropriately deployed to meets the needs of the residents. She stated they looked at the acuity of care in relation to the amount of CNAs. She was asked how she provided orientation for a new or temporary staff member regarding the resident needs and the interventions to meet those needs. She stated CNA on CNA orientation and demonstration skills test. She was asked how she ensured staff were advised of changes in the care plan. She stated the charge nurse notified the CNA of changes in care plan. At 4:44 p.m., LPN #2 was asked how she supervised and monitored the delivery of care by nursing assistants according to the residents' care plans. She stated through education, by the CNAs knowing their job duties, open communication, look back checks and reviewing charting done by the CNAs. She was asked how she ensured staff assessed resident condition changes. She stated through open communication and the CNA should come to the charge nurse with any changes in condition. She was asked how she responded to nursing assistants' requests for assistance. She stated she would help or would get them another CNA to help. She was asked how she ensured there was adequate staff to meet the needs of the residents. She stated the facility hasn't had any problems with staffing and they have had at least three CNAs per hall in the last six months. She stated she would call in additional staff members to work or the staff supervisor would jump in and work as a CNA. She was asked how she ensured the staff were knowledgeable about the needs of the residents and were capable of delivering the care as planned. She stated through open communication, education and ensuring the CNAs had access to the plan of care in the ADL book. She was asked how she ensured staff were appropriately deployed to meets the needs of the residents. She stated depending on the CNA and the level of care the resident requires, the facility knows if the CNA can care for the resident. She was asked how she provided orientation for a new or temporary staff member regarding the resident needs and the interventions to meet those needs and introduction to residents. She stated there was a three day orientation where they are assigned to another CNA and a skills test was conducted, she believed. She was asked how she ensured staff were advised of changes in the care plan. She stated she would inform the CNAs of any changes. At 5:02 p.m., the director of nursing (DON) was asked how she supervised the nurses to ensure they monitored the delivery of care according to the residents' care plans. She stated through documentation review and to visually see what they were doing. She was asked who completed the staffing schedule. She stated she did at the moment. She was asked how she determined how much staff was needed on a daily basis and the level of staffing required to meet the residents' needs. She stated she staffed based on the census and acuity level of the residents. She was asked how she took in the acuity level when staffing. She stated residents who had peg tubes, trachs (tracheostomies) or wound care could require more help. She stated those were the things she looked at to determine what help was needed. At 5:17 p.m., the administrator was asked how she determined how much staff was needed on a daily basis in order to meet the residents needs and if they staffed according to acuity level. She stated they over staffed but staffed based on the census and acuity level.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to administer pain medication per physician's orders for one (#49) of five sampled residents whose records were reviewed for medications. The assistant director of nursing (ADON) identified 30 residents who received routine pain medication. The Resident Census and Conditions report, dated 12/01/15, documented 75 residents resided in the facility. Findings: Resident #49 had [DIAGNOSES REDACTED]. A resident admission assessment, dated 11/17/15, documented the resident had pain and rated the pain at a nine out of 10. A care plan, dated 11/18/15, documented, .Pain and Comfort .Chronic pain .Medicate as ordered and needed . A physician's order, dated 11/25/15, documented Dilaudid (a narcotic pain medication) 4 mg (milligrams) IV (intravenous) every four hours as needed for severe pain. A physician's order, dated 11/30/15, documented Dilaudid 2 mg IV to be given for wound care and may be given two hours prior

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F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 26) or two hours after a Dilaudid 4 mg dose had been administered. The narcotic count sheet for Dilaudid was reviewed for 11/26/15 through 11/28/15. It documented Dilaudid 2 mg had been administered on 11/27/15 at 1:45 p.m., 3:45 p.m., 7:45 p.m., and on 11/28/15 at midnight. The dose signed out on 11/2715 at 1:45 p.m. documented it had been administered for wound care. On 12/07/2015 at 11:14 a.m., the DON was asked to review resident #49's pain medication orders. She was shown the narcotic sign out sheet and asked if the resident had received the medication as ordered by the physician. She stated no. She was asked if a new physician's order had been obtained to administer the amount of pain medication that had been given. She stated no. She was asked if the physician should have notified. She stated yes, they should have. At 2:00 p.m., licensed practical nurse (LPN) #8 was asked to review resident #49's November 2015 Medication Administration Record [REDACTED]. She was asked if the resident had received the correct amount of Dilaudid on 11/27/15 and 11/28/15. She stated no. She was asked if the physician had been notified prior to administering the incorrect dose. She stated no. She stated sometimes the nurse would decide to give less if the resident was too drowsy or if the resident's vital signs were too low. She was asked if a new physician's order should have been required to give the lesser dose of pain medication. She stated the physician should have at least been notified.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, it was determined the facility failed to provide wound care in a manner to prevent cross-contamination for one (#116) of five sampled residents reviewed for pressure ulcers. The assistant director of nursing identified 11 residents with pressure ulcers in the facility. Findings: A handwashing and hand hygiene policy, last revised 08/14, documented, .This facility considers hand hygiene the primary means to prevent the spread of infections . Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: .when hands are visibly soiled .Use an alcohol-based hand rub containing at least 62% (percent) alcohol; or; alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . Before and after direct contact with residents .Before handling clean or soiled dressings, gauze pads, etc (et cetera) .Before moving from a contaminated body site to a clean body site during resident care .After contact with blood or bodily fluids .After handling used dressings, contaminated equipment, etc After removing gloves .Hand hygiene is the final step after removing and disposing of personal protective equipment The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .Applying and Removing Gloves .Perform hand hygiene before applying non-sterile gloves . Resident #116 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED].CLEANSE RIGHT ISCHIUM WITH NORMAL SALINE, PAT DRY APPLY SANTYL NICKEL THICK AND COVER WITH DRY DRESSING FOAM CHANGE DAILY AND AS NEEDED FOR SOILAGE OR LOSS OF OCCLUSION . A physician's orders [REDACTED].CLEANSE LEFT ISCHIUM WITH NORMAL SALINE, PAT DRY, APPLY COLLAGEN TO WOUND BED AND COVER WITH FOAM/DRY DRESSING, CHANGE EVERY MON. (MONDAY), WED. (WEDNESDAY), & FRI (FRIDAY) AND AS NEEDED FOR SOILAGE OR LOSS OF OCCLUSION . On 12/03/15 at 3:04 p.m., licensed practical nurse (LPN) #1 was observed providing wound care to resident #116. The LPN collected all of her dressing supplies off of the treatment cart and entered the resident's room. She placed all items on the counter in the resident's room. She donned gloves, wiped off the resident's bedside table with Microkill disinfecting wipes and removed her gloves. The LPN then placed a pad on the bedside table and placed all of her wound care supplies on the pad. The LPN failed to wash her hands when she entered the resident's room and failed to wash her hands after removing her gloves used to disinfect the bedside table. The LPN donned a new pair of gloves without washing her hands, removed the soiled dressings to the right and left ischium. She removed her gloves and donned a new pair of gloves without washing her hands. The LPN then rinsed both wounds with normal saline, removed her gloves and donned a new pair of gloves without washing her hands. She then used gauze pads to pat the right ischium wound dry, she started at the base of the wound and patted across the wound to dry it from bottom to top with the same gauze pad. She then patted the left ischium dry with a separate gauze pad. She started at the base of the wound and patted across the wound with the same gauze pad. She removed her gloves, placed a date on the bordered dressing and donned a new pair of gloves without washing her hands. She applied Santyl to the right ischium wound bed and covered the wound with the bordered foam dressing. She removed her gloves, failed to wash her hands, cut the collagen dressing to size, and donned a new pair of gloves without washing her hands. She then placed the collagen on the left ischium wound bed and covered the wound with a bordered foam dressing. The LPN then placed all dressing items in a red biohazard bag and tied it shut. She then removed her gloves and was observed washing her hands with soap and water prior to exiting the resident's room. LPN #1 was interviewed and asked what stage the wounds were. She stated they were both a stage one. She was asked if she ever measured the wounds. She stated she did not measure the wounds. She stated she was instructed not to measure the wounds because she did not usually do the wound care. The LPN was asked if she had washed her hands when she entered the resident's room. She stated, I did not. She was asked if she had washed her hands between each change of gloves. She stated, No. She was asked if she washed her hands after she had removed the old dressing and prior to applying the new dressing. She stated she had not washed her hands, she had just changes her gloves. She was asked what the facility policy was for handwashing. She stated she had not read the actual policy. She was asked if she should have washed her hands. She stated she should have washed her hands. On 12/07/15 at 10:54 a.m., the director of nursing was asked what the facility policy was for handwashing. She stated she knew the nurse who performed wound care had not washed her hands during wound care. She stated the policy was for staff to wash their hands before treatment, between glove changes, when going from clean to dirty and after the treatment was complete. She stated the nurses weren't used to doing the treatment because the facility had a wound care nurse. She was asked how the facility evaluated the nurses to ensure they had the skills to provide wound care. She stated the nurses know how to do the wound care, they were just nervous.
F 0464 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.** Based on observation and staff and family interviews, it was determined the facility failed to adequately furnish dining room chairs in the dining room. The Census and Conditions report, dated 12/01/15, documented 75 residents resided in the facility and 13 of those residents were bedfast all or most of the time. The director of nursing (DON) identified seven residents who utilized geri (geriatric) chairs resided in the facility. Fifty-five residents who had the ability to utilize a dining room chair resided in the facility. Findings: On 11/30/15 at 11:51 a.m., the lunch dining service was observed. There were 14 large rectangular shaped dining room tables with a total of 13 dining room chairs observed for these tables. The rectangular tables measured approximately 80 inches by 40 inches. There were four round dining room tables measuring approximately four feet in diameter with a total of two dining room chairs observed for this table. The dining room tables had the ability to seat 112 residents comfortably. At 12:14 p.m., 26 residents were observed in the dining room for lunch. Twenty-two residents were observed seated in a wheelchair. One resident was observed seated in a rolling walker. Two residents were observed seated in a dining room chair. At 12:18 p.m., licensed practical nurse (LPN) #3 was asked if the residents eating in the dining room was the average number

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	375252	A. BUILDING _____ B. WING _____	12/09/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDWEST CITY HEALTHCARE RESIDENCE	8200 NATIONAL AVENUE MIDWEST CITY, OK 73110

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F 0464 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 27) of residents who generally ate in the dining room. She stated yes this was the average number of residents who ate in the dining room. She stated it depended on how the residents felt. She stated a lot of the residents ate in their rooms. On 12/02/15 at 5:10 p.m. the dinner dining service was observed. There were 14 large rectangular shaped dining room tables with 13 chairs observed at these tables. There were four small round dining room tables observed with 3 dining room chairs observed at these tables. There was a total of 26 residents seated in the dining room for the dinner meal service. There were five residents observed seated at the round dining room tables. Three were observed seated in a regular wheelchair. One was observed seated in a geri chair. One was observed seated in a highback wheelchair. Seventeen residents were observed seated in wheelchairs at the rectangular shaped tables. Three residents were observed seated in a dining room chair and one resident was observed seated in a rolling walker at the rectangular tables. Five family members were observed seated in a dining room chair at the rectangular shaped tables. At 5:29 p.m., a resident's family member was observed carrying in a folding lawn chair to the dining room and placed it at one of the rectangular tables. They were asked why they brought the lawn chair into the dining room. He/she stated they had several family members who ate with the resident at their meals. They stated there were not enough dining room chairs for everyone to sit with the resident so they keep the folding chair in the resident's room so the family has a place to sit during meal service. At 5:29 p.m., CNA #5 was asked how she determined where the residents ate their meals. She stated some residents just didn't like to go to the dining room. She stated the nurses told her if residents required assistance with eating they ate in their rooms. At 6:03 p.m., certified nurse aide (CNA) #3 was asked how the facility determined where residents ate their meals. She stated the bedbound residents, residents with wounds and residents with a fever or infections all ate meals in their rooms. She stated she tried to bring the rest of the residents down to the dining room. At 6:09 p.m., certified medication aide (CMA) #1 was asked how the facility determined where a resident ate their meals. She stated staff asked the resident where they wanted to eat. She was asked how she would determine where a resident who was unable to communicate would eat. She stated she would ask the nurse. At 6:29 p.m. CNA #4 was asked how he determined where the residents ate their meals. He stated he would ask the resident each day. He was asked how he would determine where a resident who was unable to communicate their needs would eat. He stated if a resident was unable to communicate, they should be eating in the dining room. On 12/03/15 at 8:09 a.m., resident #116 was interviewed and asked if she would like to eat her meals in the dining room with other residents. She stated she would like to eat with other residents. She was asked if staff asked her daily if she would like to go to the dining room for meals. She stated no they did not offer her to go. At 11:11 a.m., the maintenance director was interviewed and asked if the facility had additional dining room chairs. He stated he believed the chairs were scattered throughout the facility. He stated the facility had enough chairs for the residents because several of the residents ate in their wheelchairs. At 11:13 a.m. the dietician was asked if the facility had additional dining room chairs. He stated he was not sure where additional dining room chairs were. At 11:16 a.m., the administrator (ADM) was interviewed and asked if the facility had additional dining room chairs. She stated most of the residents were in wheelchairs. She stated if they had additional chairs, they were scattered. On 12/07/15 at 7:31 a.m., the ADM stated the facility had a total of 27 dining room chairs. She stated the facility was ordering additional chairs. On 12/08/15 at 5:36 p.m., the administrator (ADM) and the director of nursing (DON) were interviewed and asked what the policy was for determining where a resident ate their meals. The ADM stated every resident should be given the option to get up for their meals. The DON stated every resident, unless they had a medical reason not to, should be offered a a chance to go to meals. They were asked if any of the residents who ate in their wheelchair in the dining room were physically capable of transferring to a dining room chair. The DON stated she would definitely have to look into it. They were asked if bedridden residents were transferred to the dining room in their wheelchair and ate in their wheelchair for the convenience of the staff. The DON stated they would definitely have to look into it. Do we really need this?
F 0490 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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, staff, resident and family interviews and clinical record review, it was determined the facility failed to ensure administrative systems were in place which enabled the facility to be administered in an efficient and effective manner. The Resident Census and Conditions of Residents report, dated 12/01/15, documented 75 residents resided in the facility. Findings: 1. The facility failed to provide necessary care and services to prevent and/or promote healing of pressure ulcers for three (#49, 69 and #116) of five sampled residents who were reviewed for pressure ulcers. This resulted in actual harm for resident #69 when interventions were not implemented and the resident developed a new stage II pressure ulcer. See F314. 2. The facility failed to provide supervision to prevent falls for two (#85 and #131) of two sampled residents who were reviewed for falls. This resulted in actual harm of a head injury for resident #131, who received an anticoagulant medication, when she experienced three falls and no interventions were identified or implemented to aid in the prevention of falls. See F323. 3. The facility failed to ensure there was sufficient staff to meet the needs of residents. See F353. 4. The facility failed to: ~ Assess, monitor, and intervene for two (#85 and #131) residents who received anti-coagulant medications and experienced falls; and ~ Turn and reposition and provide incontinent care for one (#69) resident who was reviewed for the care of surgical wounds; and ~ Turn and reposition and provide surgical wound care in a manner to prevent cross-contamination for one (#116) of two sampled residents reviewed for the care of surgical wounds; and ~ Coordinate care with the [MEDICAL TREATMENT] center for one (#150) of one sampled resident who was reviewed for [MEDICAL TREATMENT]; and ~ Coordinate care with hospice for one (#64) of one sampled resident who was reviewed for hospice services. See F309. 5. The facility failed to ensure care plans were implemented related to: ~ failing to assess and monitor residents after falls for two (#85 and #131) sampled residents; and ~ failing to transport a dependent resident to and from activities for one (#116) sampled resident; and ~ failing to brush a resident's natural teeth with toothpaste and a toothbrush for one (#116) sampled resident; and ~ failing to turn and reposition a dependent resident at least every two hours for one (#116) resident; and ~ failing to assess and monitor for side effects and adverse consequences for the medication [MEDICATION NAME] (used to treat [MEDICAL CONDITION]) for one (#150) resident and ~ failing to increase the protein in a resident's diet for one (#150) resident. See F282. 6. The facility failed to notify the physician and/or family of falls and/or changes in condition following a fall for two (#85 and #131) residents who had falls and received [MEDICATION NAME], an anticoagulant medication. See F157. On 12/08/15 at 4:15 p.m., an interview was conducted with the administrator (ADM). She was asked if prior to this survey had the quality assessment and assurance (QA&A) committee identified any of the following issues: pressure ulcers, falls, assessing and monitoring, implementing resident care plans and physician notification. The ADM stated, yes, we put a plan in place. We treated the plan like a survey, reviewed it monthly and if the monitoring was not effective we changed it. If it (the issue) looked like it was doing good we would cancel the monitoring and start monitoring something else. We would go over the monitoring with the medical director since we can call him any time. The ADM was asked what type of procedures were in place to make sure the nursing needs of the residents were met. She asked for clarification of the question. The ADM was asked was the monitoring working. She stated on some things it was working but not others. The ADM was asked if the morning stand up meetings are part of QA&A. She stated any issues brought up, yes and if resolved before the QA meeting the issues were discussed anyway.

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F 0490 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 28) The ADM was asked if she monitored the director of nursing (DON). She stated, By her willingness to provide support to the staff and work together as a team to provide care to the residents. Making sure she is monitoring her staff. The ADM was asked how she monitored staff to ensure the systems put in place were monitored. She stated we have a standards of care meeting every week with dietary, nursing and therapy. We have a morning stand up meeting every morning to discuss issues, go over incident reports. She also stated the DON and assistant director of nursing (ADON) go over things with the nurses. The ADM was asked how she thought the harm situation came about with the pressure ulcers. She stated the facility needed an effective wound nurse who would document and do the job. The ADM was asked how she thought the harm situation came about with the falls. She stated the DON would have been called. That was the protocol or if the ADON had been told, she would have done the monitoring. The ADM was asked what resources were available to her. She stated they did not have a sister facility here in Oklahoma. She stated all of the sister homes were in Texas. The ADM stated they did have QA nurses. The nurses were doing everything they could to help and get things lined out. She also stated they had been working with a local consulting firm to get off the special focus list. At 4:30 p.m., an interview was conducted with the DON. She was asked what training did she ensure the nursing staff had to care for residents with pressure ulcers, falls and those residents who received anticoagulant medications. She stated the director of education and quality (DEQ) did the competency checks on the nurses and other staff. The DON was asked how she ensured the nurses were competent in their skills for assessing and monitoring. She stated the DEQ is responsible and did all of the competency checks. The DON was asked how she thought the harm situation came about with the pressure ulcers. She stated between the wound nurse calling in and not coming in to work, hopefully the new wound nurse the facility has hired will work out. The DON was asked how she thought the harm situation came about with the falls. She stated she didn't know. She stated it was frustrating she didn't know about falls. I am only as good as my nurses and we failed.
F 0502 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** SUPPLEMENTAL Based on record review and staff interview, it was determined the facility failed to obtain a stool culture laboratory (lab) test as ordered by the physician for one (#304) of five sampled residents whose clinical records were reviewed for lab services. The facility identified 79 residents resided in the facility. Findings: A facility culture test policy, last revised 01/12, documented, .Culture tests will only be performed when ordered by a physician .Should the Attending Physician order [REDACTED]. Resident #304 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED].Stool specimen for [MEDICAL CONDITION] . A physician's orders [REDACTED].Cdiff culture for stool . No lab results were located in the resident's clinical record for these orders. On 02/02/16 at 9:45 a.m., the director of nursing (DON) was asked to locate the lab results for the [MEDICAL CONDITION] order on 01/28/16. At 11:42 a.m., the DON stated the lab had rejected three samples. She stated the facility had collected another specimen this morning. The DON was asked what the facility policy was for collecting lab/specimen. She stated, I have to find the policy.
F 0507 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep complete, dated lab records in the resident's file.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** SUPPLEMENTAL Based on clinical record review and staff interview, it was determined the facility failed to ensure laboratory (lab) test results were filed in the resident records for one (#302) of five sampled residents for whom lab tests results were reviewed. The facility identified 79 residents resided in the facility. Findings: A facility test results policy, last revised 04/2007, documented, .The resident's Attending Physician will be notified of the results of diagnostic tests .Signed and dated reports of all diagnostic services shall be made a part of the resident's medical record . Resident #302 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A nursing health status note, dated 01/25/16 at 5:22 a.m., documented, .CNA (certified nurse aide) NOTIFIED THIS NURSE OF ISSUE WHILE ADMIN (administering) CARE .RES (resident) EXPELLED LARGE BM (bowel movement) WITH WHAT APPEARS TO BE BLOOD- THIS THIS (SIC) NOTIFIED (NAME DELETED) .N.O. (NEW ORDER) STAT CBC (complete blood count) & CMP (complete metabolic panel)- LAB IN FACILITY COLLECTED SAMPLE - NOTIFY MD (MEDICAL DOCTOR) AS SOON AS LAB RESULTS RECEIVED FOR FURTHER ORDERS . A physician's laboratory order, dated 01/25/16, documented, .CBC CMP STAT (immediately) NOTIFY DOCTOR WITH RESULTS . No results for the laboratory order for 01/25/16 could be located in the resident's clinical record. On 02/02/16 at 9:45 a.m., the director of nursing (DON) was asked to locate the lab results for the stat CBC and CMP order on 01/25/16. At 11:00 a.m., the DON stated she was still waiting on the lab results. At 11:32 a.m., the DON returned with a copy of the CBC and CMP lab results, dated 01/25/16. The results were signed/noted by the facility staff on 01/26/16. The DON was asked if the lab results should have been in the resident's clinical record. She stated, Yes. The DON was asked what the facility policy was when lab results were received by the facility. She stated when the lab results were received, the staff were to notify the physician of any abnormal labs, note the order, and place a copy of the lab results in the resident's chart. She stated the original lab results would be placed in the physician's folder to be signed by the physician. The DON was asked where she had located the resident's lab results. She stated the lab results were in the physician's folder. The DON was asked if a copy of the results were in the resident's clinical record. She stated, No.

F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interview, it was determined the facility failed to ensure monthly physician's orders for care of a [MEDICATION NAME] and [MEDICAL CONDITION] were complete for one (#13) of 47 sampled residents whose clinical records were reviewed for completeness. The Resident Census and Condition report, dated 12/01/15, documented 75 residents currently resided in the facility Findings: Resident #13 was readmitted to the facility on [DATE]. The 10/15/15 admission orders [REDACTED]. The October 2015 treatment administration sheets (TARs) documented the resident received [MEDICAL CONDITION] and [MEDICATION NAME] care every shift. The November and December 2015 TARs did not document the resident received [MEDICAL CONDITION] or [MEDICATION NAME] care. The November and December 2015 monthly physician orders did not document for orders for [MEDICAL CONDITION] and [MEDICATION NAME] care. On 12/07/2015 at 1:27 p.m., licensed practical nurse (LPN) #10 was asked how the nurses were aware the resident had a [MEDICAL CONDITION] and a [MEDICATION NAME]. She was asked to review the December 2015 TARs. After she had reviewed the

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F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 29) December TARs, the LPN stated they (the orders) were on there (the TARs) when she came in. The LPN was asked to review the November and December 2015 monthly physician's orders for orders for [MEDICAL CONDITION] and [MEDICATION NAME] care. After she had reviewed the orders, the LPN stated the orders should be there. At 1:41 p.m., resident #13 was interviewed. She was asked if she received [MEDICAL CONDITION] care. The resident stated yes. She stated the nurses were really good about caring for it. She stated they change the wafer as needed but she can change and burp her own bag at times. The resident was asked if she received [MEDICATION NAME] care. She stated the nurses care for it since she can't reach it.
F 0520 **Level of harm** - 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, clinical record review and staff, resident and family interviews, it was determined the facility failed to have an effective quality assessment and assurance (QA &A)committee which effectively monitored problems and put effective plans in place. The following areas were found to be deficient: the care of pressure ulcers, supervision to prevent falls, the care of surgical wounds, coordination of care for [MEDICAL TREATMENT] and hospice, care plan implementation and notification of the physician and family for changes in condition. The Resident Census and Conditions report, dated 12/01/15, documented 75 residents resident in the facility. Findings: 1. The facility failed to provide necessary care and services to prevent and/or promote healing of pressure ulcers for three (#49, 69 and #116) of five sampled residents who were reviewed for pressure ulcers. This resulted in actual harm for resident #69 when interventions were not implemented and the resident developed a new stage II pressure ulcer. See F314. 2. The facility failed to provide supervision to prevent falls for two (#85 and #131) of two sampled residents who were reviewed for falls. This resulted in actual harm of a head injury for resident #131, who received an anticoagulant medication, when she experienced three falls and no interventions were identified or implemented to aid in the prevention of falls. See F323. 3. The facility failed to ensure there was sufficient staff to meet the needs of residents. See F353. 4. The facility failed to: ~ Assess, monitor, and intervene for two (#85 and #131) residents who received anti-coagulant medications and experienced falls; and ~ Turn and reposition and provide incontinent care for one (#69) resident who was reviewed for the care of surgical wounds; and ~ Turn and reposition and provide surgical wound care in a manner to prevent cross-contamination for one (#116) of two sampled residents reviewed for the care of surgical wounds; and ~ Coordinate care with the [MEDICAL TREATMENT] center for one (#150) of one sampled resident who was reviewed for [MEDICAL TREATMENT]; and ~ Coordinate care with hospice for one (#64) of one sampled resident who was reviewed for hospice services. See F309. 5. The facility failed to ensure care plans were implemented related to: ~ failing to assess and monitor residents after falls for two (#85 and #131) sampled residents; and ~ failing to transport a dependent resident to and from activities for one (#116) sampled resident; and ~ failing to brush a resident's natural teeth with toothpaste and a toothbrush for one (#116) sampled resident; and ~ failing to turn and reposition a dependent resident at least every two hours for one (#116) resident; and ~ failing to assess and monitor for side effects and adverse consequences for the medication [MEDICATION NAME] (used to treat [MEDICAL CONDITION]) for one (#150) resident and ~ failing to increase the protein in a resident's diet for one (#150) resident. See F282. 6. The facility failed to notify the physician and/or family of falls and/or changes in condition following a fall for two (#85 and #131) residents who had falls and received [MEDICATION NAME], an anticoagulant medication. See F157. On 12/08/15 at 4:15 p.m., an interview was conducted with the administrator (ADM). She was asked if prior to this survey had the quality assessment and assurance (QA&A) committee identified any of the following issues: pressure ulcers, falls, assessing and monitoring, implementing resident care plans and physician notification. The ADM stated yes, we put a plan in place. We treated the plan like a survey, reviewed it monthly and if the monitoring was not effective we changed it. If it (the issue) looked like it was doing good we would cancel the monitoring and start monitoring something else. We would go over the monitoring with the medical director since we can call him any time. The ADM was asked what type of procedures were in place to make sure the nursing needs of the residents were met. She asked for clarification of the question. The ADM was asked was the monitoring working. She stated on some things it was working, but not others. The ADM was asked if the morning stand up meetings were a part of QA&A. She stated any issues brought up, yes and if resolved before the QA meeting the issues were discussed anyway. The ADM was asked if she monitored the director of nursing (DON). She stated, By her willingness to provide support to the staff and work together as a team to provide care to the residents. Making sure she is monitoring her staff. The ADM was asked how she monitored staff to ensure the systems in place were monitored. She stated we have a standards of care meeting every week with dietary, nursing and therapy. We have a morning stand up meeting every morning to discuss issues, go over incident reports. She also stated the DON and assistant director of nursing (ADON) go over things with the nurses. The ADM was asked how she thought the harm situation came about with the pressure ulcers. She stated the facility needed an effective wound nurse who would document and do the job. The ADM was asked how she thought the harm situation came about with the falls. She stated the DON would have been called. That was the protocol or if the ADON had been told, she would have done the monitoring. The ADM was asked what resources were available to her. She stated they did not have a sister facility here in Oklahoma. She stated all of the sister homes were in Texas. The ADM stated they did have QA nurses. The nurses were doing everything they could to help and get things lined out. She also stated they had been working with a local consulting firm to get off the special focus list. At 4:30 p.m., an interview was conducted with the DON. She was asked what training did she ensure the nursing staff had to care for residents with pressure ulcers, falls and those residents who received anticoagulant medications. She stated the director of education and quality (DEQ) did the competency checks on the nurses and other staff. The DON was asked how she ensured the nurses were competent in their skills for assessing and monitoring. She stated the DEQ is responsible and did all of the competency checks. The DON was asked how she thought the harm situation came about with the pressure ulcers. She stated between the wound nurse calling in and not coming in to work, hopefully the new wound nurse the facility has hired will work out. The DON was asked how she thought the harm situation came about with the falls. She stated she didn't know. She stated it was frustrating she didn't know about falls. I am only as good as my nurses and we failed.