		AND HUMAN SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ° ′	IPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		375098	B WING_		01	/11/2016
NAME OF F	PROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • •	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP CODE		
		OFO MIDWEOT OITY		2900 PARKLAWN DRIVE		
MANOR	CARE HEALTH SERVI	ICES-MIDWEST CITY		MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F 00	00		
		rvey was conducted on 1/07/16 and 01/11/16.				
	Below is a list of ab this survey:	breviations used throughout				
	CVA - Cerebral Vas D - day DON - Director of N DR - dining room drsg - dressing d/t - due to E. Coli - Escherichia ER - Emergency Ro GERD - Gastric Esc Hr - hour III - three IV - Intravenous LPN - Licensed Pra MAR - medication a MDS - Minimum Da MG/mg - milligrams ML - milliliter	tion dryl/Haldol er extremities Heart Failure ostructive Pulmonary Disease cular Disease lursing a coli com ophageal Reflux Disease administration record ata Set				
		ER/SUPPLIER REPRESENTATIVE'S SIG		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

PRINTED: 01/26/2016

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

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY
ND PLAN C		IDENTIFICATION NUMBER	A BUILDIN	G	co	MPLETED
		375098	B WING		01/11/2016	
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		STREET ADDRESS, CITY, STATE, ZIP C 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 000	Continued From pa	age 1	F 00	o		
F 226 SS=D	PO/po - by mouth PRN - as needed Pt/pt - patient Q -every Qhs - every night Qsh - every shift RN - Registered No S.E side effects S/S - signs and syn TAR - treatment ad TID - three times a UTI - urinary tract in VSS - vital signs st w/c - wheelchair x -times 483.13(c) DEVELO ABUSE/NEGLECT The facility must de policies and proced mistreatment, negle and misappropriation This REQUIREMENT by: Based on employee interview, it was de complete criminal b (CNA #1) of five em- were reviewed. The Resident Cens	nptoms ministration record day nfection able P/IMPLMENT , ETC POLICIES evelop and implement written	F 224	5		

Facility ID NH5512

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DAT	E SURVEY PLETED
		375098	B WING			01/	11/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-MIDWEST CITY	l l	_	2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Practice Guide, doc 'Guide' is to assist e of an abuse preven Employee Screening information from State licensing boar Criminal backgroun A review of the emp documented a hire There was no docut of a criminal backgr On 01/11/16 at 3:00 asked for any crimin CNA #1. At 3:30 p.m., the Ad	y. titled, Patient Protection cumented, "The purpose of the each center in implementation tion system gThe center utilizes the g process to identify rds and registries, d checks" ployee file for CNA #1, date of 11/05/15. mentation in the employee file	F 2	226			
F 280 SS=E	The resident has the incompetent or othe incapacitated under	NNING CARE-REVISE CP e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 2	80			

Facility ID. NH5512

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(M)		
	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
375098 B. WING	01/11/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCARE HEALTH SERVICES-MIDWEST CITY 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BY           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIA	BE COMPLETION	
F 280       Continued From page 3       F 280         A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.         This REQUIREMENT is not met as evidenced by;       Based on observation, record review and interview, it was determined the facility failed to ensure care plans were revised after falls for one (#2) of nine residents whose clinical records were reviewed for falls.         The Resident Census and Conditions Report dated 01/04/16, documented 73 residents resided in the facility.         Findings:         Resident #2 had diagnoses which included chronic pain, dementia, aphasia, diabetes, COPD, CHF and osteoarthritis.         A care plan, initiated on 02/11/10, documented, "At risk for falls due use of psychotropic medications, general weakness, and history of		

		AND HUMAN SERVICES				FC	TED: 01/26/2016 DRM APPROVED NO: 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILDI		CONSTRUCTION	(X3)	) DATE SURVEY COMPLETED
		375098	B WING				01/11/2016
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		2900	EET ADDRESS, CITY, STATE, ZIP D PARKLAWN DRIVE WEST CITY, OK 73110	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION E DATE
F 280	documented, "Fa res found on floor i There were no new care plan. An incident report, documented, "Lo RoomFall without found on floor next There were no new care plan. An incident report, documented, "Fa found by Can [sic] I bedassisted back started, skin tears t and steri strips app There were no new care plan. An incident report, documented, "Fa resident was found and recliner. Resid she fell" There were no new the care plan. On 01/04/15 at 1:00 where the intervent documented. She She was asked if th	dated 02/27/15 at 9:30 a.m., Il without injury (or minor i [sic] n dining room" v interventions identified on the dated 03/09/15 at 4:30 a.m., cation of Incident: Patient's t injury (or minor i [sic] resident	F 2	80			

If continuation sheet Page 5 of 45

		AND HUMAN SERVICES	-			FOR	D: 01/26/2010 MAPPROVEL D. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION		ATE SURVEY
		375098	B WING			0.	1/11/2016
NAME OF I	PROVIDER OR SUPPLIER	A	·	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY			0 PARKLAWN DRIVE DWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	Continued From pa	ige 5	F 2	80			
	was asked if the re- with each fall. She documented on the the problem section with an intervention interventions." At 1:50 p.m., the Di- be new intervention She stated, "Yes." ensured that new in placed on the care discussed in the ea 483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho	00 p.m., the MDS Coordinator sident's care plan was updated stated, "The falls are not care plan each time under but each fall is care planned and dated under the ON was asked if there should swith each fall occurrence. She was asked how the facility nerventions were initiated and plans. She stated, "It is gle room every morning." CARE/SERVICES FOR EING creceive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment	F 3	09			
	by: Based on observat and resident intervi- facility failed to ensi coordinated with the psychotropic medic without indication for	NT is not met as evidenced tion, record review and staff ew, it was determined the ure the resident's care was e hospice agency to ensure ations were not increased or an increase for one (#1) of ents who received hospice					

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		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	1				PLETED
		375098	B WING			01/	11/2016
NAME OF F	PROVIDER OR SUPPLIER		L	s	TREET ADDRESS, CITY, STATE, ZIP CODE		11/2010
				2	900 PARKLAWN DRIVE		
MANON	MANORCARE HEALTH SERVICES-MIDWEST CITY			N	NIDWEST CITY, OK 73110		
(X4) ID		TEMENT OF DEFICIENCIES	ID PREFIX	,	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
F 309	Continued From pa	ae 6	F 3	00			
1 000	Continued I form pa	geo	F 5	09			
	The Resident Cens	us and Conditions report,					
		cumented seven residents					
	received hospice se	ervices.					
	Findings:						
	A policy Phase 3: I	mplement, dated 2015,					
	documented, "Uni		1				
	1 Each resident's	drug regimen must be free					
	from unnecessary c any drug when used	Irugs. An unnecessary drug is					
		se (including duplicate					
	therapy): or						
	(ii) For excessive d		-				
	<ul><li>(iii) Without adequa</li><li>(iv) Without adequa</li></ul>	ate indications for its use: or					
	(v) In the presence	of adverse consequences					
		lose should be reduced or					
	discontinued: or (vi) Any combinatio	ons of the reasons above"					-
		admitted to the facility on					
		oses which included e, anxiety and depression. He					
	was admitted to hos	spice on 08/26/15 with					
		cluded failure to thrive and					
	chronic obstructive	pulmonary disease.					
		nysician's orders, dated					
		ted the resident was to					
		mg TID and Ativan 0.5 mg hese were antianxiety					
	medications.	need more unitalizity					
		detend 10/01/1E determines of the					
		dated 10/01/15, documented nax to 0.25 mg every eight					
	hours PRN.						

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		375098	B WING			01/	11/2016
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 PARKLAWN DRIVE IDWEST CITY, OK 73110	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	had been administe on 10/01/15, 10/02/ anxiety and on 10/1 with cough. The re- with an upper respi- week. Twenty two nursing documented betwe There was no docu anxious behaviors of of increased anxiety documentation the resident's care with A hospice nursing r documented the res "pt. sleeps 16 + hrs A nursing progress documented, "New May give Xanax 0.2 [sic] change Xanax A physician's order, to hold the Ativan u 0.25 mg was to be a Ativan was available decreased to TID F Ativan change was The October 2015 I documentation the administered a PRN through 10/22/15. A hospice nursing r	MAR documented the resident ared one PRN Xanax 0.25 mg (15, 10/12/15 for increased 15/15 for increased anxiety sident had been diagnosed ratory infection the previous progress notes were en 10/01/15 and 10/17/15. mentation of restlessness, or of the resident complaining y. There was no nurses had coordinated the the hospice nurses. note, dated 10/15/15, sident had anxiety "@ X's" and a day". note, dated 10/17/15, order for Ativan 0.5 mg tid. 25 tid until Ativan arrives the to tid prn" dated 10/17/15, documented until available. The Xanax administered TID until the e and then was to be PRN. No written order for the located. MAR contained no	F 3	09			

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		AND HUMAN SERVICES				FORM	: 01/26/201 APPROVE . 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		375098	B WING			01/	11/2016
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY			00 PARKLAWN DRIVE DWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	<b>K</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 8	F 3	09			
	"pt. sleeps 16 + hrs a day".						[
	to increase the Xar	, dated 10/22/15, documented nax to 0.25 mg two tabs (0.5 PRN for restlessness.					
		ng notes, dated 10/23/15 and nted the resident's anxiety eferred.					
		MAR documented the resident ered one PRN Xanax on 5/15.					
	from 10/17/15 throu documentation of r behaviors or of the increased anxiety.	gress notes were documented ugh 10/29/15. There was no estlessness, anxious resident complaining of There was no documentation ordinated the resident's care arses.					
	documented the re "pt. sleeps 16 + hrs the resident comple cough "and he can" name deleted] notif orders" The note nurse had notified t	note, dated 10/29/15, sident had anxiety "@ X's" and a day". It also documented ained of a nonproductive It get anything up. [Physician's fied [and] received new a documented the hospice the attending physician of the ad had received new orders.					
	to increase the Ativ	, dated 10/29/15, documented an to 0.5 mg every six hours gnosis of anxiety as essness.					
		note, dated 10/30/15, sident's anxiety status had					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A BUILDING 375098 **B** WING 01/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 309 Continued From page 9 F 309 been deferred. The November 2015 MAR documented the resident had been administered one PRN Xanax on 11/02/15. The next time the PRN Ativan was administered was on 11/19/15. A hospice nursing note, dated 11/05/15, documented the resident had anxiety "@ X's" and "pt. sleeps 16 + hrs a dav". A hospice nursing note, dated 11/06/15, documented the resident's anxiety status had heen deferred Six nursing progress notes were documented from 10/29/15 through 11/12/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses. A hospice nursing note, dated 11/12/15, documented the resident had anxiety "@ X's [increased]" and "pt. sleeps 16 + hrs a day". It also documented, "...pt. reports [increased] anxiety [and] thick sputum that makes him gag [and] vomit. [Physician's name deleted] notified [and] new orders received ... " The note documented the hospice nurse had notified the attending physician of the resident's status and had received new orders. A physician's order, dated 11/12/15, documented to increase the Ativan to 0.5 mg two tabs (1 mg) every eight hours routinely for the diagnosis of anxiety as manifested by restlessness.

FORM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES			FORM	01/26/201 APPROVE 0.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LE CONSTRUCTION		TE SURVEY
		375098	B WING	· · · · · · · · · · · · · · · · · · ·	01	/11/2016
	ROVIDER OR SUPPLIER	ICES-MIDWEST CITY	2	STREET ADDRESS, CITY, STATE, ZIP CC 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	locate the document indicated the need antianxiety medicat On 01/06/16 at 2:50 was documentation the resident's beha facility should have behaviors. She sta facility everyday an they don't think abo On 1/11/16 at 10:50 asked what she wo of increased anxiet the physician and ta She was asked if s the use of PRN me physician. She sta She was asked, if s observed the reside a PRN medication to the physician. She ask the facility nurs dose and monitor th	0 p.m., the DON was asked to htation of behaviors which for the increase in the tions. 5 p.m., the DON stated there in the hospice notes about viors. She was asked if the also documented those ated the hospice nurse is in the d "They probably talk so much but documenting it." 0 a.m., the hospice nurse was huld do if a resident complained y. She stated she would call alk to the facility nurse. he ever checked the MARs for dications before calling the ted she "could do that." she reviewed the MARs and ent had not been administered for two weeks, would she call stated she would probably e to give the resident a PRN	F 309			
	DON stated she ha coordinate care wit	acility the previous week. The d not had a chance to h her. ed if she had located any				
F 040	facility documentati behaviors. She sta	on regarding the resident's ted, "No."	F 0.40			
F 312	483.25(a)(3) ADL C	CARE PROVIDED FOR	F 312			

Facility ID NH5512

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		375098	B WING		01/	11/2016	
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	i.	STREET ADDRESS, CITY, STATE, Z 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETIO DATE	
	Continued From pa	-	F 312	2		ľ	
SS=D	DEPENDENT RES	SIDENTS				ľ	
	daily living receives	nable to carry out activities of s the necessary services to ition, grooming, and personal					
	by: Based on observa interview, it was de ensure thorough in	NT is not met as evidenced tion, record review and staff termined the facility failed to continent care was provided sampled residents whose as observed					
	dated 01/04/15, do occasionally or free	sus and Conditions report, cumented 21 residents were quently incontinent of bowel ad indwelling or external					
	Findings:						
	"Focus Use of indwelling u bladder and urinary	d on 11/26/12, documented, rinary catheter for neurogenic retention neter care every shift and as					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/26/2016 APPROVED 0938-0391
r	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	. ,			(X3) DAT	E SURVEY PLETED
l.		375098	B WING			01/	11/2016
l .	OVIDER OR SUPPLIER	CES-MIDWEST CITY		290	REET ADDRESS, CITY, STATE, ZIP CODE 0 PARKLAWN DRIVE DWEST CITY, OK 73110	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
Constraints of the second seco	equired extensive a ansfers. She requine person for bed and personal hygier ange of motion of the was not ambula rinary catheter and owel. TAR for Januar esident was to rece <u>n 01/05/16 at 10:3</u> continent care for NA #2 and CNA #2 esponsible for provesident. CNA #2 st onna do." The resident stated 2:30 a.m. and was eaned. As care was perved to have dr uttocks. CNA #2 st as no observation e resident at this ti to 10:45 a.m., CNA #3 st ill let us know."	aily decision making. She assistance of two people for ired extensive assistance of mobility, dressing, toilet use he. She had a limitation in he bilateral lower extremities. atory. She had an indwelling was always incontinent of y 2016 documented the eive catheter care every shift. 0 a.m.,the provision of the resident was observed. 8 were asked who was iding catheter care for the cated, "That's what we are that she had an accident at not sure how well she was as initiated, the resident was ied brown feces on her tated, "Still got a little." There of catheter care provided to	F 3	12			

Facility ID NH5512

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		375098	B WING_		01/11/2016		
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP			
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLÉTI LE APPROPRIATE DATE		
F 312	Continued From pa	age 13	F 312	2			
	catheter care for th	ed of the need to observe the e day shift. No observation o observed on the day shift.					
F 323 SS=E	catheter care was g 01/05/16. She state her chair." 483.25(h) FREE OI		n) F 32:	3			
	environment remain as is possible; and	isure that the resident ns as free of accident hazards each resident receives on and assistance devices to	3				
	by: Based on observat interviews, it was de provide supervision consistently identify to aid in the preven	NT is not met as evidenced tion, record review and staff etermined the facility failed to to prevent falls and to and implement interventions tion of falls for one (#2) of nin whose clinical records were					
		sus and Conditions report, cumented 73 residents reside	d				
	Findings:						
	Resident #2 had dia	agnoses which included					

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TATEMENT	OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
		375098	B WING	·		01/11/2016	
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		2	TREET ADDRESS, CITY, STATE, ZIP COE 900 PARKLAWN DRIVE NIDWEST CITY, OK 73110	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 323	Continued From pa	age 14	F3	323			
	chronic pain, deme COPD, CHF and o	entia, aphasia, diabetes, isteoarthritis.					
	"At risk for falls due	d on 02/11/10, documented, e to use of psychotropic ral weakness, and history of					
	Interventions inclue	ded:					
l	"Bed in low posit 02/11/2010	ion. Date initiated:					
		on rock and go chair when she can not move ed 12/16/2014					
		t resident up and out of bed g. Date initiated: 10/22/2014	•				
	Encourage activitie [sic] Date initiated:	es when resident is up is up 11/11/2014					
	Encourage and ass and non slip footwe 02/11/2010	sist as needed to wear proper ear. Date Initiated:					
	Have commonly us Date Initiated: 09/1	sed articles within easy reach. 14/2013					
	assist resident into	restless or anxious in bed, rock and go chair for tated: 01/08/2015					
	Notify physician, fa Date Initiated: 06/*	mily, and hospice of any falls. 10/2014					
	Nurse to check on Initiated: 02/11/20	patient frequently. Date 10					

Facility ID<sup>.</sup> NH5512

If continuation sheet Page 15 of 45

		AND HUMAN SERVICES	- <b></b>		FORM	): 01/26/201 / APPROVE ) <u>. 0938-039</u>		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION G		TE SURVEY MPLETED		
		375098	B WING_		01/11/2010			
NAME OF I	PROVIDER OR SUPPLIER	• <u>•</u>	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIF				
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY	2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE		
F 323	Continued From page 15 Place no skid material in wheelchair. Date InitiatedL 11/24/2014			3				
	mental status, ADL	nt of pain, bruises, change in function, appetite, or per facility guidelines post fall. 31/2012						
	Rock and go wheel 11/12/2014	chair. Date Initiated:						
	laying down and up	et resident before and after meals before ng down and upon rising and during the night e awake. Date Initiated: 08/08/2014						
	Wide bed. Date Ini	itated: 11/11/2014"						
		dated 02/27/15 at 9:30 a.m., Il without injury (or minor i [sic] n dining room"						
	There were no inter incident report.	rventions documented on the						
	There were no new care plan.	interventions identified on the						
	documented, "Lo	dated 03/09/15 at 4:30 a.m., cation of Incident: Patient's : injury (or minor i [sic] resident to bed"						
	There were no inter incident report.	rventions documented on the						
	There were no new care plan.	interventions identified on the						

Facility ID NH5512

If continuation sheet Page 16 of 45

		AND HUMAN SERVICES			PRINTED: 01/26/20 FORM APPROVE OMB NO. 0938-039		
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		375098	B WING		01/11/2016		
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE COMPLETIO D THE APPROPRIATE DATE		
F 323	documented, "Fa found by Can [sic] I bedassisted back [sic]started, skin tea NS and steri strips There were no inter incident report. There were no new care plan. An incident report, of documented, "Fa Resident upside do with feet in bed tang to bed with extensiv An update to the ca documented, "Medi An incident report, of documented, "Fal resident was found and recliner. Resid she fell" There were no inter incident report. There were no new the care plan. An incident report, of documented, "Fal resident report.	dated 03/12/15 at 3:15 a.m., Il without injury (or minor i [sic] ying on floor next to a to bed, VSS and neuro,s ars to right arm cleaned with applied, drsg applied" rventions documented on the r interventions identified on the dated 05/21/15 at 11:00 p.m., Il without injury (or minor i wn with torso on the ground gled in blankets. Assist back /e assist x 3"	F3	323			

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		AND HUMAN SERVICES			FORM	: 01/26/201 APPROVEI . 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION		E SURVEY IPLETED
		375098	B WING		01/	/11/2016
NAME OF I	PROVIDER OR SUPPLIER		s.	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		900 PARKLAWN DRIVE IIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 17	F 323			
i	There were no inte incident report.	rventions documented on the				
		are plan, initiated on 07/21/15, not leave unattended in room."				
		are plan, intiated on 08/28/15, o wheelchair slightly reclined				
		are plan, initiated on 09/17/15, st resident to bed if sleeping in				
	documented, "Lo HallwayFall witho reaching forward an wheelchairGotter	ut injury (or minor i Pt was nd fell out of n back into chair, taken to room 1cm skin tear to L side of				
	There were no inter incident report.	rventions documented on the				
	Updates to the care documented: "non slip grip mat ir Tilt wheelchair seat					
	documented, "Lou RoomFall without was on the hall pas make a thud noise. investigate this nurs	dated 10/09/15 at 9:15 p.m., cation of Incident: Patient's t injury (or minor i This nurse ssing meds and heard this res Went this nurse went to se found this resident witting left side of bed with legs				

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Facility ID NH5512

If continuation sheet Page 18 of 45

TATEMENT	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
		375098	B. WING		01	//11/2016	
	PROVIDER OR SUPPLIER	/ICES-MIDWEST CITY		STREET ADDRESS, CITY, STATE, ZIP C 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CON (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 323	Continued From pa	age 18	F 3:	23			
	There were no inte incident report.	erventions documented on the					
	documented, "Ens putting to bed.	e plan, initiated on 10/12/15, ure resident is tired before l into wheelchair if restless."					
	documented the re- impaired in cognitive making. She required one person for transperson for transpersonal hygiene.	ge assessment, dated 12/06/15, esident was moderately ve skills of daily decision ired extensive assistance of nsfers, dressing, toileting and She used a wheelchair for The resident was not					
	where the interven documented. She She was asked if t	0 p.m., the DON was asked tions for falls would be stated, "On the care plans." hey are documented on the the stated, "No, only on the					
	was asked if the re with each fall. She documented on the the problem section	00 p.m., the MDS Coordinator esident's care plan was updated e stated, "The falls are not e care plan each time under n but each fall is care planned n and dated under the					
	be new intervention She stated, "Yes." ensured that new in	ON was asked if there should ns with each fall occurrence. She was asked how the facility nterventions were initiated and plans. She stated "It is					

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TATEMENT	OF DEFICIENCIES	A MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
		375098	B WING		01	/11/2016	
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	29	TREET ADDRESS, CITY, STATE, ZIP COD 900 PARKLAWN DRIVE IIDWEST CITY, OK 73110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 323	Continued From page 19		F 323				
F 329 SS=E	483.25(I) DRUG R	agle room every morning." EGIMEN IS FREE FROM DRUGS	F 329				
	unnecessary drugs drug when used in duplicate therapy); without adequate n indications for its u adverse consequen	ig regimen must be free from a. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any e reasons above.					
	resident, the facility who have not used given these drugs of therapy is necessa as diagnosed and of record; and resider drugs receive grad behavioral interven	ehensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical nts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by: Based on record re	NT is not met as evidenced eview and staff interview, it e facility failed to ensure:					
		edication was not increased for the increases for one (#1)					

Facility ID NH5512

If continuation sheet Page 20 of 45

STATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		375098	B. WING			01/11/2016	
	PROVIDER OR SUPPLIER	VICES-MIDWEST CITY		STRE 2900 MID			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 329	Continued From pa antianxiety medica	-	F 32	29			
	~ side effects for a	ntipsychotic medications were e (#2, 4 and #8) of six sampled					
	monitored for three (#2, 3 and #8) of r	antianxiety medications were e hine sampled residents who ty medications; and					
	were monitored for	ntidepressant medications one (#8) of seven sampled eived antidepressant					
	dated 01/04/16, do received antipsych received antianxief	sus and Conditions report, cumented nine residents otic medications, 22 residents ty medications, and 32 antidepressant medications.					
	Findings:						
	documented, "Ur 1Each resident's from unnecessary any drug when use (i) In excessive do	drug regimen must be free drugs. An unnecessary drug is					
	(v) In the presence						

Facility ID: NH5512

If continuation sheet Page 21 of 45

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				D. 0938-039 TE SURVEY MPLETED	
	375098	B WING	·	0.	1/11/2016	
		2	900 PARKLAWN DRIVE	P CODE		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLETIO DATE	
Continued From pa	age 21	F 329				
08/22/15 with diagr Parkinson's Diseas was admitted to ho diagnoses which in chronic obstructive The post hospital p 08/22/15, documen receive Xanax 0.25 TID PRN. Both of t medications. A physician's order to decrease the Xa hours PRN. The October 2015 had been administe on 10/01/15, 10/02/ anxiety and on 10/1 with cough. The re	noses which included se, anxiety and depression. He ispice on 08/26/15 with included failure to thrive and pulmonary disease. Thysician's orders, dated inted the resident was to 5 mg TID and Ativan 0.5 mg these were antianxiety , dated 10/01/15, documented nax to 0.25 mg every eight MAR documented the residen ered one PRN Xanax 0.25 mg /15, 10/12/15 for increased 15/15 for increased anxiety sident had been diagnosed	t				
documented betwe There was no docu anxious behaviors of of increased anxiet documentation the resident's care with A hospice nursing r	en 10/01/15 and 10/17/15. Imentation of restlessness, or of the resident complaining y. There was no nurses had coordinated the the hospice nurses.					
	PROVIDER OR SUPPLIER CARE HEALTH SERV SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Ontinued From particles of the content of the post of the content of the c	DF CORRECTION       IDENTIFICATION NUMBER:         375098         PROVIDER OR SUPPLIER         CARE HEALTH SERVICES-MIDWEST CITY         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 21         1. Resident #1 was readmitted to the facility on 08/22/15 with diagnoses which included Parkinson's Disease, anxiety and depression. He was admitted to hospice on 08/26/15 with diagnoses which included failure to thrive and chronic obstructive pulmonary disease.         The post hospital physician's orders, dated 08/22/15, documented the resident was to receive Xanax 0.25 mg TID and Ativan 0.5 mg TID PRN. Both of these were antianxiety medications.         A physician's order, dated 10/01/15, documented to decrease the Xanax to 0.25 mg every eight hours PRN.         The October 2015 MAR documented the residen had been administered one PRN Xanax 0.25 mg on 10/01/15, 10/02/15, 10/12/15 for increased anxiety and on 10/15/15 for increased anxiety with cough. The resident had been diagnosed with an upper respiratory infection the previous	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING         375098       B WING         PROVIDER OR SUPPLIER       375098         CARE HEALTH SERVICES-MIDWEST CITY       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 21       F 329         1. Resident #1 was readmitted to the facility on 08/22/15 with diagnoses which included Parkinson's Disease, anxiety and depression. He was admitted to hospice on 08/26/15 with diagnoses which included failure to thrive and chronic obstructive pulmonary disease.         The post hospital physician's orders, dated 08/22/15, documented the resident was to receive Xanax 0.25 mg TID and Ativan 0.5 mg TID PRN. Both of these were antianxiety medications.         A physician's order, dated 10/01/15, documented to decrease the Xanax to 0.25 mg every eight hours PRN.         The October 2015 MAR documented the resident had been administered one PRN Xanax 0.25 mg on 10/01/15, 10/02/15, 10/12/15 for increased anxiety and on 10/15/15 for increased anxiety with cough. The resident had been diagnosed with an upper respiratory infection the previous week.         Twenty two nursing progress notes were documented between 10/01/15 and 10/17/15. There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses.	oper correction       IDENTIFICATION NUMBER:       A BUILDING         375098       B WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZI         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PROVIDER'S CITY, OK 73110         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CACH CORRECTIVE ACT CROSS-REFERENCED 10 T DEFICIENC         Continued From page 21       F 329       F 329         1. Resident #1 was readmitted to the facility on 08/22/15 with diagnoses which included Parkinson's Disease, anxiety and depression. He was admitted to hospice on 08/26/15 with diagnoses which included failure to thrive and chronic obstructive pulmonary disease.       F 329         The post hospital physician's orders, dated 08/22/15, documented the resident was to receive Xanax 0.25 mg TID and Ativan 0.5 mg TID PRN. Both of these were antianxiety medications.       A physician's order, dated 10/01/15, documented to decrease the Xanax to 0.25 mg every eight hours PRN.         The October 2015 MAR documented the resident had been administered one PRN Xanax 0.25 mg on 10/01/15, 10/02/15, 10/12/15 for increased anxiety and on 01/15/15 for increased anxiety and on 01/15/15 for increased anxiety and on 01/01/15 and 10/17/15.         There was no documentation of restlessness, anxious behaviors or of the resident complaining of increased anxiety. There was no documentation the nurses had coordinated the resident's care with the hospice nurses. <td>operiod construction       Dentrification NuMBER:       A Building</td>	operiod construction       Dentrification NuMBER:       A Building	

		AND HUMAN SERVICES				F	ITED: 01/26/20 ORM APPROV 3 NO: 0938-03
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER					3) DATE SURVEY COMPLETED
		375098	B WING	i			01/11/2016
	PROVIDER OR SUPPLIER	CES-MIDWEST CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
F 329	May give Xanax 0 [sic] change Xanax A physician's order to hold the Ativan 0.25 mg was to be Ativan was availab decreased to TID Ativan change was The October 2015 documentation the administered a PR through 10/22/15. A hospice nursing 1 documented the re "pt. sleeps 16 + hrs A physician's order to increase the Xar mg) every 4 hours Two hospice nursin 10/26/15, documer status had been de The October 2015 had been administe 10/24/15 and 10/25 Twelve nursing pro from 10/17/15 throu documentation of r behaviors or of the increased anxiety.	<ul> <li>v order for Ativan 0.5 mg tid.</li> <li>25 tid until Ativan arrives the c to tid prn"</li> <li>c, dated 10/17/15, documented until available. The Xanax administered TID until the le and then was to be PRN. No written order for the located.</li> <li>MAR contained no resident had been N Xanax from 10/15/15</li> <li>note, dated 10/22/15, sident had anxiety "@ X's" and s a day".</li> <li>dated 10/22/15, documented hax to 0.25 mg two tabs (0.5 PRN for restlessness.</li> <li>ng notes, dated 10/23/15 and the resident's anxiety sferred.</li> <li>MAR documented the resident ered one PRN Xanax on 5/15.</li> <li>gress notes were documented ugh 10/29/15. There was no estlessness, anxious resident complaining of There was no documentation ordinated the resident's care</li> </ul>	FS	329			

STATEMENT	OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DA	) <u>. 0938-039</u> TE SURVEY MPLETED	
		375098	B WING			01	/11/2016	
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		STREET ADDRESS, CITY, STATE, ZIP COD 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 329	Continued From page 23		F 32	29				
	documented the re "pt. sleeps 16 + hrs the resident compl cough "and he can	note, dated 10/29/15, sident had anxiety "@ X's" and s a day". It also documented ained of a nonproductive 't get anything up. [Physician's fied [and] received new						
	to increase the Ativ	, dated 10/29/15, documented an to 0.5 mg every six hours ignosis of anxiety as essness.						
		note, dated 10/30/15, sident's anxiety status had						
	resident had been	5 MAR documented the administered one PRN Xanax next time the PRN Ativan was on 11/19/15.						
		note, dated 11/05/15, sident had anxiety "@ X's" and s a day".						
		note, dated 11/06/15, sident's anxiety status had						
	from 10/29/15 throu documentation of r behaviors or of the increased anxiety.	as notes were documented ugh 11/12/15. There was no estlessness, anxious resident complaining of There was no documentation ordinated the resident's care						

Facility ID. NH5512

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		AND HUMAN SERVICES				FORM	: 01/26/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	· ′		CONSTRUCTION	(X3) DA	E SURVEY MPLETED
		375098	B WING_			01/11/2016	
NAME OF I	PROVIDER OR SUPPLIER	••••••••••••••••••••••••••••••••••••••			REET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	MANORCARE HEALTH SERVICES-MIDWEST CITY				00 PARKLAWN DRIVE DWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 329	A hospice nursing r documented the res [increased]" and "pl also documented, " anxiety [and] thick s [and] vomit. [Physic [and] new orders res A physician's order, to increase the Ativa every eight hours ro anxiety as manifest On 01/05/16 at 5:00 locate the document indicated the need the antianxiety medicat On 01/06/16 at 2:55 was documentation the resident's behave facility should have behaviors. She star facility everyday and they don't think abo On 01/11/16 at 10:5 asked what she woo of increased anxiety the physician and ta She was asked if sh the use of PRN med physician. She stat	<ul> <li>a bote, dated 11/12/15, sident had anxiety "@ X's</li> <li>a sident had anxiety "@ X's</li> <li>a sleeps 16 + hrs a day". It</li> <li>pt. reports [increased]</li> <li>a bottom that makes him gag</li> <li>cian's name deleted] notified</li> <li>ceived"</li> <li>dated 11/12/15, documented</li> <li>an to 0.5 mg two tabs (1 mg)</li> <li>bottinely for the diagnosis of</li> <li>ed by restlessness.</li> <li>b p.m., the DON was asked to</li> <li>bottation of behaviors which for the increase in the</li> <li>ions.</li> <li>b p.m., the DON stated there in the hospice notes about viors. She was asked if the also documented those ted the hospice nurse is in the d' "They probably talk so much ut documenting it."</li> <li>i0 a.m., the hospice nurse was uld do if a resident complained v. She stated she would call alk to the facility nurse.</li> <li>an e ever checked the MARs for dications before calling the ed she "could do that."</li> </ul>	F 32	29			
	observed the reside a PRN medication f	he reviewed the MARs and ent had not been administered or two weeks, would she call stated she would probably					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A BUILDING 375098 **B** WING 01/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MANORCARE HEALTH SERVICES-MIDWEST CITY MIDWEST CITY, OK 73110 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 329 Continued From page 25 F 329 ask the facility nurse to give the resident a PRN dose and monitor them. At 11:05 a.m., the DON was asked if she had located any facility documentation regarding the resident's behaviors. She stated, "No." 2. Resident #2 had diagnoses which included chronic pain, dementia, aphasia, diabetes, COPD. CHF and osteoarthritis. A care plan, dated 02/11/10, documented, "...Focus At risk for adverse effects related to: use of antianxiety medication... Interventions...Monitor for dizziness, drowsiness, blurred vision and orthostatic hypotension ... " A treatment administration record, dated November 2015, documented, "...ABH GEL 1-25-1 GEL APPLY 1 TOPICALLY .5XD (five times a day)...MONITOR FOR S/S OF SIDE EFFECTS, INITIALS INDICATE ABSENCE OF SIDE EFFECTS...' ABH gel contains the antianxiety medication, Ativan, and the antipsychotic medication, Haldol. There was no documentation of the monitoring of side effects for the ABH gel administration in the resident's clinical record for November 2015. 3. Resident #8 had diagnoses which included chronic kidney disease, bipolar disorder, neuromuscular dysfunction of bladder, Rheumatoid arthritis and paraplegia. A care plan, dated 10/18/09, documented, "...Focus

FORM CMS-2567(02-99) Previous Versions Obsolete

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		HAND HUMAN SERVICES E & MEDICAID SERVICES				FOR	D: 01/26/201 MAPPROVE D. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		375098	B WING			0.	1/11/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	/ICES-MIDWEST CITY			900 PARKLAWN DRIVE IIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 329	Continued From pa	age 26	F 3	29			
	antidepression me	effects related to: use of odicationantianxiety sychotic medication		1			
	Goalto show min medications taken	imal/no side effects of					
	InterventionsAnti Antidepressants- M Antipsychotic- Mor	Aonitor					
	documented, " E	n's order, dated May 2015, XCITALOPRAM OXALATE 1 TAB BY MOUTH DAILY		ſ			
	BEDTIME MONIT	MG1 CAP BY MOUTH AT FOR SIDE EFFECTS INITIALS CE OF S/S OF SIDE		- 7-11-11-11-11-11-11-11-11-11-11-11-11-11			
	BEDTIME MONIT	MG1 TAB BY MOUTH AT FOR SIDE EFFECTS INITIALS CE OF S/S OF SIDE					
	BY MOUTH THRE	HCL 5MGVIVACTIL 1 TAB E TIMES DAILYMONITOR IITIALS INDICATE ABSENCE EFFECTS					
	Klonopin 0.5mgd	laily @ HS for anxiety"					
		dications. Haldol is an cation. Klonopin is an					
		umentation in the resident's ie monitoring of side effects for					

If continuation sheet Page 27 of 45

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
					3			
		375098	B WING			01/	11/2016	
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	і 1X	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 329	the administration of Haldol, Vivactil and 2015. An admission phys documented, "Le S/S of A/R(check Doxepin 50 mgQ A/RQsh [sic] Clonazepam 0.5mg A medication admir October 2015, docu H.S Ativan 0.5 mgq B Clonazepam and A medications. There was no docu clinical record that to monitored for the ad Doxepin, Clonazepa month of October 2 A monthly physiciar 2015, documented,	of the Lexapro, Doxepin, Klonopin for the month of May ician's order, dated 10/07/15, xapro 20 mgQD(check) for ) Qsh [sic] D(check) for S/S of gQ HS" histration record, dated umented, "Haldol 0.5mgq ID PRN" tivan are both antianxiety mentation in the resident's the side effects were dministration of the Lexapro, am, Haldol and Ativan for the 015. h's order, dated November "Ativan 0.5 mgBid onitor for s/s of side effects.	F	329				
	clinical record that t	mentation in the resident's he side effects were dministration of the Ativan for nber 2015.						
	2015, documented, 0.5MGHALDOL 1	i's order, dated November "HALOPERIDOL TAB BY MOUTH AT OR FOR S/S OF SIDE						

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		AND HUMAN SERVICES			FORM	): 01/26/201 MAPPROVE ). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TPLE CONSTRUCTION		TE SURVEY MPLETED
		375098	B WING_		01	/11/2016
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE,		
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 329	Continued From pa EFFECTS, INITIAL SIDE EFFECTS"	S INDICATE ABSENCE OF	F 32	29		
	December 2015, de "LORAZEPAM/ TWICE DAILY AS ANXIETYMONIT	ATIVAN 1 TAB BY MOUTH				
	clinical record that monitored for the a	imentation in the resident's the side effects were dministration of the Haldol and h of December 2015.				
	what the facility pol effects of psychotro "Side effects are do MAR. Initials mean She was asked who	0 p.m., the DON was asked icy was for monitoring side opic medications. She stated, ocumented each shift on the n there are no side effects." o was responsible for de effect monitoring. She is do."				
	stated antianxiety, a antipsychotics were	#5 was asked what nonitored for side effects. She antidepressants and e monitored. She was asked mented. She stated, "On the				
		s admitted with diagnoses neimer's, depressive disorder				
i	A physician's order "Ativan 0.5 mg Po	, dated 06/19/15, documented, O QID"				

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
		375098	B WING		01/11/2016		
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	29	TREET ADDRESS, CITY, STATE, ZIP COD 900 PARKLAWN DRIVE IIDWEST CITY, OK 73110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 329	There was no docu clinical record that monitored for the a the month of June A physician's order " Ativan 0.5 mg one tab by neededmonitor for indicate absence o There was no docu clinical record that monitored for the a the month of Septe 5. Resident #4 was which included den anxiety disorder. A physician's order documented, "Ris medication] 1 mg o There was no docu clinical record that monitored for the a Risperidone for the A medication admin October 2015, docu "RISPERIDONE. DAILYMONITOR INITIALS INDICATI	imentation in the resident's the side effects were idministration of the Ativan for 2015. , dated 09/10/15, documented, mouth every 4 hours as or s/s of side effects, initials f side effects" imentation in the resident's the side effects were dministration of the Ativan for mber 2015. s admitted with diagnoses nentia, psychosis and general , dated July 2015, speridone [antipsychotic ne tab po bid" imentation in the resident's the side effects were dministration of the month of July 2015. histration record, dated umented, 0.5MG1 TAB TWICE FOR S/S OF SIDE EFFECTS, E ABSENCE OF SIDE					

Facility ID NH5512

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ` <i>'</i>		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		375098	B WING	i		01/	11/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
MANOR	CARE HEALTH SERVI	CES-MIDWEST CITY			2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 F 332 SS=E	Risperidone for the On 01/04/16 at 2:00 what the facility poli effects of psychotro "Side effects are do MAR. Initials mean She was asked who documenting the sid stated, "The nurses 483 25(m)(1) FREE RATES OF 5% OR The facility must en medication error rat This REQUIREMEN by: Based on observat interview, it was det ensure a medication three (#16, #17 and observed during the medication error rat from four errors in 2 The Resident Cens dated 01/05/16, doc in the facility. Findings: 1. Resident #16 was	month of October 2015. D p.m., the DON was asked cy was for monitoring side ppic medications. She stated, cumented each shift on the there are no side effects." D was responsible for de effect monitoring. She do." OF MEDICATION ERROR MORE sure that it is free of tes of five percent or greater. NT is not met as evidenced ion, record review and staff termined the facility failed to n error rate of less than 5% for #18) of eight residents a medication passes. The e was 16% which resulted 5 opportunities. us and Conditions report, cumented 73 residents resided s admitted to the facility with cluded, CVA, coronary artery		329	3		

STATEMENT	OF DEFICIENCIES DF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			PLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
		375098	B WING			01	/11/2016
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 332	A physician's telep documented, "Co A medication admi January 2016, doc 3.125MG TABLET MOUTH TWICE D On 01/05/16 at 9.1 LPN #1 as she pre for administration t was viewed by the instruction to "1" DAILY" The LPN medication and pla	hone order, dated 12/31/15, breg to 3.125 mg po BID" nistration record, dated umented, "Carvedilol (RP: COREG) 1 TAB BY AILY" 3 a.m., the surveyor observed pared the Coreg medication to the resident. The medication surveyor and the label gave TAB BY MOUTH TWICE I was observed to crush the ace in a cup. She was observed ed the medication thru the	F3				
	At 3:15 p.m., LPN that the medication She stated, "I look to confirm the direc medication. She c	#1 was asked how it is ensured as are administered as ordered. at the MAR." She was asked ction label of the Coreg onfirmed the medication label edication was to be given by					
	medication to the r crush order." She	ed how she administered the esident. She stated, "I have a was asked if she gave the oth or by tube. She stated the ven by tube.					
	12/03/15 with diag	as readmitted to the facility on nosis which included, 2D, weakness and COPD.					
		e instruction form, dated nted, "Stopped buspirone					

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		AND HUMAN SERVICES					FORM	01/26/2016 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 · · ·		PLE CONSTRUCTION G		(X3) DAT	0938-0391 E SURVEY PLETED
		375098	B WING	)			01/	11/2016
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	•		STREET ADDRESS, CITY, STATE, ZIP COE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 332	Continued From pa	ge 32	F	332	2			
	There was no docu administration of th readmission orders	e Buspar 5MG on the facility						
		n's order report, dated January "DOCUSATE SODIUM MOUTH DAILY"						
	There was no docu administration of th	mentation of an order for the e Buspar 5MG.						
	LPN #2 as she prep administration to the Docusate Sodium in stated, "I have to go LPN #2 returned to stated, "I am out of	05 a.m., the surveyor observed bared the morning medication e resident. There was no in the medication cart. LPN #2 o check the medication room." the medication cart and Colace, it is not here from the II the doctor and get the on hold."						
	to prepare the medi observations of the with the MAR as sh The surveyor obser the medication cup. by the surveyor and "Buspar 5 mg"	ved LPN #2 as she continued ications. There were no LPN verifying the medications e prepared each medication. ved the LPN punch a pill into The medication was viewed the label documented, The LPN was observed to ication to the resident.						
		mentation for an order for the e Buspar 5MG on the January					i	
	medications were a	v the facility ensured vailable for administration to stated, "I try to order them						

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
		375098	B WING_	······	01/11/2016		
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		STREET ADDRESS, CITY, STATE, ZIP C 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110	and the second sec		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 332		age 33 • two days left or 3-11 will order	F 33	32			
	them." She was as	ked who was responsible for ns. She stated, "We all are."					
	the Docusate Sodiu 01/05/16 upon rece	0 a.m., LPN #2 was asked if um was administered on eipt from the pharmacy. She n't get it in until late last night. ng."					
	Buspar administrati started on it before verified there was r	here was an order for the ion. She stated, "She was just she went to the hospital." She no order documentation for the e Buspar upon readmission to					
	readmission order of "Whoever gets the	o was responsible for the documentation. She stated, resident back. We have a se. She does what she can."					
	removing the disco	o was responsible for ntinued medications from the Whoever the nurse is that					
	01/04/16 with diagn	as admitted to the facility on loses which included right hip ge B Cell Lymphoma, n.					
		ician order, dated 01/04/16, saconazole 300 mg po daily"					
	LPN #1 as she prep for administration to	5 a.m., the surveyor observed bared the morning medication the resident. There was no Posaconazole in the					

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TATEMENT	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		375098	B WING			- 01/11/2016		
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		290	EET ADDRESS, CITY, STATE, ZIP CODE D PARKLAWN DRIVE DWEST CITY, OK 73110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 332	Continued From pa medication cart.	age 34	F 3	32				
		#1 asked LPN #4 to assist in ation from the medication						
med state	medication was no stated she called t	#4 returned and stated the t in the medication room. She he pharmacy and the ailable until later in the day.						
	ensured medicatio stated, "Normally t that they can't prov call the physician f She was asked if it medication was no	#1 was asked how the facility ns were available for use. She he pharmacy will call to report ride the medication and we will or a change or hold orders." t was reported to her that the t available. She stated, "No. say anything about it in						
F 425 SS=E	and stated, "The p medication won't b She was asked wh 01/04/16 that the n should the physicia stated, "Yes."	I #1 approached the surveyor harmacy called and the e in until tomorrow." en the facility was notified on hedication was unavailable an have been notified. She RMACEUTICAL SVC - CEDURES, RPH	F 4;	25				
50-L	The facility must pr drugs and biologica them under an agr §483.75(h) of this p unlicensed person	rovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit nel to administer drugs if State ily under the general						

Facility ID<sup>,</sup> NH5512

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		AND HUMAN SERVICES	_			FORM	01/26/201 APPROVE 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		375098	B WING			01/	11/2016
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 425	Continued From pa	age 35	۶Z	25			
	(including procedur acquiring, receiving administering of all the needs of each The facility must er a licensed pharmad	drugs and biologicals) to meet resident. nploy or obtain the services of cist who provides consultation e provision of pharmacy					
	by: Based on observat interview, it was de have pharmacy pro timely acquisitions of	NT is not met as evidenced tion, record review and termined the facility failed to ocedures in place to ensure of medications for four (#1, 3, e sampled residents whose wed.					
		sus and Conditions Report, cumented 73 residents resided					
	Findings:						
	A facility policy, title Shortages/Unavaila "Procedure	d Medication able Medications, documented,					
	supply of a medicat Facility staff should obtain the medicati	that Facility has an inadequate tion to administer to a resident, immediately initiate action to on from Pharmacy. If the e is discovered at the time of					

Facility ID NH5512

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		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DAT	<u>0938-0391</u> E SURVEY IPLETED
		375098	B WING			01/	11/2016
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	medication adminis immediately take ad 2. If a medication is normal Pharmacy h call Pharmacy to de order. If the medica the licensed Facility or reorder for the ne 4. If an emergency Facility nurse shoul physician to obtain 1. Resident #3 was which included Alzh and anxiety. The physician's ord documented, "Ativ The medication adm 2015, documented, 06/21 9aativan 0. 1pativan 0.5mg 0 1700 (5 p.m.)ativa delivery called phar 2100 (9 p.m)ativa Why the Ativan 0.5 r the physician on 06 medication adminis She stated, "I don't She was asked wha on the medication adminis	etration, Facility staff should ction shortage is discovered during noursFacility nurse should etermine the status of the ation has not been ordered, y nurse should place the order ext scheduled delivery r delivery is unavailable, d contact the attending orders or directions" a admitted with diagnoses neimer's, depressive disorder er, dated 06/19/15, van 0.5 mg qid" ninistration record, dated June "Ativan 0.5 mg PO QID 5mg 0 given - 0 available given - 0 available an 0.5mg - awaiting pharmacy macy @1730 (5:30 p.m.) an 0.5mg awaiting delivery" 80 p.m., LPN #3 was asked mg QID, which was ordered by /19/15, was not placed on the tration record until 06/21/15.	F	125			

		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DAT	E SURVEY IPLETED
		375098	B WING			01/	11/2016
	PROVIDER OR SUPPLIER	CES-MIDWEST CITY		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 PARKLAWN DRIVE NIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	or maybe not here." 2. Resident #1 was 08/22/15 with diagn Parkinson's Diseas was admitted to hos diagnoses which inc chronic obstructive A physician's order, the resident was to mg three times a da The October MAR of held on 10/17/15 at nurse's medication the MARs documer [nurses notes]" A nurse's note, date documented, "New May give Xanax tid change Xanax to tic A physician's order, to increase the Ativa The November 201 had not been admir 11/18/15. The back "11/18/15 GamAtiva awaiting new script 11/18/15 for the third missed On 01/05/16 at 5:00 she could locate the	<ul> <li>a readmitted to the facility on loses which included</li> <li>e, anxiety and depression. He spice on 08/26/15 with cluded failure to thrive and pulmonary disease.</li> <li>dated 08/22/15, documented be administered Ativan 0.5 ay.</li> <li>documented the Ativan was 8:00 a.m. and 2:00 p.m. The notes located on the back of nted, "Ativan on hold see nn</li> <li>ed 10/17/15 at 8:55 a.m., order for Ativan 0.5 mg tid. until Ativan arrives the [sic] f PRN"</li> <li>dated 11/12/15, documented an to 1 mg every eight hours.</li> <li>5 MAR documented the Ativan istered all three doses on a of the MAR documented, /an 0.5 mg 2 tabs - not given - from physician</li> </ul>	F 4	25			

STATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
	J CONRECTION	DENTIFICATION NOMBER	A BUILDIN	NG			
		375098	B WING			01	/11/2016
	PROVIDER OR SUPPLIER	/ICES-MIDWEST CITY		2900	EET ADDRESS, CITY, STATE, ZIP CODE PARKLAWN DRIVE WEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 425	Continued From p	age 38	F 42	25			
	again about the At stated she thought change on those d had been no chang to locate the date t reordered.	5 p.m., the DON was asked ivan not being available. She t there had been an order lays. She was informed there ge documented and was asked the medications had been					
	she had located th reordered. She sta	40 a.m., the DON was asked if e dates the Ativan had been ated, "No, I didn't dig that deep I she would look for the dates.					
	medications. She reorder three days be out and to fax the	hat the policy was on reordering stated the policy was to before the medication would he physician if a new equired for the reorder.					
		of the dates the Ativan had are presented prior to the					
		as admitted with diagnosis pertension, GERD, weakness					
	2016, documented	n's order report, dated January I, "DOCUSATE SODIUM Y MOUTH DAILY"					
	LPN #2 as she pre administration to th Docusate Sodium cart. LPN #2 state medication room."	05 a.m., the surveyor observed pared the morning medication he resident. There was no observed in the medication ed, "I have to go check the LPN #2 returned to the d stated, "I am out of Colace, it					

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		AND HUMAN SERVICES				FORM	: 01/26/2016 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DAT	E SURVEY IPLETED
		375098	B WING			01/	11/2016
j	PROVIDER OR SUPPLIER	CES-MIDWEST CITY		29	REET ADDRESS, CITY, STATE, ZIP CODE 100 PARKLAWN DRIVE IDWEST CITY, OK 73110	<u>.                                    </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	is not here from the doctor and get the r She was asked how medications were a the residents. She when I have one or them." She was as ordering medication On 01/06/16 at 9:00 the Docusate Sodiu 01/05/16 upon rece stated, "No, we didr I gave it this mornin 4. Resident #18 w 01/04/16 with diagn fracture, diffuse Lar depression and pair An admission physi documented, "Pos On 01/05/16 at 9:45 LPN #1 as she prep for administration to observation of the F medication cart. At 9:48 a.m., LPN # locating the medicar room. At 9:50 a.m., LPN #	<ul> <li>pharmacy. I will call the medication placed on hold."</li> <li>w the facility ensured vailable for administration to stated, "I try to order them two days left or 3-11 will order ked who was responsible for its. She stated, "We all are."</li> <li>a.m., LPN #2 was asked if its was administered on ipt from the pharmacy. She it get it in until late last night. g."</li> <li>as admitted to the facility on oses which included right hip ge B Cell Lymphoma, n.</li> <li>cian's order, dated 01/04/16, saconazole 300 mg po daily"</li> <li>a.m., the surveyor observed bared the morning medication the resident. There was no Posaconazole in the</li> <li>1 asked LPN #4 to assist in tion from the medication room. She</li> </ul>	F 4	25			

Facility ID: NH5512

If continuation sheet Page 40 of 45

		& MEDICAID SERVICES	<b></b>		OMB NO	MAPPROVE 0. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				te survey Mpleted
		375098	B WING		01	/11/2016
	PROVIDER OR SUPPLIER	ICES-MIDWEST CITY	2	TREET ADDRESS, CITY, STATE, ZIP CO 900 PARKLAWN DRIVE 11DWEST CITY, OK 73110	DE	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 425 F 441 SS=D	At 9:51 a.m., LPN # ensured medication stated, "Normally th that they can't prov call the physician for She was asked if it medication was not The last shift didn't report." At 10:30 a.m., LPN and stated, "The ph medication won't be 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c to help prevent the of disease and infer (a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a reco	<ul> <li>#1 was asked how the facility ins were available for use. She he pharmacy will call to report ide the medication and we will or a change or hold orders."</li> <li>was reported to her that the t available. She stated, "No. say anything about it in</li> <li>#1 approached the surveyor harmacy called and the e in until tomorrow."</li> <li>N CONTROL, PREVENT</li> <li>A CONTROL, PREVENT</li> <li>A confortable environment and development and transmission ction.</li> <li>I Program stablish an Infection Control ch it - ntrols, and prevents infections</li> <li>rocedures, such as isolation, o an individual resident; and ord of incidents and corrective iffections.</li> <li>and of Infection tion Control Program esident needs isolation to of infection, the facility must</li> </ul>	F 425			

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	<u> </u>				. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ` '				TE SURVEY MPLETED
		375098	B WING			01	/11/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	ICES-MIDWEST CITY			900 PARKLAWN DRIVE NIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	communicable dise from direct contact direct contact will tr (3) The facility must hands after each di hand washing is inc professional practic (c) Linens Personnel must han transport linens so a infection. This REQUIREMEN by: Based on observat interview, it was det ensure recurrent un unavoidable and that was provided to rem catheter care was p sampled residents of reviewed for urinary catheter care. The Resident Cens dated 01/04/16 doc residents who had i Findings: Resident #8 had dia	t prohibit employees with a base or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which licated by accepted	F 4	141			
	neuromuscular dysl Rheumatoid arthritis						
CODM ONO OF	67(02-99) Previous Versions	Obsolete Event ID KBY411		<b>F</b>	vility ID_NH5512 If continue	<b>.</b>	Page 42 of 45

Facility ID NH5512

If continuation sheet Page 42 of 45

PRINTED: 01/26/2016

		AND HUMAN SERVICES				FORM	: 01/26/2016 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l` '			(X3) DAT	E SURVEY
		375098	B WING			01/	11/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-MIDWEST CITY			2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	"Focus Use of indwelling un bladder and urinary InterventionsCath needed" A urine culture and 01/29/15, documen >100,000 colonies/i ORG #1 ESBL Pos Cephalosporins and ORG#2 >100,000 C Organism #1: Esch Organism #1: Esch Organism #2: Ente Escherichia coli and organisms that live A urine culture and 03/26/15, documen colonies/ml Organism #1: Esch A urine culture and 06/07/15, documen Organism #1: Esch A hand-written note documented, "6/9/1 to ER for IV ABT the A hospital progress documented, "UT A urine culture and	d on 11/26/12, documented, rinary catheter for neurogenic retention heter care every shift and as sensitivity report, dated ted, "ORG#1 [organism #1] ml . (resistant to all d Penicillins) Colonies/ml herichia coli rococcus spp" d Enterococcus are both in the digestive tract. sensitivity report, dated ted, "ORG#1 100,000 herichia coli" sensitivity report, dated ted, ">100,000 colonies /ml herichia coli" on the lab report 5 allergic to Sulfa PCN Send erapy." note, dated 09/03/15, 1 c E. Coli"	F4	41			

Facility ID. NH5512

If continuation sheet Page 43 of 45

PRINTED: 01/26/2016

		AND HUMAN SERVICES					FORM	01/26/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION		X3) DATH	E SURVEY PLETED
		375098	B WING		<u> </u>		01/ <sup>,</sup>	11/2016
	PROVIDER OR SUPPLIER	CES-MIDWEST CITY		2900	EET ADDRESS, CITY, STATE, ZIP C D PARKLAWN DRIVE DWEST CITY, OK 73110	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD E		(X5) COMPLETION DATE
F 441	Continued From pa	ge 43	F4	41				
	documented the rescognitive skills for d required extensive a transfers. She required extensive a transfers. She required extensive a and personal hygical limitation in range of extremities. She was an indwelling urinar incontinent of bowe On 01/05/16 at 10:3 incontinent care for CNA #2 and CNA # responsible for provi- resident. CNA #2 s gonna do." The resident stated 12:30 a.m. and was cleaned. As care w observed to have do buttocks. CNA #2 s was no observation the resident at this to At 11:00 a.m., LPN responsible for perf stated, "We do." Sh stated the nurses w observed to check to shift."	30 a.m.,the provision of resident #8 was observed. 3 were asked who was viding catheter care for the tated, "That's what we are that she had an accident at a not sure how well she was ras initiated the resident was ried brown feces on her stated, "Still got a little." There of catheter care provided to						

Facility ID. NH5512

If continuation sheet Page 44 of 45

		AND HUMAN SERVICES				FORM	01/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ° '	IPLE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		375098	B. WING			01/*	11/2016
	PROVIDER OR SUPPLIER	CES-MIDWEST CITY		STREET ADDRESS, CI 2900 PARKLAWN DF MIDWEST CITY, C	RIVE	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORI	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	catheter care was g 01/05/16. She state her chair." At 11:00 a.m., Phys resident was at risk infections due to im failure to perform in manner. He stated an indwelling cather Physician #1 was ir observation and ob stated, "That could Hyprex and see wh On 01/11/16 at 10:4 how often catheter residents. She state ordered." She was asked who catheter care. She hall." She was asked how monitored. She state and trending reports She was asked what resident with recurre	<ul> <li>a.m., LPN #2 was asked if given during the day shift on ed, "No, she was already up in a sician #1 was asked if the for the recurrent E. coli proper incontinent care and continent care in a timely, "It is possible. She also has ter which places her at risk."</li> <li>a.m., the places her at risk."</li> <li>b.a.m., the DON was asked care is provided to the ed, "Typically every shift or as the place on the stated, "The nurse on the place on the stated, "We do monthly track</li> </ul>	F 44	41			

Facility ID NH5512

If continuation sheet Page 45 of 45

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CON		
		NH5512	B WING		01/	11/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
IANORO	CARE HEALTH SERV	ICES-MIDWEST C	RKLAWN DRIN ST CITY, OK 7				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE	(X5) COMPLET DATE	
LL000	Initial Comments		LL000				
		vey was conducted on 1/07/16 and 01/11/16.					
	Below is a list of abbreviations used throughout this survey:						
	CVA - Cerebral Vas D - day DON - Director of N	tion dryl/Haldol er extremities Heart Failure ostructive Pulmonary Disease scular Disease					
	Hr - hour III - three						
	IV - Intravenous LPN - Licensed Pra MAR - medication a MDS - Minimum Da MG/mg - milligrams ML - milliliter NS - normal saline PCN - Penicillin	administration record ata Set					

STATEMEN	na State Department IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION		E SURVEY PLETED				
	,	NH5512	B WING		01/	11/2016				
IAME OF I	PROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, S	TATE, ZIP CODE	DDE					
IANOR	CARE HEALTH SERV		RKLAWN DRIV T CITY, OK 73							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE				
LL000	Continued From pa	ge 1	LL000							
	PC/po - by mouth PRN - as needed Pt/pt - patient Q -every Qhs - every night Qsh - every shift RN - Registered Nu S.E side effects S/S - signs and syn TAR - treatment ad TID - three times a UTI - urinary tract in VSS - vital signs sta w/c - wheelchair x -times	nptoms ministration record day nfection								
LL023	Checks 1. Upon receipt of the identification requires section, an employed name, any aliases, which the applicant number, and date of portal maintained b in subsection V of the conducting a check established pursuant regulations for any If the findings of the basis that would pre- applicant pursuant and where the appli- monitored employm provisions in subsec Department shall and	Criminal History Background he written consent and ed under subsection H of this er shall submit an applicant ' s address, former states in resided, social security of birth, through an Internet y the Department, as provided his section, for the purpose of of all relevant registries nt to federal and state law and findings barring employment. e check do not reveal any event the employment of the to subsection D of this section, icant does not have a nent record pursuant to the ction S of this section, the uthorize the collection and rprints through an authorized								

,

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	. ,	CONSTRUCTION		E SURVEY PLETED	
		NH5512	B. WING		01/11/2016		
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
ANORO	CARE HEALTH SERVI	CES-MIDWEST C	RKLAWN DRIV ST CITY, OK 73				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE1 DATE	
LL023	Continued From pa	ge 2	LL023		<u></u>		
	of a criminal history applicant, pursuant the Oklahoma State U.S. Public Law 11 <sup>2</sup> conducted through databases shall be Department.	Bureau for the performance record check on the to Section 150.9 of Title 74 of utes and in accordance with I-148. Results of such search both the Bureau and FBI returned electronically to the					
	in the Automated Fi	retain one set of fingerprints ngerprint Identification System er set to the FBI for a national ords search.	ו				
	Bureau or the FBI.	es may be rejected by the A rejection of the fingerprints e FBI shall require the erprinted agaın.					
	days, after receipt of this subsection, to s through an authoriz application shall be	all have ten (10) calendar of authorization as provided in submit his or her fingerprints ed collection site or his or her deemed withdrawn and the equired to commence the from the beginning.					
	interview, it was det complete criminal b	et as evidenced by: a file review and staff ermined the facility failed to ackground checks for one ployees whose personnel files	5				
		us and Condition Report, cumented 73 residents who y.					

Oklahor	na State Departmen	t of Health				
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 · ·	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY
		NH5512	B WING		01/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-MIDWEST C 2900 PA	RKLAWN DI	RIVE		
MANOR		MIDWES	ST CITY, OK	73110		. <u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
LL023	Continued From pa	age 3	LL023			
	Findings:					
	Practice Guide, doo	titled, Patient Protection cumented, "The purpose of the each center in implementation ition system				
		ngThe center utilizes the g process to identify				
	State licensing boa	rds and registries,				
	Criminal backgrour	id checks"				
	A review of the emp documented a hire	bloyee file for CNA #1, date of 11/05/15.				
	There was no docu of a criminal backg	mentation in the employee file round check.				
		) p.m., the Administrator was nal background checks for				
		dministrator stated, "There d checks for [CNA#1]."				
LL361	310:675-9-5.1.(c)(2 ASSESSMENT	)(D)(E) RESIDENT PAIN	LL361			
	of pain at least once vital signs are taker (i) Licensed nursing screening at least of	y staff shall perform the once every 30 days. Certified erform the screening more				- 
Oklahoma S STATE FORI	ate Department of Health M	1	6899	KBY411	If continuat	on sheet 4 of 43

TATEMEN	na State Department	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION		E SURVEY PLETED
			A BUILDING	<u>.</u> .		
		NH5512	B WING		01/11/2016	
AME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		2900 PAR	RKLAWN DRIN	/E		
		MIDWESTC	T CITY, OK 7	3110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
LL361	Continued From pa		LL361	<u> </u>		
		strument shall grade the ty of pain using a				
	conducted by a reg resident: (i) In conjunction wi and annual assess 310:675-9-5.1.(c)(1	in not previously addressed in				
	assisting the reside of functioning as po shall include, but no (i) A statement of pain;	lleviate or minimize pain while nt to maintain as high a level ossible. The pain assessment ot be limited to: how the resident describes the overity of pain graded using a				
	resident-specific pa (iii) Recent changes (iv) Location(s); (v) Onset and dura within the last 3 day	in scale;				
	<ul> <li>(vi) Type of pain re resident, such as co duration or frequent (vii) Current pain m greatest levels;</li> </ul>	neasured at its least and				
	therapies, including used to minimize pa (x) Effects of pair	luding a review of all medication, and the regimen ain; n and effectiveness of therapy				
	on physical and soc (xi) Resident's tre	ial functions; atment preferences and				

Oklahor	na State Department	of Health				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	. ,		(X3) DATE COMF	SURVEY PLETED
		NH5512	B. WING		01/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MANOR		CES-MIDWEST C	KLAWN DRI CITY, OK 7			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
LL361	Continued From pa	ge 5	LL361			
	expectations and he and (xii) If applicable, r for the cognitively ir (D) Results shall be clinical record show changes in level of shall be contacted a	e recorded in the resident's ving changes in pain scale and functioning. The physician as necessary. eated promptly, effectively and				
	determined the faci comprehensive pair nurse on admission annually and quarten nine sampled reside reviewed for compre- The Resident Cens dated 01/04/16, doo in the facility. Findings: 1. Resident #9 was	view and interviews, it was lity failed to perform a n assessment by a registered o, with a significant change, erly for five (#2-5 and #9) of ents whose records were ehensive pain assessments. us and Conditions Report, cumented 73 residents resided admitted on 07/10/15 with cluded dementia with				
Oklahoma Si	ate Department of Health	· · · · · · · · · · · · · · · · · · ·				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				E SURVEY PLETED
		NH5512	B WING		01/11/2016	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S RKLAWN DRIV			11/2010
		MIDWES	T CITY, OK 7			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
LL361	Continued From pa	age 6	LL361			
	A pain assessment had been completed on 07/10/15 and 07/20/15 by an LPN.					
	07/29/15 and 08/07	: had been completed on 7/15 by an RN. No other pain bleted by an RN were located				
	she could locate th	05 a.m., the DON was asked if e comprehensive pain le July admission and the				
	assessment dated since this had beer	DON presented the pain 07/29/15. She was asked if n performed 19 days after the consider this an admission stated, "No."				
		he had located an RN tober. She stated there was r.				
		d diagnoses which included ntia, aphasia, diabetes, steoarthritis.				
	documented the re	e assessment, dated 12/06/15 sident was moderately daily decision making.	1			
		rterly comprehensive pain e last 12 months in the ecord.				
		s admitted to the facility on noses which included e and depression.				
	No comprehensive	pain assessments for the				

Oklahon	na State Department	t of Health				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		NH5512	B WING		01/11/20	)16
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES_MIDWEST C	RKLAWN DR T CITY, OK			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CC	(X5) DMPLETE DATE
LL361	Continued From pa	ige 7	LL361			
	August and Novem completed by a reg	ber quarters had been istered nurse.				
		s admitted to the facility on loses which included dementia /.				
		pain assessments by a Id been completed on admit in Id November				
		s admitted with diagnoses eimer's disease, neurogenic /.				
	Dementia Scales' c through December addressed one (sig	n Assessment in Advanced ompleted from January 2015. These scales only ns of pain) of the 12 elements rehensive pain assessment.				
		erly comprehensive pain rmed by a registered nurse nonth period.				
	who documented th assessments. She She was asked if th	5 p.m., the DON was asked he pain evaluations or stated, "It's whoever." he RN conducted n assessments quarterly. She				
LL771	310:675-7-11.1(a) N	MEDICATION RECORDS	LL771			
	procedures for safe	aintain written policies and and effective acquisition, a, control, and use of antrolled drugs.				
Oklahoma St STATE FORM	ate Department of Health M		6899	КВҮ411	If continuation she	eet 8 of 43

STATEMEN	na State Departme	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED
		NH5512	B WING		01/11/2016
NAME OF I	PROVIDER OR SUPPLIEF			STATE, ZIP CODE	
MANOR	CARE HEALTH SER	VICES-MIDWESTC	RKLAWN DRI T CITY, OK 7		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET
LL771	Continued From p	page 8	LL771		
	Based on record r determined the fac procedures in plac of medications for sampled residents The Resident Cert	net as evidenced by: review and interview, it was cility failed to have pharmacy ce to ensure timely acquisitions four (#1, 3, 17 and #18) of nine s whose records were reviewed. usus and Conditions Report, ocumented 73 residents resided			
	Findings:				
	A facility policy, titl Shortages/Unavai "Procedure	ed Medication lable Medications, documented	,		
	supply of a medica Facility staff shoul obtain the medica medication shorta	y that Facility has an inadequate ation to administer to a resident d immediately initiate action to tion from Pharmacy. If the ge is discovered at the time of istration, Facility staff should action			
	normal Pharmacy call Pharmacy to c order. If the medie the licensed Facili	shortage is discovered during hoursFacility nurse should determine the status of the cation has not been ordered, ty nurse should place the order next scheduled delivery			
	Facility nurse shou	y delivery is unavailable, uld contact the attending orders or directions"			
(lahoma St	1. Resident #3 wa ate Department of Heal	as admitted with diagnoses			
ATE FORM			6899 K	BY411	If continuation sheet 9 of

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				E SURVEY PLETED
		NH5512	B WING		01/11/2016	
AME OF I	PROVIDER OR SUPPLIER	STREET A				11/2010
IANOR	CARE HEALTH SERV	ICES.MIDWEST C	RKLAWN DRIV 5T CITY, OK 7:			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
LL771	Continued From pa	age 9	LL771		<u></u>	
	which included Alz and anxiety.	heimer's, depressive disorder				
	The physician's oro documented, "At	der, dated 06/19/15, ivan 0.5 mg qid"				
		ministration record, dated June , "Ativan 0 5 mg PO QID				
	1pativan 0.5mg 0 1700 (5 p.m.)ativ delivery called pha	.5mg 0 given - 0 available ) given - 0 available an 0.5mg - awaiting pharmacy rmacy @1730 (5:30 p.m.) an 0.5mg awaiting delivery"				
	why the Ativan 0.5 the physician on 06	30 p.m., LPN #3 was asked mg QID, which was ordered by 5/19/15, was not placed on the stration record until 06/21/15. : know."				
	on the medication	at did it mean when the initials administration record were , "Well, either it wasn't given "				
	08/22/15 with diagr Parkinson's Diseas was admitted to ho diagnoses which in	s readmitted to the facility on noses which included se, anxiety and depression. He spice on 08/26/15 with included failure to thrive and pulmonary disease.				
		, dated 08/22/15, documented be administered Ativan 0.5 ay.				
		documented the Ativan was t 8:00 a m. and 2:00 p.m. The				

Oklahon	na State Department	of Health			
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A BUILDING	B	COMPLETED
		NH5512	B. WING		01/11/2016
	PROVIDER OR SUPPLIER	STREETAD	DRESS. CITY.	STATE, ZIP CODE	
		2000 DAE		,	
MANOR	CARE HEALTH SERVI	MIDWEST C MIDWES	Г СІТҮ, ОК		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
LL771	Continued From pa	ge 10	LL771		
		notes located on the back of nted, "Ativan on hold see nn			
	documented, "New	ed 10/17/15 at 8:55 a.m., order for Ativan 0.5 mg tid. until Ativan arrives the [sic] d PRN"			
		dated 11/12/15, documented an to 1 mg every eight hours.			
	had not been admir 11/18/15. The back "11/18/15 6amAtiv awaiting new script 11/18/15 1200 [noo	n]Ativan 0.5mg not given d/t planation was documented			
	she could locate the	) p.m., the DON was asked if e reason the Ativan had not on 10/17/15 and 11/18/15.			
	again about the Ativ stated she thought t change on those da had been no change	5 p.m., the DON was asked van not being available. She there had been an order ays. She was informed there e documented and was asked he medications had been			
	she had located the reordered. She star	0 a.m., the DON was asked if dates the Ativan had been ted, "No, I didn't dig that deep she would look for the dates.			
-	medications. She s	at the policy was on reordering stated the policy was to			
Oklahoma St STATE FORN	ate Department of Health /I		6899	KBY411	If continuation sheet 11 of 43

STATEMEN	na State Departmen IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	CONSTRUCTION		E SURVEY PLETED	
		NH5512	B WING	B WING		01/11/2016	
	PROVIDER OR SUPPLIER	STREET A 2900 PA	DDRESS, CITY, S RKLAWN DRIN		<u> </u>	11/2010	
. <u> </u>		MIDVE	ST CITY, OK 7				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC) CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
LL771	Continued From pa	age 11	LL771				
	be out and to fax th prescription was re No documentation	before the medication would he physician if a new quired for the reorder. of the dates the Ativan had re presented prior to the					
	survey exit. 3. Resident #17 w	as admitted with diagnosis ertension, GERD, weakness					
	A monthly physicial	n's order report, dated January , "DOCUSATE SODIUM ' MOUTH DAILY"					
	LPN #2 as she pre administration to th Docusate Sodium of cart LPN #2 state medication room." medication cart and is not here from the	05 a.m., the surveyor observer pared the morning medication e resident. There was no observed in the medication d, "I have to go check the LPN #2 returned to the d stated, "I am out of Colace, i e pharmacy. I will call the medication placed on hold."					
	medications were a the residents. She when I have one or them." She was as	v the facility ensured vailable for administration to stated, "I try to order them two days left or 3-11 will orde ked who was responsible for ns. She stated, "We all are."	r				
	the Docusate Sodiu 01/05/16 upon rece	D a.m., LPN #2 was asked if um was administered on hipt from the pharmacy. She n't get it in until late last night. ng."					
	4. Resident #18 w ate Department of Health	as admitted to the facility on					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION		e survey Pleted
		NH5512	B WING		01/11/2016	
	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	Æ	<u>·</u> _·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ST CITY, OK 7: ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE	(X5) COMPLE DATE
LL771	Continued From pa	age 12	LL771			
		noses which included right hip rge B Cell Lymphoma, in.				
		ician's order, dated 01/04/16, saconazole 300 mg po daily				
	LPN #1 as she pre for administration to	5 a.m., the surveyor observed pared the morning medication o the resident. There was no Posaconazole in the				
		#1 asked LPN #4 to assist in ation from the medication				
	medication was not stated she called th	#4 returned and stated the t in the medication room. She he pharmacy and the ailable until later in the day.				
	ensured medication stated, "Normally th that they can't prov	#1 was asked how the facility ns were available for use. She he pharmacy will call to report ide the medication and we will or a change or hold orders."				
	medication was not	was reported to her that the t available. She stated, "No. say anything about it in				
, E	and stated, "The ph	#1 approached the surveyor narmacy called and the e in until tomorrow."				
LL784	310:675-7-12.1(h)	INCIDENT REPORTS	LL784			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		NH5512	B WING		01/11/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
MANOR	CARE HEALTH SERV	ICES-MIDWEST C	RKLAWN DRIV T CITY, OK 73			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECT)REGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCE		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
LL784	Continued From pa	ige 13	LL784			
	director of nursing a	shall be reviewed by the and the administrator and shall action taken where health and				
	determined the faci corrective actions/in incident reports rela and #9) of six samp were reviewed for f	view and interview, it was lity failed to document nterventions on the facility ated to falls for three (#2, 3 bled residents whose records alls. us and Conditions, dated,				
	facility.	ted 73 residents resided in the				
	Findings:					
	07/10/15 with diagn	s admitted to the facility on loses which included muscle lentia with behaviors.				
	The resident had ex admission.	xperienced five falls since				
		s on the falls did not contain ns or interventions put into				
	where the intervent documented. She s She was asked if th	) p.m., the DON was asked ions for falls would be stated, "On the care plans." ley are documented on the ne stated, "No, only on the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				E SURVEY PLETED
		NH5512	B WING		01/11/2016	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, S	TATE, ZIP CODE	• • • • • • • • • • • • • • • • • • • •	
IANOR		ICES_MIDWESTC				
		MIDWES	T CITY, OK 7			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
LL784	Continued From pa	ige 14	LL784			
		l diagnoses which included ntia, aphasia, diabetes, steoarthritis.				
Ċ	An incident report, "Fall without injur	dated 02/27/15, documented, y''				
	There were no inter incident report.	rventions documented on the				
	An incident report, o "Fall without injur	dated 03/09/15, documented, y"				
	There were no inter incident report.	rventions documented on the				
	An incident report, o "Fall without injury	dated 03/12/15, documented, y"				
97 <b>9</b>	There were no inter incident report.	ventions documented on the				
	An incident report, o "Fall without injury	dated 06/02/15, documented, y"				
	There were no inter incident report.	ventions documented on the				
	An incident report, o "Fall without injury	dated 10/09/15, documented, y"				
	There were no inter incident report.	ventions documented on the				
	documented the res impaired in cognitiv making. She requir one person for trans	e assessment, dated 12/06/15, sident was moderately e skills of daily decision red extensive assistance of sfers, dressing, toileting and She used a wheelchair for				

Oklahon	na State Departmen	t of Health				ATTROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		E CONSTRUCTION	(X3) DATE	
	of connection	IDENTITION NONDER.	A BUILDING		COM	
		NH5512	B WING		01/1	1/2016
		· · · · · · · · · · · · · · · · · · ·				1/2010
	PROVIDER OR SUPPLIER		DRESS, CITY, S RKLAWN DRI			
MANOR	CARE HEALTH SERV	ICES-MIDWEST C	T CITY, OK 7			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
LL784	Continued From pa	age 15	LL784			
	primary mobility.					
	where the intervent documented. She She was asked if th	0 p.m., the DON was asked tions for falls would be stated, "On the care plans." ney are documented on the he stated, "No, only on the				
	was asked if the re with each fall. She documented on the the problem section	00 p.m., the MDS Coordinator sident's care plan was updated stated, "The falls are not care plan each time under but each fall is care planned and dated under the				
	be new intervention She stated, "Yes." ensured that new in placed on the care	ON was asked if there should as with each fall occurrence. She was asked how the facility nterventions were initiated and plans. She stated "It is agle room every morning."				
		s admitted with diagnoses neimer's, depressive disorder				
	06/19/15, 07/09/15 falls. The incident	orts, dated 06/10/15, and 07/18/15 documented reports did not contain any terventions related to that				
Oklahoma St	where the intervent documented. She She was asked if th	0 p.m., the DON was asked tions for falls would be stated, "On the care plans." hey are documented on the he stated, "No, only on the				

Oklahor	na State Department	t of Health			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	. ,		(X3) DATE SURVEY COMPLETED
		NH5512	B WING		01/11/2016
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE	
MANOR	CARE HEALTH SERV	ICES-MIDWEST C	RKLAWN DRI ST CITY, OK 7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
LL810	The facility shall ha and procedures to environment. The prevention and tran infection. The facili practice the universi- the Centers for Dis- shall demonstrate t	INFECTION CONTROL ve an infection control policy provide a safe and sanitary policy shall address the ismission of disease and ity, and its personnel, shall sal precautions identified by ease Control. All personnel heir knowledge of universal n performance of duties.	LL810		
	interview, it was det ensure recurrent un unavoidable and that was provided to ren catheter care was p sampled residents of reviewed for urinary catheter care. The Resident Censs dated 01/04/16 doc residents who had it	et as evidenced by: ion, record review and staff termined the facility failed to inary tract infections were at thorough incontinent care nove fecal material and performed for one (#8) of six whose clinical records were y tract infections related to the stand Conditions report, numented there were 11 indwelling urinary catheters.			
Oklahoma St		s and paraplegia.			
STATE FOR	M		<sup>6899</sup> K	BY411	If continuation sheet 17 of 43

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				E SURVEY PLETED
		NH5512	B. WING		01/11/2016	
AME OF I	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		
IANOR	CARE HEALTH SERV	CES-MIDWEST C	RKLAWN DRIV T CITY, OK 7:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
LL810	Continued From pa	ge 17	LL810			
	A care plan, revised "Focus Use of indwelling up bladder and urinary InterventionsCath needed" A urine culture and 01/29/15, documen >100,000 colonies// ORG #1 ESBL Pos Cephalosporins and ORG#2 >100,000 C Organism #1: Esch Organism #1: Esch Organism #2: Enter Escherichia coli and organisms that live A urine culture and 03/26/15, documen colonies/ml Organism #1: Esch A urine culture and 06/07/15, documen Organism #1: Esch A hand-written note documented, "6/9/1 to ER for IV ABT the A hospital progress documented, "UT	d on 11/26/12, documented, rinary catheter for neurogenic retention heter care every shift and as sensitivity report, dated ted, "ORG#1 [organism #1] ml . (resistant to all d Penicillins) Colonies/ml herichia coli rococcus spp" d Enterococcus are both in the digestive tract. sensitivity report, dated ted, "ORG#1 100,000 herichia coli" sensitivity report, dated ted, ">100,000 colonies /ml herichia coli" on the lab report 5 allergic to Sulfa PCN Send erapy."				
		ted, "ORG#1 100,000				

NH5512         B. WING           WAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           WANORCARE HEALTH SERVICES-MIDWEST C         2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110           (xp.ip)         (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY WILLS THE PRECEDED BY FULL (EACH DEFICIENCY WILLS THE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH ODEFICIENCY MUST BE PRECEDED BY FULL (EACH ODEFICIENCY MUST BE PRECEDED BY FULL (EACH ODEFICY WILL BE PRECEDED BY THE (EACH ODEFICY WILL BE ASSISTANCE OF transfers. She required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. She had functional limitation in range of motion of the bilateral lower extremities. She was not ambulatory. She had an indwelling urinary catheter care for the resident. CNA #2 stated, "That's what we are gonna do."           The resident stated that she had an accident at 12:30 a.m. and was not sure how well she was cleaned. As care was initiated the resident was observation of catheter care provided to the resident at this time.           At 11:00 a.m., LPN #2 was asked who was responsible for performing catheter care. She stated the nurses were responsible. She was observed to check the TAR and stated, "Every shift."		E SURVEY
MANORCARE HEALTH SERVICES-MIDWEST CITY, OK 73110         2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110           (X4) ID TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED TO TAG           LL810         Continued From page 18         LL810         IL         Continued From page 18           A quarteriy assessment, dated 11/19/15, documented the resident was independent in cognitive skills for daily decision making. She required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. She had functional limitation in range of motion of the bilateral lower extremities. She was not ambulatory. She had an indwelling urinary catheter and was always incontinent care for resident #8 was observed. CNA #2 and CNA #3 were asked who was responsible for providing catheter care for the resident. CNA #2 stated, "That's what we are gonna do."         The resident stated that she had an accident at 12:30 a.m. and was not sure how well she was observed to have dried brown feces on her buttocks. CNA #2 stated, "Still got a little." There was no observation of catheter care. She stated, "We do." She was asked who was responsible for performing catheter care. She stated the nurses were responsible. She was obs	01	/11/2016
(X4) ID PREFIX         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE           LL810         Continued From page 18         LL810         LL810           A quarterly assessment, dated 11/19/15, documented the resident was independent in cognitive skills for daily decision making. She required extensive assistance of two people for transfers. She required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. She had functional limitation in range of motion of the bilateral lower extremities. She was not ambulatory. She had an indwelling urinary catheter and was always incontinent of bowel.         On 01/05/16 at 10:30 a.m., the provision of incontinent care for resident #8 was observed. CNA #2 and CNA #3 were asked who was responsible for providing catheter care for the resident. CNA #2 stated, "That's what we are gonna do."           The resident stated that she had an accident at 12:30 a.m. and was not sure how well she was cleaned. As care was initiated the resident was observed to have dried brown feces on her buttocks. CNA #2 stated, "Still got a little." There was no observation of catheter care. She stated, "We do." She was asked who was responsible for performing catheter care. She stated, "We do." She was asked to clarify. She stated the nurses were responsible. She was observed to check the TAR and stated, "Every		
A quarterly assessment, dated 11/19/15, documented the resident was independent in cognitive skills for daily decision making. She required extensive assistance of two people for transfers. She required extensive assistance of one person for bed mobility, dressing, toilet use and personal hygiene. She had functional limitation in range of motion of the bilateral lower extremities. She was not ambulatory. She had an indwelling urinary catheter and was always incontinent of bowel. On 01/05/16 at 10:30 a.m.,the provision of incontinent care for resident #8 was observed. CNA #2 and CNA #3 were asked who was responsible for providing catheter care for the resident. CNA #2 stated, "That's what we are gonna do." The resident stated that she had an accident at 12:30 a.m. and was not sure how well she was cleaned. As care was initiated the resident was observed to have dried brown feces on her buttocks. CNA #2 stated, "Still got a little." There was no observation of catheter care provided to the resident at this time. At 11:00 a.m., LPN #2 was asked who was responsible for performing catheter care. She stated, "We do." She was asked to clarify. She stated the nurses were responsible. She was observed to check the TAR and stated, "Every	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE
LPN #2 was informed of the need to observe the catheter care for the day shift. No observation of catheter care was observed on the day shift. On 01/06/16 at 9:00 a.m., LPN #2 was asked if		

STATEMEN	na State Department IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION		E SURVEY PLETED
		NH5512	B WING		01/11/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, 3	STATE, ZIP CODE		
IANOR	CARE HEALTH SERV	ICES-MIDWEST C	RKLAWN DRI T CITY, OK			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
LL810	Continued From pa	age 19	LL810			
	01/05/16. She stat her chair.''	ed, "No, she was already up in				
	resident was at risk infections due to im failure to perform in manner. He stated	sician #1 was asked if the c for the recurrent E. coli aproper incontinent care and acontinent care in a timely l, "It is possible. She also has ther which places her at risk."				
	observation and ob	nformed of the incontinent care servation of dried feces. He be a reason. I will put her on at happens."				
	how often catheter	45 a.m., the DON was asked care is provided to the ted, "Typically every shift or as				
		o is responsible for providing stated, "The nurse on the				
		w recurrent infections are ated , "We do monthly track s."				
	resident with recurr	at the facility policy was for a rent urinary tract infections. ends. Staff inservices."				
LL816	310:675-9-1.1.(b)(1 PERSONAL CARE	)(2) BASIC NURSING AND	LL816			
	provided for resider	nd personal care shall be nts as needed. hall include, but not be limited				
ahoma St ATE FOR	ate Department of Health	1	6899	KBY411	If continuati	on sheet 2

Oklahoma State Department of Health	
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				E SURVEY PLETED
		NH5512	B WING		01/1	
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		2900 PAR	RKLAWN DRIV	/E		
	CARE HEALTH SERVI	MIDWEST C MIDWES	т сіт <mark>у, ок</mark> 7	3110		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)		COMPLET DATE
LL816	Continued From pa	ge 20	LL816			
	(A) Encouraging r	esidents to be active and out				
	of bed for reasonab					
	(B) Measuring res	ident temperature, blood				
		respirations at least once				
		d more frequently if warranted				Ì
	5	ndition, with the results				
	recorded in the clini					
		dent weight at least once				
		d more frequently if warranted				
		ndition, with the results				
	recorded in the clini					
		ident pain whenever vital I more frequently if warranted				
		ndition, with the results				
	recorded in the clini					
		and making fluids available,				
	to maintain proper h					
		per nutritional practices for				
		arenteral feedings and				
	assistance in eating					
		er skin care to prevent skin				
and a state	breakdown.					
	(F) Providing prop	er body alignment.				
		portive devices to promote				
	proper alignment ar	nd positioning.				
	(H) Turning bed re	sidents every two hours or as				
		pressure areas, contractures,				
	and decubitus.					
		ge of motion exercises in				
		lividual assessment and care				
	plans.					
		esidents positions are				
	chair and are toilete	hours or as needed when in a				
		nd implementing bowel and				
		o promote independence, or				
		schedules to promote				
	continence.	somedules to promote				
		heter care with proper				
	(_/ · · · · · · · · · · · · · · · · · · ·	inerest out o man propos				

Oklahor	na State Department	t of Health				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		NH5512	B WING		01/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-MIDWEST C	KLAWN DRI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
LL816	Continued From pa	ige 21	LL816			
	positioning of bag a (M) Recording acc records for resident catheters. (N) Assessing the condition of the res (O) Updating the a care plan when the the resident's physi functioning. (P) Recognizing a symptoms of illness treat the illness or in treatments and med (2) Personal care s to: (A) Keeping reside (B) Keeping bed li (C) Keeping reside and neat. (D) Ensuring that n appropriately for ac participate; bedfast appropriately dress cover for comfort an (E) Ensuring that t groomed. (F) Providing oral twice daily with read toothbrush and den cleaning/soaking de available and maint needed.	and tubing at all times. curate intake and output ts with tube feedings or general mental and physical ident on admission. assessment and individual re is a significant change in cal, mental, or psychosocial and recording signs and s or injury with action taken to njury, and the response to dications. shall include, but not be limited ents clean and free of odor. nens clean and dry. ent's personal clothing clean residents are dressed tivities in which they /chairfast residents shall be ed and provided adequate and privacy. he resident's hair is clean and hygiene assistance at least dily available dental floss,				
Oklahoma St	ate Department of Health		r	· · · · · · · · · · · · · · · · · · ·		

Oklahor	na State Department	t of Health				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		NH5512	B WING		01/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-MIDWEST C	RKLAWN DR ST CITY, OK			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
LL816	This Rule is not me Based on observati and resident intervit facility failed to ensu- coordinated with the psychotropic medic without indication for five sampled reside services The Resident Cens dated 01/04/16, door received hospice set Findings: A policy, Phase 3: If documented, "Un 1Each resident's of from unnecessary of any drug when used (i) In excessive door therapy): or (ii) For excessive do (iii) Without adequa (iv) Without adequa (v) In the presence	et as evidenced by: on, record review and staff ew, it was determined the ure the resident's care was a hospice agency to ensure ations were not increased or an increase for one (#1) of onts who received hospice us and Conditions report, cumented seven residents ervices. mplement, dated 2015, necessary drugs drug regimen must be free drugs. An unnecessary drug is d: se (including duplicate luration: or	LL816			
Oklahoma St	ate Department of Health			··		
STALE FOR	VI		6899	KRV411	It continuatio	n sheet 23 of 43

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				E SURVEY PLETED
		NH5512	B WING		01/	11/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IANORO	CARE HEALTH SERV	ICES-MIDWEST C	RKLAWN DRIV T CITY, OK 73			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE
LL816	Continued From pa	age 23	LL816		<u></u>	
	discontinued: or (vi) Any combination	ons of the reasons above"				
	08/22/15 with diagr Parkinson's Diseas was admitted to ho diagnoses which in	eadmitted to the facility on noses which included se, anxiety and depression He spice on 08/26/15 with cluded failure to thrive and pulmonary disease.				
1	08/22/15, documer receive Xanax 0.25	hysician's orders, dated ated the resident was to ang TID and Ativan 0.5 mg these were antianxiety				
		, dated 10/01/15, documented nax to 0.25 mg every eight				
	had been administer on 10/01/15, 10/02, anxiety and on 10/7 with cough. The re	MAR documented the resident ered one PRN Xanax 0.25 mg /15, 10/12/15 for increased 15/15 for increased anxiety esident had been diagnosed ratory infection the previous				
	documented betwe There was no docu anxious behaviors of increased anxiet documentation the	progress notes were en 10/01/15 and 10/17/15. mentation of restlessness, or of the resident complaining y. There was no nurses had coordinated the the hospice nurses.				
		note, dated 10/15/15, sident had anxiety "@ X's" and a day".				

# Oklahoma State Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING <sup>.</sup> _			E SURVEY PLETED
		NH5512	B WING		01/	11/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-MIDWEST C	RKLAWN DRIV ST CITY, OK 73			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
LL816	documented, "New May give Xanax 0.2 [sic] change Xanax A physician's order, to hold the Ativan u 0.25 mg was to be Ativan was available decreased to TID F Ativan change was The October 2015 F documentation the administered a PRN through 10/22/15. A hospice nursing m documented the res "pt. sleeps 16 + hrs A physician's order, to increase the Xan mg) every 4 hours F Two hospice nursin 10/26/15, documen status had been der The October 2015 F had been administer 10/24/15 and 10/25 Twelve nursing prog from 10/17/15 throu documentation of re behaviors or of the increased anxiety.	note, dated 10/17/15, order for Ativan 0.5 mg tid. 25 tid until Ativan arrives the to tid prn" dated 10/17/15, documented intil available. The Xanax administered TID until the e and then was to be PRN. No written order for the located. WAR contained no resident had been N Xanax from 10/15/15 Note, dated 10/22/15, sident had anxiety "@ X's" and a day". dated 10/22/15, documented ax to 0.25 mg two tabs (0.5 PRN for restlessness. g notes, dated 10/23/15 and ted the resident's anxiety ferred. MAR documented the resident pred one PRN Xanax on	a t			

STATEMEN	na State Departmen IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION		E SURVEY PLETED
					01/11/201	
		NH5512	B WING		01/	11/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S <sup>-</sup> RKLAWN DRIV			
MANOR	CARE HEALTH SERV	ICES.MIDWEST C	T CITY, OK 7			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE	(X5) COMPLET DATE
LL816	Continued From pa	age 25	LL816		<u></u>	
	documented the re "pt. sleeps 16 + hrs the resident comple cough "and he can" name deleted] notif orders" The note nurse had notified t resident's status an A physician's order, to increase the Ativ	note, dated 10/29/15, sident had anxiety "@ X's" and a day". It also documented ained of a nonproductive "t get anything up. [Physician's fied [and] received new e documented the hospice the attending physician of the ad had received new orders. , dated 10/29/15, documented an to 0.5 mg every six hours gnosis of anxiety as essness.				
s 		note, dated 10/30/15, sident's anxiety status had				
	resident had been a	5 MAR documented the administered one PRN Xanax time the PRN Ativan was on 11/19/15.				
		note, dated 11/05/15, sident had anxiety "@ X's" and a day".				
		note, dated 11/06/15, sident's anxiety status had				
,	from 10/29/15 throu documentation of re behaviors or of the increased anxiety.					

Oklahoma State Departme	nt of Health
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING			E SURVEY PLETED
		NH5512			01/	01/11/2016
NAME OF PROVIDER OR SUPPLIER STREET AL			DDRESS, CITY, STATE, ZIP CODE			
	ARE HEALTH SERVI	CES-MIDWEST C	RKLAWN DRIV			
		MIDWES	T CITY, OK 7	3110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COF PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		(X5) COMPLETI DATE
LL816	Continued From pa	ge 26	LL816			
	documented the res [increased]" and "pf also documented, " anxiety [and] thick s [and] vomit. [Physic [and] new orders re documented the ho attending physician had received new o A physician's order, to increase the Ativa every eight hours ro anxiety as manifest On 01/05/16 at 5:00 locate the document	spice nurse had notified the of the resident's status and orders. dated 11/12/15, documented an to 0.5 mg two tabs (1 mg) outinely for the diagnosis of ed by restlessness. 0 p.m., the DON was asked to atation of behaviors which for the increase in the				
	was documentation the resident's behave facility should have behaviors. She stat	5 p.m., the DON stated there in the hospice notes about viors. She was asked if the also documented those ted the hospice nurse is in the d "They probably talk so much ut documenting it."				
	asked what she wor of increased anxiety	) a.m., the hospice nurse was uld do if a resident complained y. She stated she would call alk to the facility nurse.	ŀ			
	the use of PRN med	ne ever checked the MARs for dications before calling the ed she "could do that."				
	She was asked, if s	he reviewed the MARs and				[

Oklahoma	State	Department of Health	
Onanoma	olulo	Dopuration: or rigation	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				E SURVEY PLETED
		NH5512	B WING	·····	01/	11/2016
NAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		
MANORO	CARE HEALTH SERVI	CES-MIDWEST C	RKLAWN DRIV T CITY, OK 7:			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	TION SHOULD BE THE APPROPRIATE	COMPLET
LL816	Continued From pa	ge 27	LL816			
	a PRN medication the physician. She	ent had not been administered for two weeks, would she call stated she would probably e to give the resident a PRN nem.				
	had trained in the fa	OON stated the hospice nurse acility the previous week. The d not had a chance to h her.				
		ed if she had located any on regarding the resident's ted, "No."				
	******	******				
	interview, it was def ensure thorough inc	on, record review and staff termined the facility failed to continent care was provided sampled residents whose s observed.				
	dated 01/04/15, doc occasionally or freq	us and Conditions report, cumented 21 residents were uently incontinent of bowel id indwelling or external				
	Findings:					
	A care plan, revised	l on 11/26/12, documented,				

STATE FORM

KBY411

If continuation sheet 28 of 43

Oklahon	na State Department	of Health				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	. ,	E CONSTRUCTION	(X3) DATE SU COMPLE	
		NH5512	B WING		01/11/	/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-MIDWEST C	KLAWN DRI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
LL816	Continued From pa	ge 28	LL816			
	bladder and urinary	inary catheter for neurogenic retention eter care every shift and as				
	documented the res cognitive skills for d required extensive a transfers. She requ one person for bed and personal hygier range of motion of t She was not ambul	nent, dated 11/19/15, sident was independent in laily decision making. She assistance of two people for uired extensive assistance of mobility, dressing, toilet use ne. She had a limitation in he bilateral lower extremities. atory. She had an indwelling d was always incontinent of				
		y 2016 documented the eive catheter care every shift.				
	incontinent care for CNA #2 and CNA # responsible for prov	30 a.m.,the provision of the resident was observed. 3 were asked who was riding catheter care for the tated, "That's what we are				
	12:30 a.m. and was cleaned. As care w observed to have du buttocks. CNA #2 s	that she had an accident at not sure how well she was as initiated, the resident was ried brown feces on her stated, "Still got a little." There of catheter care provided to ime.				
	how often incontine	#2 and CNA #3 were asked nt care was offered to the tated, "In the morning and she				:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING	re SURVEY //PLETED /11/2016 (X5)
NH5512     B WING     O1       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     01       MANORCARE HEALTH SERVICES-MIDWEST C     2900 PARKLAWN DRIVE	/11/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE	
2900 PARKLAWN DRIVE	(X5)
I MANORCARE HEALTH SERVICES-MIDWEST C	(X5)
	(X5)
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE TAG         CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
LL816 Continued From page 29 LL816	
At 11:00 a.m., LPN #2 was asked who was responsible for performing catheter care. She stated, "We do." She was asked to clarify. She stated the nurses were responsible. She was observed to check the TAR and stated, "Every shift." LPN #2 was informed of the need to observe the catheter care for the day shift. No observation of catheter care was observed on the day shift. On 01/06/16 at 9:00 a.m., LPN #2 was asked if catheter care was given during the day shift on	
01/05/16. She stated, "No, she was already up in her chair."	
LL830 310:675-9-5.1.(b) WRITTEN RESIDENT LL830 ASSESSMENT	
The written resident assessment and care plan shall be reviewed and updated, at least quarterly, and as needed when the resident's condition indicates.	
This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure care plans were revised after falls for one (#2) of nine residents whose clinical records were reviewed for falls. The Resident Census and Conditions Report dated 01/04/16, documented 73 residents resided	
Oklahoma State Department of Health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER NH5512				(X2) MULTIPLE CONSTRUCTION A BUILDING		E SURVEY PLETED
		B WING	11/2016			
IAME OF F	PROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE			
IANORO	CARE HEALTH SERV		RKLAWN DRIV			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
LL830	Continued From pa	age 30	LL830			
	Findings:					
		agnoses which included ntia, aphasia, diabetes, steoarthritis.				
	"At risk for falls due	d on 02/11/10, documented, to use of psychotropic al weakness, and history of				
		dated 02/27/15 at 9:30 a.m., Il without injury (or minor i [sic] n dining room"				
	There were no new care plan.	interventions identified on the				
	documented, "Lo	dated 03/09/15 at 4:30 a.m., cation of Incident: Patient's : injury (or minor i [sic] resident to bed"				
:	There were no new care plan.	interventions identified on the				
	documented, "Fa found by Can [sic] I bedassisted back started, skin tears t	dated 03/12/15 at 3:15 a.m., Il without injury (or minor i [sic] ying on floor next to to bed, VSS and neuro,s [sic] o right arm cleaned with NS lied, drsg applied"				
	There were no new care plan.	r interventions identified on the				
	documented, "Fa	dated 06/02/15 at 5:30 a.m., Il without injury (or minor i [sic] on the floor between her bed				

Oklahoma State Department of Health	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER NH5512					(X3) DATE SURVEY COMPLETED	
		B. WING		01/	11/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
MANORO		CES-MIDWEST C	RKLAWN DRIV			
		MIDWES	T CITY, OK 73			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
LL830	Continued From pa	ge 31	LL830			
4k	and recliner. Resid she fell"	ent is not able to tell us how				
	There were no new the care plan.	interventions documented on				
	where the intervent documented. She She was asked if th	0 p.m., the DON was asked ions for falls would be stated, "On the care plans." iey are documented on the ne stated, "No, only on the				
	was asked if the res with each fall. She documented on the the problem section	00 p.m., the MDS Coordinator sident's care plan was updated stated, "The falls are not care plan each time under but each fall is care planned and dated under the				
	be new intervention She stated, "Yes." ensured that new in placed on the care	ON was asked if there should s with each fall occurrence. She was asked how the facility iterventions were initiated and plans. She stated, "It is gle room every morning."	4			
LL846	310:675-9-9.1.(c) M ACCOUNTABILITY		LL846			
	physician's order. (2) The person res medications shall p observe the swallow record the medicati prepared within one	all be administered only on a ponsible for administering ersonally prepare the dose, ving of oral medication, and on. Medications shall be a hour of administration. itten record of medications				

Oklahoma State Department of Health STATE FORM

STATEMEN	TA State Departmer	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				E SURVEY PLETED
	NH5512		B WING		01/	11/2016
AME OF PROVIDER OR SUPPLIER STREET AL			DDRESS, CITY, S RKLAWN DRIV			
MANUR	ARE HEALIH SERV	MIDWEST C MIDWEST	T CITY, OK 7	3110	_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
LL846	Continued From p	age 32	LL846			
	medication record (A) The identity a administering the r (B) The medication hour of the schedu (C) Medications a condition may requ immediately, includ medication, and ac (D) Adverse reac (E) Injection sites (F) An individual i maintained for eac prescribed for a re (G) Medication er (4) A resident's ad	nd signature of the person medication. on administered within one iled time. administered as the resident's uire (p.r.n.) are recorded ding the date, time, dose, dministration method. tions or results. b. inventory record shall be th Schedule II medication				
	Based on record red determined the fact ~ an antianxiety m without indications of nine sampled re antianxiety medica ~ side effects for a monitored for three residents who rece medications;	ntipsychotic medications were e (#2, 4 and #8) of six sampled				
	monitored for three	antianxiety medications were				

Oklahor	na State Departmen	t of Health				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	· , ,	LE CONSTRUCTION	(X3) DATE S COMPLI	
		NH5512	B WING		01/11	/2016
NAME OF	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY,	STATE, ZIP CODE		
MANOR		2900 PA		RIVE		
WANUR	CARE HEALTH SERV	MIDWEST C MIDWEST	ST CITY, OK	73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
LL846	Continued From pa	age 33	LL846			
	(#2, 3 and #8) of n received antianxiet	ine sampled residents who y medications; and				
	were monitored for	ntidepressant medications one (#8) of seven sampled ived antidepressant				
	dated 01/04/16, do received antipsycho received antianxiety	sus and Conditions report, cumented nine residents otic medications, 22 residents y medications, and 32 antidepressant medications.				
	Findings:					
	documented, "Un 1Each resident's from unnecessary of any drug when use	drug regimen must be free drugs. An unnecessary drug i d:	s			
	therapy): or (ii) For excessive of					
	(v) In the presence	ate monitoring: or ate indications for its use: or of adverse consequences lose should be reduced or				
	discontinued: or	ons of the reasons above"				
	08/22/15 with diagr Parkinson's Diseas	s readmitted to the facility on loses which included e, anxiety and depression. He spice on 08/26/15 with	e			
	diagnoses which in	cluded failure to thrive and pulmonary disease.				
Oklahoma Si		hysician's orders, dated ted the resident was to				
STATE FOR			6899	KBY411	If continuation	sheet 34 of 43

AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
		B WING		01/	11/2016	
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			11/2010
MANORO	CARE HEALTH SERV	ICES-MIDWESTC	RKLAWN DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
LL846	Continued From pa	ige 34	LL846			
		i mg TID and Ativan 0.5 mg these were antianxiety				
		, dated 10/01/15, documented nax to 0.25 mg every eight				
	had been administer on 10/01/15, 10/02/ anxiety and on 10/1 with cough. The re	MAR documented the resident ered one PRN Xanax 0.25 mg (15, 10/12/15 for increased 15/15 for increased anxiety sident had been diagnosed ratory infection the previous				
	documented betwe There was no docu anxious behaviors of of increased anxiet documentation the	progress notes were en 10/01/15 and 10/17/15. mentation of restlessness, or of the resident complaining y. There was no nurses had coordinated the the hospice nurses.				
		note, dated 10/15/15, sident had anxiety "@ X's" and a day".				
	documented, "New	note, dated 10/17/15, order for Ativan 0.5 mg tid. 25 tid until Ativan arrives the to tid prn"				
	to hold the Ativan u 0.25 mg was to be Ativan was available	dated 10/17/15, documented intil available. The Xanax administered TID until the e and then was to be PRN. No written order for the				

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Oklahoma	State	Department of Health
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER NH5512					(X3) DATE SURVEY COMPLETED	
		B WING		01/	11/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	TATE, ZIP CODE		
MANOR	CARE HEALTH SERV	CES-MIDWEST C	RKLAWN DRIV ST CITY, OK 73			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
LL846	through 10/22/15. A hospice nursing r documented the res "pt. sleeps 16 + hrs A physician's order, to increase the Xan mg) every 4 hours I Two hospice nursin 10/26/15, documen status had been de The October 2015 I had been administe 10/24/15 and 10/25 Twelve nursing prog from 10/17/15 throu documentation of re behaviors or of the increased anxiety. the nurses had coo with the hospice nu A hospice nursing r documented the res "pt sleeps 16 + hrs the resident compla cough "and he can' name deleted] notif orders" A physician's order, to increase the Ativa	MAR contained no resident had been N Xanax from 10/15/15 Note, dated 10/22/15, sident had anxiety "@ X's" and a day". dated 10/22/15, documented ax to 0.25 mg two tabs (0.5 PRN for restlessness. g notes, dated 10/23/15 and ted the resident's anxiety ferred. MAR documented the resident ered one PRN Xanax on /15. gress notes were documented ugh 10/29/15. There was no estlessness, anxious resident complaining of There was no documentation rdinated the resident's care	t d s			

	na State Departmen IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED 01/11/2016	
		NH5512	B WING			
	PROVIDER OR SUPPLIER	2900 PA	DDRESS, CITY, S			
MANOR	CARE HEALTH SERV		T CITY, OK 7			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
LL846	Continued From pa	age 36	LL846	<u></u>		
	manifested by restl	essness.				
	A hospice nursing note, dated 10/30/15, documented the resident's anxiety status had been deferred.					
	resident had been a	5 MAR documented the administered one PRN Xanax next time the PRN Ativan was on 11/19/15.				
		note, dated 11/05/15, sident had anxiety "@ X's" and s a day".				
		note, dated 11/06/15, sident's anxiety status had				
	from 10/29/15 throu documentation of re behaviors or of the increased anxiety.	as notes were documented ugh 11/12/15. There was no estlessness, anxious resident complaining of There was no documentation ordinated the resident's care press.				
	documented the re [increased]" and "p also documented, ' anxiety [and] thick s	note, dated 11/12/15, sident had anxiety "@ X's t. sleeps 16 + hrs a day". It 'pt. reports [increased] sputum that makes him gag cian's name deleted] notified eceived"				
	to increase the Ativ every eight hours re	, dated 11/12/15, documented an to 0.5 mg two tabs (1 mg) outinely for the diagnosis of ted by restlessness.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED	
		NH5512	B WING		01/	11/2016
	PROVIDER OR SUPPLIER	ICES-MIDWEST C 2900 PA	DDRESS, CITY, S RKLAWN DRIV T CITY, OK 7	Æ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
LL846	On 01/05/16 at 5:0 locate the document indicated the need antianxiety medication the resident's beha facility should have behaviors. She sta facility everyday and they don't think about On 01/11/16 at 10:3 asked what she wo of increased anxiet the physician and ta She was asked if s the use of PRN me physician. She sta She was asked, if s observed the reside a PRN medication the physician. She ask the facility nurs dose and monitor the At 11:05 a.m., the D located any facility resident's behaviors 2. Resident #2 had chronic pain, deme COPD, CHF and os A care plan, dated the side a context of the side a contex	<ul> <li>0 p.m., the DON was asked to natation of behaviors which for the increase in the tions.</li> <li>5 p.m., the DON stated there in the hospice notes about viors. She was asked if the also documented those ited the hospice nurse is in the d "They probably talk so much but documenting it."</li> <li>50 a.m., the hospice nurse was uld do if a resident complained y. She stated she would call alk to the facility nurse.</li> <li>he ever checked the MARs for dications before calling the ted she "could do that."</li> <li>she reviewed the MARs and ent had not been administered for two weeks, would she call stated she would probably e to give the resident a PRN nem.</li> <li>DON was asked if she had documentation regarding the s. She stated, "No."</li> <li>4 diagnoses which included ntia, aphasia, diabetes,</li> </ul>				
	"Focus	oznanie, documenteu,				

Oklahon	na State Departmen	t of Health				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	. ,			E SURVEY PLETED
		NH5512	B WING		01/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES MIDWEST C 2900 PA	RKLAWN DRI	VE		
		MIDWEST	ST CITY, OK 7	/3110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
LL846	Continued From pa	age 38	LL846			
	At risk for adverse antianxiety medicat InterventionsMon blurred vision and o A treatment admini November 2015, do 1-25-1 GEL APPLY times a day)MON EFFECTS, INITIAL SIDE EFFECTS" ABH gel contains th Ativan, and the anti There was no docu side effects for the resident's clinical re 3. Resident #8 had	effects related to: use of tion itor for dizziness, drowsiness, orthostatic hypotension" stration record, dated ocumented, "ABH GEL 1 TOPICALLY .5XD (five IITOR FOR S/S OF SIDE .S INDICATE ABSENCE OF the antianxiety medication, ipsychotic medication, Haldol. imentation of the monitoring of ABH gel administration in the ecord for November 2015.				
	"Focus At risk for adverse antidepression med	s and paraplegia. 10/18/09, documented, effects related to: use of dicationantianxiety ychotic medication				
		mal/no side effects of				
	InterventionsAntia Antidepressants- M Antipsychotic- Mon	lonitor				
Oklahoma St	documented, " EX	n's order, dated May 2015, KCITALOPRAM OXALATE 1 TAB BY MOUTH DAILY				

STATEMEN	na State Departmen IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION		E SURVEY PLETED
		NH5512	B WING		01/	11/2016
	PROVIDER OR SUPPLIER		DDRESS, CITY, S RKLAWN DRIN	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
LL846	Continued From pa	age 39	LL846			
	BEDTIME MONIT	MG1 CAP BY MOUTH AT FOR SIDE EFFECTS INITIALS CE OF S/S OF SIDE	3			
	BEDTIME MONIT	IG1 TAB BY MOUTH AT OR SIDE EFFECTS INITIALS CE OF S/S OF SIDE	3			
, , , ,	BY MOUTH THRE	HCL 5MGVIVACTIL 1 TAB E TIMES DAILYMONITOR IITIALS INDICATE ABSENCE FFECTS				
1	Klonopin 0.5mgd	aily @ HS for anxiety"				
		dications. Haldol is an cation. Klonopin is an				
j I	clinical record of th the administration	imentation in the resident's e monitoring of side effects for of the Lexapro, Doxepin, I Klonopin for the month of May				
	documented, "Le S/S of A/R(check	D(check) for S/S of	r			
j		nistration record, dated umented, "Haldol 0.5mgq				

Oklahoma State Department of Health STATE FORM

STATEMEN	na State Departmen IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION		E SURVEY PLETED	
		NH5512	B WING		01/	01/11/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, S	TATE, ZIP CODE	- <u> </u>		
MANOR	CARE HEALTH SERV	ICES-MIDWEST C	RKLAWN DRIV				
			T CITY, OK 7:	PROVIDER'S PLAN OF			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
LL846	Continued From page 40		LL846				
	Clonazepam and Ativan are both antianxiety medications.						
	clinical record that monitored for the a	imentation in the resident's the side effects were dministration of the Lexapro, am, Haldol and Ativan for the 2015.					
	2015, documented	n's order, dated November , "Ativan 0.5 mgBid nonitor for s/s of side effects. ence of S.E"					
	clinical record that	imentation in the resident's the side effects were dministration of the Ativan for mber 2015.					
	2015, documented 0.5MGHALDOL 1 BEDTIMEMONIT	n's order, dated November , "HALOPERIDOL I TAB BY MOUTH AT OR FOR S/S OF SIDE S INDICATE ABSENCE OF					
	December 2015, de "LORAZEPAM/ TWICE DAILY AS ANXIETYMONIT	ATIVAN 1 TAB BY MOUTH					
, , ,	clinical record that monitored for the a	imentation in the resident's the side effects were dministration of the Haldol and h of December 2015.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION		E SURVEY PLETED
		NH5512	B WING		01/	11/2016
AME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		
IANORO	CARE HEALTH SERV	ICES-MIDWEST C	RKLAWN DRIN T CITY, OK 7			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
LL846	Continued From pa	age 41	LL846			
	what the facility pol effects of psychotro "Side effects are do MAR. Initials mean She was asked who documenting the si stated, "The nurses At 2:15 p.m., LPN #	#5 was asked what				
	stated antianxiety, a antipsychotics were where it was docum MAR." 4. Resident #3 was	nonitored for side effects. She antidepressants and e monitored. She was asked nented. She stated, "On the s admitted with diagnoses neimer's, depressive disorder				
,	·	, dated 06/19/15, documented, ጋ QID"				
	clinical record that	mentation in the resident's the side effects were dministration of the Ativan for 2015.				
	" Ativan 0.5 mg one tab by i	, dated 09/10/15, documented, mouth every 4 hours as or s/s of side effects, initials f side effects"				
	clinical record that	mentation in the resident's the side effects were dministration of the Ativan for mber 2015.				
	5. Resident #4 was	s admitted with diagnoses				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED	
		NH5512	B WING		01/	11/2016
AME OF F	PROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, S	TATE, ZIP CODE		
ANOR	CARE HEALTH SERVI		RKLAWN DRIV T CITY, OK 7:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
LL846	Continued From page 42		LL846			
	which included dementia, psychosis and general anxiety disorder.					
	A physician's order, documented, "Ris medication] 1 mg o	speridone [antipsychotic				
	clinical record that t monitored for the a	mentation in the resident's the side effects were dministration of the month of July 2015.				
, , , , ,	October 2015, docu "RISPERIDONE DAILYMONITOR	nistration record, dated umented, .0.5MG1 TAB TWICE FOR S/S OF SIDE EFFECTS E ABSENCE OF SIDE				
	clinical record that t monitored for the a	mentation in the resident's he side effects were dministration of the month of October 2015.				
	what the facility poli effects of psychotro "Side effects are do MAR. Initials mean She was asked who	D p.m., the DON was asked icy was for monitoring side ppic medications. She stated, ocumented each shift on the there are no side effects." o was responsible for de effect monitoring. She is do."				

		AND HUMAN SERVICES				FORM	: 01/11/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		375098	B WING	i		01/	/07/2016
NAME OF F	PROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • •	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	ARE HEALTH SERVI	CES-MIDWEST CITY			2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	ĸ	000			
	demonstrate non-co of Regulations, §48 The requirement is facility's failure to m Protection Associat K3 BUILDING: 010 K6 PLAN APPROV/ K7 SURVEY UNDE K8 S/NF TYPE OF STRUCT unprotected wood f automatic sprinkler spaces. NFPA 101 LIFE SA Doors protecting co required enclosures hazardous areas ar those constructed of wood, or capable of minutes. Doors in s required to resist th no impediment to th are provided with a the door closed. Do are permitted. 19	1 AL: Unknown R: 2000 Existing URE: Type V (000) One story rame building. Complete protection including attic FETY CODE STANDARD orridor openings in other than a of vertical openings, exits, or re substantial doors, such as of 1 <sup>3</sup> / <sub>4</sub> inch solid-bonded core f resisting fire for at least 20 sprinklered buildings are only e passage of smoke. There is ne closing of the doors. Doors means suitable for keeping utch doors meeting 19.3.6.3.6 0.3.6.3 wrohibited by CMS regulations	ĸ	018			
		ER/SUPPLIER REPRESENTATIVE'S SIGI			TITLE		(X6) DATE

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

		AND HUMAN SERVICES				FORM	): 01/11/2016 1 APPROVED ): 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		375098	B WING	i		01	/07/2016
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY	2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 018	Continued From pa	ge 1	ĸ	018	8		
	Based on observat failed to provide con the passage of smo compartments. Thi 22 residents, who co identified by the Ma 01/06/2016. The co residents. Findings 1. During a tour of following resident ro a. At 9:07 a m. res b. At 9:09 a.m. resident.	is practice could affect 22 of currently resided on Hall 3, as intenance Director on ensus in the facility was 76 the facility on 01/06/2016 the boom doors did not latch: ident room 339.					
	door on the latch si 3. The maintenanc during the tour and						
	Guidance from CM corridor doors.	S on allowable gaps around					
	sprinklered, a gap b	mary tment that is not fully between the face of a corridor stop should not exceed ¼-inch,					

If continuation sheet Page 2 of 10

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		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		. 0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER.		- MAIN BUILDING 01		IPLETED	
		375098	B WING		01/	07/2016	
IAME OF I	PROVIDER OR SUPPLIEF	<pre></pre>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	· · · · ·		
MANOR	CARE HEALTH SER	VICES-MIDWEST CITY	2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
K 018	Continued From p	age 2	K 018				
	provided that the of functioning.	door latch mechanism is					
	a gap between the door stop should r	artment that is fully sprinklered, e face of a corridor door and the not exceed ½-inch, provided mechanism is functioning.				-	
K 025 SS=E	NFPA 101 LIFE S	AFETY CODE STANDARD	K 025				
	least a one half ho accordance with 8 terminate at an at	e constructed to provide at our fire resistance rating in a.3. Smoke barriers may rium wall. Windows are ated glazing or by wired glass					
	panels and steel fi separate compart floor. Dampers are penetrations of sm heating, ventilating	rames. A minimum of two ments are provided on each e not required in duct noke barriers in fully ducted g, and air conditioning systems. 19 1.6.3, 19.1.6.4					
	19.9.7.9, 19.9.7.9,	10 1.0.0, 10.1.0.4					
	Based on observation failed to maintain	is not met as evidenced by: ation and interview, the facility 1 of 4 attic smoke barrier walls					
	resistance. This p residents, who cu identified by the M	at least a 1/2 hour fire practice affected 22 of 22 rrently resided in the facility, as laintenance Director on facility had a census of 76 gs:					
	01/06/2016 at 12: smoke wall obser	ection of the facility on 26 p.m., the following attic vation was made. The Hall 3 Il around the perimeter of the					

Event ID KBY421 Facility ID NH5512

If continuation sheet Page 3 of 10

	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER		IG 01 - MAIN BUILDING 01		IPLETED
_		375098	B WING		01/	07/2016
	PROVIDER OR SUPPLIER	/ICES-MIDWEST CITY		STREET ADDRESS, CITY, STATE, ZIP COE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
K 025	Continued From p	age 3	K 02	25		
	end. One was app	to have two holes on the east proximately five feet from the ne second was at the corner wall.				
		ce Director was present during acknowledged the holes.	1			
	continuous from a wall, from a floor to barrier to a smoke thereof. Such barri through all concea	quired by this Code shall be n outside wall to an outside o a floor, or from a smoke barrier or a combination iers shall be continuous led spaces, such as those ing, including interstitial				
	Exception: A smol occupied space be not be required to space, provided th forming the bottom provides resistanc equal to that provide NFPA 101 LIFE SA	ke barrier required for an elow an interstitial space shall extend through the interstitial at the construction assembly n of the interstitial space e to the passage of smoke ded by the smoke barrier. AFETY CODE STANDARD	К 03	18		
SS=E		nged so that exits are readily nes in accordance with sectior				
	Based on observation facility failed to ens	is not met as evidenced by: ation and staff interview, the sure 2 of 9 designated exit e fire alarm was activated. This	5			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 01/11/2016 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ° ′		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DA	TE SURVEY MPLETED
		375098	B WING	;		01	/07/2016
	PROVIDER OR SUPPLIER	CES-MIDWEST CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	had the potential to residents, who coul identified by the Ma 01/06/2016. The far residents. Findings 1. A fire alarm test at 1:06 p.m. It was door and the activiti locked while the fire doors were equipped that worked. 2 The Maintenance the alarm test and a not unlock while the 7.2 MEANS OF EG 7.2.1 Doors. 7.2.1.6 Special Lock 7.2.1.6 Special Lock 7.2.1.6 Special Lock 7.2.1.6 Special Lock 7.2.1.6 Special cord 7.2.1.6 Special cord fire detection system 9.6, or an approved sprinkler system in and where permitte provided that the fo (a) The doors shall approved, supervise in accordance with actuation of any hea more than two smo	affect approximately 3 of 3 d ambulate independently, as intenance Director on icility had a census of 76 was conducted on 01/06/2016 noted that the service hall exit ies office exit door were still e alarm was sounding. Both ed with delayed egress locks e Director was present during acknowledged the doors did a alarm was going off. RESS COMPONENTS king Arrangements.	K	038			

Facility ID NH5512

If continuation sheet Page 5 of 10

CENTERS FOR MEDICARE & MEDICAID SERVICES         TATEMENT OF DEFICIENCIES         ND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER         375098			(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			
		A BUILDING				
		B WING		01	01/07/2016	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	E	
MANORO	CARE HEALTH SERV	ICES-MIDWEST CITY	í	2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
K 038	Continued From pa	age 5	K 038			1
1	accordance with S			1		1
		II unlock upon loss of power				ļ
		or locking mechanism. process shall release the lock				
1		upon application of a force to		1		1
	the release device	required in 7.2.1.5.4 that shall	1	1		1
1		exceed 15 lbf (67 N) nor be inuously applied for more that	n			
		tiation of the release process	•			
i		udible signal in the vicinity of				
I		door lock has been released of force to the releasing device	_ د			
l		by manual means only.	·,			
	Exception: Where	approved by the authority				1
	having jurisdiction, seconds shall be p	a delay not exceeding 30	1			1
:		adjacent to the release device	j 5 -			1
1		adily visible, durable sign in	l.			1
		n 1 in. (2.5 cm) high and not .3 cm) in stroke width on a				
1		ound that reads as follows:				1
	PUSH UNTIL ALA			]		1
K 054		PENED IN 15 SECONDS	K 054			
K 054 SS=C '			1004			1
		detectors, including those		1		1
		d-open devices, are approved sted and tested in accordance		1		1
		irer's specifications. 9.6.1.3		1		
						1
!		. , ,				1
		is not met as evidenced by: tion and interview, the facility				4
		iannual smoke sensitivity test	[			
1	on smoke detector	s Without this biannual				
	testing the facility f detectors would fur	had no assurance the smoke	Í			1

CENTERS FOR MEDICARE & MEDICAID SERVICES           TATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           IND PLAN OF CORRECTION         IDENTIFICATION NUMBER           375098         375098		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		NAME OF PROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 054	Continued From pa	age 6	K 05	54		
		/fire. This has the potential to				
		dents who currently reside in				
	<sup>i</sup> the facility as identi	ified by the Maintenance				1
	Director on 01/06/2	2016. The facility census was				 , 
	76. Findings:					
	1 During record re	aview on 01/06/2016 at 1:20				
	1. During record review on 01/06/2016 at 1:20 p.m., it was determined the last annual fire inspection dated 06/16/2015 did not document					
						1
:	1	ad been performed.				1
	2. An interview wa	s conducted with the				1
		tor on 01/07/2016 at 8:15 a.m.				
		company that performs the				
	sensitivity testing had record of doing it in 2011 and 2013 but not in 2015.		1	1		l
	and 2013 but not in	12015.				
	NFPA 72, Sec 7-3.2	2.1				
		shall be checked within 1 year				
		d every alternate year		1		
		e second required calibration sts indicate that the detector		ſ		
		n its listed and marked				
		r 4 percent obscuration light				
		marked), the length of time				
		n tests shall be permitted to be		ļ		
		imum of 5 years. If the		}		
:	frequency is extend detector-caused nu			}		
		of these alarms shall be		1		
	I I I I I I I I I I I I I I I I I I I	es or in areas where nuisance		1		I
	alarms show any ir	ncrease over the previous year,		1		
1	calibration tests sh			1		
		h smoke detector is within its				
		sensitivity range, it shall be <sup>5</sup> the following methods:				
	(1) Calibrated test			1		
		s calibrated sensitivity test		1		
	instrument					

	· · · · · · · · · · · · · · · · · · ·	& MEDICAID SERVICES				0. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		375098	B WING		01	/07/2016
AME OF I	PROVIDER OR SUPPLIER	······································		STREET ADDRESS, CITY, STATE, ZIP COD	ie	
MANOR	CARE HEALTH SERV	ICES-MIDWEST CITY		2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 054	Continued From pa	age 7	K OS	54		
	(3) Listed control e purpose	equipment arranged for the				
	(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its					
	listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and					
						74500 B 1010
	cleaned and recalit replaced. Exception No. 2: T	brated, or they shall be This requirement shall not apply tectors referenced in 7-3.3 and				
	measured using ar	tivity shall not be tested or ly device that administers an entration of smoke or other				
K 062 SS≃F		tector. FETY CODE STANDARD	K 06	32		
55-r   	Required automation continuously maint condition and are in	c sprinkler systems are ained in reliable operating hspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,				
	Based on observa interview, the facilit	s not met as evidenced by: tion, record review and staff y failed to maintain the system in reliable working				

Facility ID<sup>,</sup> NH5512

If continuation sheet Page 8 of 10

		AND HUMAN SERVICES				FOR	D. 01/11/2016 M APPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		375098	B WING	;		0-	1/07/2016
NAME OF I	PROVIDER OR SUPPLIER		4	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE HEALTH SERVI	CES-MIDWEST CITY					
					IDWEST CITY, OK 73110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 062	Continued From pa	ge 8	K	062			
	The Post Indicator was stuck open. A	not have sprinkler protection. Valve for the sprinkler system nd the facility failed to perform nspection for the 2nd quarter					
	of 2015. This pract residents, who curr identified by the Ma	ice could affect 76 of 76 ently resided in the facility, as intenance Director. The	   				]
		y was 76 residents Findings:					{
	9:12 a.m., the follow In Hall 3 shower roo	the facility on 01/06/2016 at wing observations was made. om a former shower stall that to a linen closet did not have a					
	attempt was made valve (main sprinkle	ring testing of the fire alarm an to close the post indicator er control valve) to check the Maintenance Director was alve closed.					
	p.m., it was determ sprinkler inspection	eview on 01/06/2016 at 1·20 ined the only quarterly had been performed nnual sprinkler inspection was					
	01/07/2016 that the unable to find any c the last year. Durin	e Director stated on inspection company was other quarterly inspections for ag the inspection of the facility he findings in items 1 and 2					
	devices including, t water motor gong, and pressure switcl visual signals shall	esting of water flow alarm but not limited to, mechanical vane-type water flow devices, hes that provide audible or be tested quarterly. NFPA 25					
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID KBY42	1	Fac	ality ID NH5512 If conti	inuation she	et Page 9 of

		AND HUMAN SERVICES			FOR	D: 01/11/2016	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		375098	B WING		o	1/07/2016	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-MIDWEST CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 PARKLAWN DRIVE MIDWEST CITY, OK 73110				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
K 062	sprinkler system to	ige 9 equires every required be continuously maintained in ondition. NFPA 25 table 2-1.		62			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID KBY42	       !	Facility ID NH6512	If continuation she	et Page 10 of 10	