STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375446	A. BUILDING _____ B. WING _____	09/27/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET ESTATES	201 WEST WALNUT TECUMSEH, OK 74873

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined the facility failed to provide interventions according to resident's needs to prevent the development of avoidable moisture associated skin damage (MASD) for one (#99) of four sampled residents. The facility's failure to provide interventions according to the resident's needs resulted in harm with the development of avoidable MASD in two areas. The director of nurses identified 39 residents who were dependant on staff for assistance with incontinent care. Findings: Resident #99 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An admission assessment dated [DATE], documented the resident exhibited clear speech, was able to understand and be understood. The assessment further documented the resident required extensive assistance from two staff for bed mobility, hygiene, toilet use, and was always incontinent of bowel and bladder and was totally dependant on staff for transfers. A care plan last updated 07/12/16, documented the resident had an overactive bladder, was at risk for skin breakdown due to frequent incontinence, brief use and medications. The goal was to remain free from skin breakdown by preventing any new breakdown by checking the resident frequently and as required for incontinence. Interventions included to use two persons and the Hoyer lift (machine used to lift) for all ADLs (activities of daily living), incontinent care as needed, and apply a protective moisture barrier after all incontinent episodes. Physicians orders, dated 08/07/16 and 09/08/16, documented, [MEDICATION NAME] (water pill) 40 milligrams (mg), one tablet daily for excess fluid, and [MEDICATION NAME] (potassium sparing water pill) 25 mg, one time daily for [MEDICAL CONDITION]. On 09/27/16 at 1: 55 p.m., the resident was observed sitting in a recliner in the corner of her room. She was interviewed and asked about the care she received. The resident was able to answer the questions slowly, but appropriately. She stated the care she received was, OK most of the time. She was asked when was the care not OK. She stated, When I have to sit in a wet diaper for 2 or 3 hours. She was asked how often did she wait 2 to 3 hours in a wet brief. She stated she wasn't sure, But its more often than not. At 2:30 p.m., 3: 50 p.m., and again at 4:40 p.m., the resident was observed to remain in the recliner. Staff was not observed to reposition, offer or provide incontinent care during this time period. On 09/27/16 at 9:00 a.m., the resident was observed in bed, with her eyes closed. A family member was seated at the bedside. The family member was interviewed regarding the resident's allegations of lack of care. She was asked if the staff provided care for the resident as expected. She stated she didn't think so and she thought there was not nearly enough staff working to make sure residents were provided with timely care. She stated she had been in the room for an entire evening and the call light, if turned on, would never be answered and incontinent care was only done if they insisted on it. She was asked how often the resident's briefs were changed while she visited. She stated two to three times a day. She was asked to clarify if this meant two to three times while she was present or two to three times during the entire day. The family member asked the resident to answer the question posed by the surveyor. The resident clearly stated, All day. An ADL record documenting incidents of incontinence was reviewed from 09/01/16 through 09/27/16, and documented the resident was incontinent of bladder, once a day for six days, twice a day for 16 days and three times a day for five days during the 26 day time frame. The resident was then asked if she was experiencing any other problems. She stated, Yes, my bottom hurts. The family member then stated she had spoken with the facility staff regarding providing more timely incontinent care after finding the resident lying in bed completely saturated in urine one day. She was asked how long ago had the incident occurred. She stated, About three weeks. A nurses note, dated 09/08/16 at 12:10 p.m., documented, Focused assessment r/t (related/to) residents care. This writer spoke with residents daughter (name withheld) on 9/7/2016 to discuss residents care and family concerns to schedule a care plan meeting. (Name withheld) reported to this writer that she had addressed her concerns and felt comfortable with her mother's care at present because she received a quick response with her concerns. This writer discussed with (Name withheld) that the IDT (interdisciplinary department team) would still like to meet with family to have a care conference with (Name withheld) agreeing to meeting. (Name withheld) wanted to communicate with her sister and father to discuss convenient times and that she would call back with times. Awaiting return call at present. A second nurses note, dated 09/08/16 at 1600 (4:00 p.m.) documented, Resident, husband, DON (director of nursing), Corporate Nurse, Administrator and (name withheld) via phone, met for care plan conference. Resident and family expresses concerns involving her care and necessary interventions. Resident is on diuretic and is unable to tell when she needs to void, until it happens. She is wet often, resident would prefer to wear a brief day and night for comfort. Staff to check on resident frequently. Resident has agreed to be up for noon meal and follow with going to an activity. This will hopefully increase resident's strength . Weekly skin assessments dated 09/05/16, 09/12/16, and 09/19/16, did not identify any type of MASD on the resident. The weekly skin assessment, dated 09/26/17, documented, New skin breakdown was identified on the left and right buttocks and the sacrum. Treatments were in place. On 09/27/16 at 9:15 a.m., certified nurse aide (CNA) #1 was observed in the north east hall pushing a Hoyer lift. She was asked which hall she was working. The CNA stated she had been called in to perform baths for the day, but was changed to work on the north east hall due to another CNA who had called in. She was asked how many residents on the north east hall required the use of the Hoyer lift for ADLs. The CNA stated she wasn't sure because she did not usually work this hall, but she thought there were at least four residents who required the lift. She was asked how many staff members were needed to provide care when the Hoyer lift was used. She stated at least two staff members were always required. CNA #1 observed CNA #2 coming down the hall and asked for her assistance. She then stated, This is her hall so she will know more about the residents. CNA #2 was asked how long it took to provide incontinent care when using the Hoyer lift.

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

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

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) She stated the lift takes two persons and generally 10 to 15 minutes. She was asked if there were any incidents in which it took longer or more staff to help. The CNA pointed to the room in which resident #99 resided and stated, She's heavier and taller and it takes us a while longer to change her. At 9:30 a.m., registered nurse (RN) #1 was asked to assist the resident and staff to position the resident so an observation of her skin could be made. At 9:45 a.m. licensed practical nurse (LPN) #1, and LPN #2, entered the residents room. LPN #1 was observed to have a small container with a creme ointment inside. She stated,Were going to go ahead and do her treatment now. The LPN was then asked how often incontinent care should be provided for incontinent residents'. She stated. Every two hours or more if necessary. She was asked when care had last been provided for the resident. She stated, At 7:30 this morning. The two LPNs and the director of nursing (DON) entered the resident's room and repositioned her onto her left side, and removed the draw sheet and the bed pad. The residents buttocks, sacrum/coccyx area was observed. The left upper inner buttock was observed to have an area approximately 2 inches in length and 1 inch in width which was reddened and excoriated. The areas were not observed to blanche when wiped during incontinent care. Once care was completed the resident was repositioned onto the right side and the left buttock was observed to have a smaller reddened area on the outer most part of the buttock. This area also did not blanche when cleansed by the LPN. LPN #2, (wound care nurse) was asked if she knew what the cause of the reddened areas were. She stated, Moisture. LPN #1 was asked again how often incontinent care was provided for the resident. She stated, They come in and ask her if she's wet all the time. She was asked if the lift was needed for incontinent care if the resident was up in her recliner. LPN #1 stated, No, sometimes she is placed on the bedside commode to toilet. The three staff members assisting with the positioning were asked since the resident received two water pills every day, wouldn't that put her at an even higher risk for MASD. The DON was heard to say, The [MEDICATION NAME] (water pill) she gets does make it difficult to keep her dry. The DON was asked if she thought this type of MASD was avoidable. She stated, Yes. This is avoidable. On 09/27/16 at 3:00 p.m., the administrator, corporate administrator, DON, corporate nurse, and a QA (quality assurance) nurse were all informed of the above findings and asked if they had questions. The administrator stated, We have added staff and use bath aides to help make sure everyone gets their baths and timely care. What else are we supposed to do? The corporate administrator stated, We are going to have to make sure the staff we have are doing their job.
F 0312 **Level of harm** - Actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined the facility failed to ensure incontinence care was provided for one (#99) and nail care was provided for one (#17) of four sampled residents reviewed for assistance with activities of daily living (ADLs). The facility's failure to provide incontinent care resulted in the development of moisture associated skin damage (MASD) to the resident's buttocks, resulting in harm. The facility identified 70 residents who required assistance with ADLs and 39 residents who were incontinent of bladder. Findings: 1. Resident #99 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An admission assessment dated [DATE], documented the resident exhibited clear speech, was able to understand and be understood. The assessment further documented the resident required extensive assistance from two staff for bed mobility, hygiene, toilet use, was always incontinent of bowel and bladder and was totally dependant on staff for all aspects of transfers. A care plan last updated 07/12/16, documented the resident had an overactive bladder, was at risk for skin breakdown due to frequent incontinence, brief use and medications. The goal was for the resident to remain free from skin breakdown. Interventions included to use two persons and the Hoyer lift (machine used to lift) for all ADLs (activities of daily living), incontinent care as needed, and apply protective moisture barrier cream after all incontinent episodes. Physician orders, dated 08/07/16 and 09/08/16, documented, daily medications included: [MEDICATION NAME] 40 milligrams (mg), one tablet daily for excess fluid, and [MEDICATION NAME] 25 mg, one time daily for [MEDICAL CONDITION]. On 09/27/16 at 1: 55 p.m., the resident was observed sitting in a recliner in the corner of her room. She was interviewed and asked about the care she received from the staff. The resident was able to answer questions slowly, but appropriately. She stated the care she received was, OK most of the time. She was asked when was the care not OK. She stated, When I have to sit in a wet diaper for 2 or 3 hours. She was asked how often did she think she had to wait long periods before being provided incontinent care. She stated she wasn't sure, But it's more often than not. At 2:30 p.m., 3: 50 p.m and 4:40 p.m., the resident was observed to remain in the same recliner. Staff was not observed to reposition, offer or provide incontinent care for the resident during this time. On 09/27/16 at 09:00 a.m., the resident was observed in bed, with her eyes closed. A family member was seated at the bedside. The family member was interviewed regarding the resident's allegations of lack of care. She was asked if the facility staff provided care for the resident as expected. She stated she didn't think so and she thought there was not nearly enough staff working to make sure residents were provided with timely care. She stated she had been in the room for an entire evening and the call light, if turned on, would never be answered and incontinent care was only done if they insisted on it. She was asked how often the resident's briefs were changed while she visited. She stated two to three times a day. She was asked to clarify if this meant two to three times while she was present or for the entire day. The family member asked the resident to answer the question posed by the surveyor. The resident clearly stated, All day. The resident was then asked if she was experiencing any other problems. She stated, Yes, my bottom hurts. The family member then stated she had spoken with the facility staff regarding providing more timely incontinent care after finding the resident one day lying in bed completely saturated in urine. She was asked how long ago did the incident occur. She stated, About three weeks. A nurses note, dated 09/08/16 at 12:10 p.m., documented, Focused assessment rt (related/to) residents care. This writer spoke with residents daughter (name withheld) on 9/7/2016 to discuss residents care and family concerns to schedule a care plan meeting. (Name withheld) reported to this writer that she had addressed her concerns and felt comfortable with her mothers care at present because she received a quick response with her concerns. This writer discussed with (Name withheld) that the IDT (interdisciplinary department team) would still like to meet with family to have a care conference with (Name withheld) agreeing to meeting. (Name withheld) wanted to communicate with her sister and father to discuss convenient times and that she would call back with times. Awaiting return call at present. A second nurses note, dated 09/08/16 at 1600 (4:00 p.m.) documented, Resident, husband, DON, Corporate Nurse, Administrator and (name withheld) via phone, met for care plan conference. Resident and family expresses concerns involving her care and necessary interventions. Resident is on diuretic and is unable to tell when she needs to void, until it happens. She is wet often, resident would prefer to wear a brief day and night for comfort. Staff to check on resident frequently. Resident has agreed to be up for noon meal and follow with going to an activity. This will hopefully increase resident's strength . An ADL record for episodes of bladder incontinence, dated 09/01/16 through 09/27/16, documented the resident was incontinent of bladder, once a day for six days, twice a day for 16 days and three times a day for five days. On 09/27/16 at 9:15 a.m., certified nurse aide (CNA) #1 was observed in the north east hall pushing a Hoyer lift. She was

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SUNSET ESTATES	201 WEST WALNUT TECUMSEH, OK 74873

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0312 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) asked which hall was she assigned to. The CNA stated she had been called in to perform baths for the day, but was changed to work on the north east hall due to another CNA who had called in. She was asked how many residents on the north east hall required the use of the Hoyer lift for ADLs. The CNA stated she wasn't sure because she did not usually work this hall, but she thought there were at least four residents who required the lift. She was asked how many staff members were needed to provide care when the Hoyer lift was used. She stated at least two staff members were always required. CNA #1 observed CNA #2 coming down the hall and asked for her assistance. She then stated, This is her hall so she will know more about the residents. CNA #2 was asked, how long it took to provide incontinent care when using the Hoyer lift. She stated the lift took two persons and usually 10 to 15 minutes. She was then asked which of the four residents usually took the longest. The CNA pointed to the room in which resident #99 resided and stated, Shes heavier and taller and it takes us awhile to change her. The LPN was asked how often incontinent care should be provided for the resident. She stated. Every two hours or more if necessary. She was asked when care had last been provided for the resident. She stated, At 7:30 this morning. The two LPNs and the DON repositioned the resident onto her left side, removed the draw sheet and bed pad, exposing the residents buttocks. The left upper inner buttock was observed to have an area approximately 2 inches in length and 1 inch in width, to be reddened and excoriated. The areas were not observed to blanche when wiped during the care. Once care was completed the resident was repositioned onto the right side and the left buttock was observed to have a smaller reddened area on the outer most part of the buttock. This area also did not blanche when cleansed by the LPN. LPN #2, was asked if she knew what the cause of the reddened areas were. She stated, Moisture. LPN #1 was asked again how often incontinent care was provided for the resident. She stated, They come in and ask her if she's wet all the time. The DON was heard to say, With all the [MEDICATION NAME] (water pill) she gets makes it difficult to keep her dry. The DON was asked if she thought this type of MASD was avoidable. She stated, Yes, this is avoidable. 2. Resident #17 was admitted to the facility with [DIAGNOSES REDACTED]. An annual assessment, dated 07/15/16, documented the resident was cognitively intact and was able to understand others and make himself understood. The resident required extensive to total assistance with all ADLs except eating. The resident's care plan, last updated 08/29/16, documented: .Focus .limited physical mobility r/t (related to) Disease Process (OA [MEDICAL CONDITION]) . Interventions .Bath days are Mon (Monday)-Wed (Wednesday)-Fri (Friday) in the evening .prefers a bed bath only . Requires one person assist with dressing, and personal hygiene . On 09/26/16 at 1:52 p.m., the resident was observed to have long jagged fingernails on both hands. The fingernails were observed to have brownish black debris under all ten nails. The resident stated staff had not cut or cleaned his fingernails in a long time. At 3:40 p.m., certified nursing assistant (CNA) #2 was asked when residents' fingernails were to be trimmed and cleaned. She stated they were to be trimmed and cleaned when they received their baths. At 3:55 p.m., licensed practical nurse (LPN) #1 was asked when residents' fingernails were to be trimmed and cleaned. She stated the CNAs were to trim nails with baths unless the resident was diabetic. The LPN then stated fingernails were to be cleaned with baths and as needed. She stated they should be cleaned with baths and checked and cleaned as needed after meals. At 4:10 p.m., LPN #1 and the director of nursing were shown the resident's fingernails. They both agreed they were long/dirty and should be trimmed and cleaned.
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** Based on record review, observation and interview, it was determined the facility failed to provide sufficient nursing staff to provide care and services according to residents' individualized needs. The facility failed to: a) provide incontinent care according to the resident's needs to prevent the development of avoidable moisture associated skin damage for one (#99) of four sampled residents reviewed for activities of daily living (ADLs). The facility identified 39 residents who were incontinent of bladder. Please refer to F309. The facility also failed to provide sufficient nursing staff as evidenced by: b) the lack of nail care for one (#17) of four sampled residents reviewed for ADLs and c) seven confidential resident/family interviews who complained of lack of care being provided by the facility, including call lights not being answered in a timely manner. The DON identified all 70 residents as requiring some type of assistance with most ADLs. Please refer to F312. On 09/26/16 and 09/27/16, confidential resident/family interviews were conducted. Residents were asked if their needs were being met by the staff. They were also asked if they were able to receive the care they needed without having to wait for long periods of time. Confidential resident #1: On 09/26/16 at 1:40 p.m., a resident was observed sitting in his room on the side of the bed. He was asked if he was able to receive the care he needed without having to wait a long time. The resident stated the staff usually took a long time to answer his call light. He was asked how long did he generally have to wait after activating his call light. He stated at least 30 minutes. Confidential resident #2: On 09/26/16 at 1:52 p.m., a resident interview was conducted at the bedside. The resident was observed to have long, untrimmed, unclean nails. The resident stated he needed to have his hair cut, his face shaved and he had missed his last scheduled shower. He was asked when he was last scheduled for a shower. He stated, Saturday. He was asked when the staff last trimmed his nails. He stated, It's been a while. Confidential resident #3: On 09/26/16 at 1: 55 p.m., a resident was observed sitting in a recliner in the corner of her room. She was interviewed and asked about the care she received from the staff. The resident was able to answer questions slowly, but appropriately. She stated the care she received was, OK most of the time. She was asked when was the care not OK. She stated, When I have to sit in a wet diaper for 2 or 3 hours. She was asked how often did she think she had to wait long periods before being provided incontinent care. She stated she wasn't sure, But it's more often than not. Confidential resident #4: On 09/26/16 at 1:58 p.m., a resident interview was conducted at the bedside. The resident was asked if he was receiving baths/showers as scheduled. He stated he was scheduled for a shower on Saturday, but did not receive a shower. He was asked if staff responded to his call light when he turned it on. He stated they did, but was sometimes slow on answering the light.

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F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) Confidential resident #5: On 09/27/16 at 09:00 a.m., a family member was seated at the bedside of a resident. The family member was asked if the staff had provided care as expected. She stated she didn't think so and she thought, There was not nearly enough staff working to make sure residents were cared for. The family member stated during most of the visit with the loved one, the call light could be on the entire time and no one would respond. The family member further stated the staff only provided incontinent care for the resident if the family insisted on it. The family member stated there was an incident in which they lifted the resident to position her to change her, and Urine poured from the pad she was sitting on. This was unacceptable! Confidential resident #6: On 09/27/16 at 1:40 p.m., a resident was interviewed in her room, in bed. She was asked if her needs were being met in a timely manner by the staff. The resident stated call lights often went unanswered for a long time. She was asked how long. She stated for at least two to three hours or more. She was asked how often this occurred. She stated, Always. Confidential resident #7: On 09/27/16 at 3:30 p.m., a family member was interviewed as they sat at the bedside of their loved one. The family member was asked if the residents needs were being met in a timely manner. The family member stated, For the most part, but sometimes it takes them a long time to come answer the call light. They were asked how often did it take a long time. The family member stated four out of five times.