STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375508	A. BUILDING _____ B. WING _____	04/06/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSE MANOR NURSING CENTER	1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804

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 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **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 assistance with toileting and/or incontinent care in a dignified manner for two (#5 and #6) of two sampled residents observed to receive assistance with toileting and/or incontinent care. This had the potential to affect 52 residents identified by the facility who required assistance with toileting. Findings: 1. Resident #5 was readmitted to the facility on [DATE] following hospitalization for surgical repair of a fracture to the left femur. Other [DIAGNOSES REDACTED]. A reentry assessment, dated 03/02/16, documented the resident displayed severe cognitive impairment and required extensive assistance of one to two persons with all activities of daily living, including bed mobility, transfers, personal hygiene and toileting. The care plan, dated 01/21/15 and last updated on 03/29/16, documented the resident required assistance with activities of daily living related to weakness and a recent [MEDICAL CONDITION]. The care plan documented the resident was incontinent of bladder, and staff were to check the resident every two hours and as required for incontinence. On 04/04/16 at 4:15 p.m. to 5:30 p.m., the resident was observed sitting in a Geri chair in the living area outside the assisted dining room. At 5:30 p.m., she was observed to receive help with the evening meal while continuing to sit in the Geri chair. At 6:25 p.m., staff assisted the resident to her room from the dining room, still seated in the Geri chair, where she remained until 7:15 p.m. During this time no staff were observed to assist the resident with repositioning. At 7:15 p.m., CNAs (certified nurse aides) #1 and #3 entered the resident's room with a mechanical lift. They were asked what care the resident needed. They stated the resident was incontinent of bowel and bladder, and unable to recognize or verbalize her needs, so she was to be checked for incontinence at least every two hours and incontinent care provided to keep her skin clean. The CNAs assisted the resident from the Geri chair to the bed, utilizing a mechanical lift. CNA #3 assisted with positioning the resident to her side, and CNA #1 then removed the incontinent brief from the resident, which was observed to be heavily soiled with urine and feces. They cleansed the resident's buttocks and perineum, and then applied a clean brief. The CNAs were asked what care the resident had received since they had arrived at 3:00 p.m. They stated they had provided no care for the resident since arriving at 3:00 p.m. They stated the resident had been up in the Geri chair since noon to eat lunch in the dining room, and no staff had checked the resident for incontinence or provided assistance with repositioning since that time. They stated the staff working prior had not had time to lay the resident down after lunch to provide any personal care or repositioning. They stated they had been busy assisting other residents with personal care and assisting residents up for the evening meal since arriving at 3:00 p.m. They stated they were aware the resident needed to be checked for incontinence and incontinent care provided every two hours, as well as repositioning the resident every one to two hours due the presence of a pressure ulcer on the coccyx. 2. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly assessment, dated 08/26/16, documented the resident was severely impaired in cognition, required extensive assistance with transfers and toileting, utilized a wheelchair for mobility, was frequently incontinent of urine and always incontinent of bowel. The resident's care plan, last revised on 03/24/16, documented the resident was incontinent of bladder due to cognitive loss and general debility. Interventions included the resident was to be checked frequently and as required for incontinence, incontinent care was to be provided as needed and clothing was to be changed as needed after incontinence episodes. On 04/04/16 at 4:40 p.m., the resident was observed propelling herself in her wheelchair from the lobby area towards hall 400. She stopped at the entrance end of hall 400, next to the meal cart sitting in the hall, talking outloud to herself. During her self conversation, a staff member walked up beside the resident and stood looking at the trays on the meal cart. While the staff member was standing next to the resident, the resident repeatedly stated, I'm about to pee my pants. The staff member walked away from the hallway and disappeared. Immediately after the staff member walked away, a steady stream of urine was observed from under the seat of the resident's wheelchair to form a puddle, which soaked into the carpet and made a wet circle approximately nine to ten inches in diameter. The resident's pants were visibly wet. A second resident was sitting in a wheelchair directly behind her as this was occurring. When the resident was incontinent of urine, the second resident looked up at the surveyor and pointed to the stream of urine coming from the resident's chair. The resident continued to sit there, in her wheelchair talking to herself, during which time a staff member came, moved the meal cart and began delivering meal trays at 4:45 p.m. At 4:47 p.m., the resident propelled herself behind the nurse's station area in the front lobby. While the resident was behind the nurse's station area, a total of three different staff members were observed in the same area and within vision of the resident's soiled garment. One of these staff members got down on their knees at the resident's eye level and spoke with her, then left, without alerting any other staff of the resident's soiled garment. At 4:55 p.m., the resident propelled herself from the nurse's station area to the entrance area of the dining room. A CNA bent down to the resident's eye level and asked her if she wanted to go into the dining room or wanted a cup of coffee, then went on, without alerting staff of the resident's soiled garment or assisting the resident to her room to clean and change her clothing. At 4:57 p.m., another staff member came over and spoke with the resident and then went on, again not alerting any staff of the resident's soiled garment. At 5:03 p.m., the resident was observed to speak with another surveyor, who could not understand her and asked a sixth different staff member to see what the resident was trying to ask. This sixth staff member immediately went to the resident and was observed to push her towards the 300 hall. At 5:15 p.m., the resident was brought into the dining room wearing a different pair of clean, dry pants. On 04/06/16 at 2:55 p.m., CNA #3 was asked about the resident remaining in wet clothing for 25 minutes in the common areas of the facility. The CNA stated the resident should have been cleaned and changed immediately and that it was an undignified for any residents not receive incontinent care when they needed.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and**

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

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ROSE MANOR NURSING CENTER	1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804

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F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to develop a comprehensive care plan for one (#3) of six sampled residents whose care plans were reviewed. The facility census was 85. Findings: Resident #3 was admitted to the facility with [DIAGNOSES REDACTED]. anorexia and [MEDICAL CONDITION]. An admission assessment, dated 02/23/16, documented the resident was moderately impaired in cognition, required extensive assistance for all ADLs (activities of daily living), was able to make his needs known, experienced minimal difficulty with hearing but did not use a hearing aid and wore glasses. The assessment further documented the resident exhibited physical behaviors directed toward others one to three times a week, had occasional pain which made it hard to sleep and limited his activity. A care plan dated 02/17/16, addressed the following care areas as a focus area: ~skin impairment secondary to a lesion on the ear, ~skin impairment secondary to a scab on the left forearm and ~potential for skin breakdown related to Braden score < 18. The care plan failed to address any additional needs of the resident. The care area assessment (CAA), dated 03/01/16, documented the following areas were to be addressed in the care plan: ~Cognitive loss/Dementia ~Communication ~ADL Function/Rehabilitation Potential ~Urinary incontinence ~Behavioral symptoms ~Falls ~Nutritional status ~Pressure ulcer ~[MEDICAL CONDITION] drug use ~Pain On 04/06/16 at 2:30 p.m., the director of nursing was interviewed about the care plan. She was asked if the resident had any additional care plan documents which addressed the triggered areas of concern. She stated there were none, and what you have is all he was care planned for.
F 0282 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, it was determined the facility failed to: a) implement the care plan regarding scheduled showers/bathing for two (#8 and #9) of seven sampled residents who required assistance with bathing and b) implement the care plan regarding assistance with toileting/incontinance for two (#5 and #6) of four sampled residents who required assistance with toileting/incontinent care. The facility census was 85. Findings: 1. Resident #8 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The medicare fourteen day assessment, dated 03/17/16, documented the resident was cognitively intact. The assessment also documented the resident was dependent on staff for bathing with two person physical assist. The care plan, dated 04/01/16, documented the resident had an activity of daily living (ADL) self care performance deficit related to impaired mobility, fatigue and weakness after hospitalization for pancreatitis. The care plan also documented the resident had the option of when to bathe and what kind of bath to take, with scheduled days suggested, but had the option to change as she chose to. An interview was conducted with the resident on 04/04/16 at 4:30 p.m. The resident was asked about her bathing. The resident stated she had asked for a shower the day before and was told she could not get one because there was not enough staff available to help. She was asked when she had last received a shower. She stated it had been six days since she had received a shower. She further stated the facility did not have enough help. She stated there was only one certified nurse aide (CNA) on the hall she resided on. An interview was conducted with the resident on 04/06/16 at 2:55 p.m. She was asked if she had received any bed type baths since she had been at the facility. She stated when she had been incontinent that staff cleansed only the parts of her body which had been soiled. 2. Resident #9 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The medicare fourteen day assessment, dated 03/21/16, documented the resident was cognitively intact. The assessment also documented the resident was dependent on staff for bathing with two person physical assist. The care plan, dated 04/05/16, documented the resident had an ADL self performance deficit related to a recent hip replacement. The care plan also documented the resident had the option of when to bathe and what kind of bath to take, with scheduled days suggested, but had the option to change as he chose to. An interview was conducted with the resident on 04/04/16 at 6:15 p.m. The resident was asked about his bathing. He stated it had been over a week since he had received a shower. He was asked how often he would like to have a shower. He stated he would like one every day or at least every other day. He stated he was scheduled to receive a shower three times a week, however he did not receive them because there was not enough staff. He stated there was only one CNA on the hall. An interview was conducted with licensed practical nurse (LPN) #1 on 04/06/16 at 2:15 p.m. She was asked if the residents on her hall received three showers a week. She stated the residents sometimes received a wash up or a bed type bath in place of a shower. She stated they also had a type of no rinse product they used to cleanse the residents. The surveyor informed her that some of the residents stated they had not received a shower in six or more days. She stated the residents always got cleansed at least three times a week. An interview was conducted with the resident on 04/06/16 at 2:40 p.m. He was asked if he had received any bed type baths since he had been at the facility. He stated no. He stated he had been at the facility for about thirty days and had received four showers since he had been admitted . He was asked if he had specifically asked for a shower. He stated he had asked four or five times in the last two weeks for a shower and was told, I can't get to you today because I'm by myself. 3. Resident #5 was readmitted to the facility on [DATE] following hospitalization for surgical repair of a fracture to the left femur. Other [DIAGNOSES REDACTED]. The reentry assessment, dated 03/02/16, documented the resident displayed severe cognitive impairment and required extensive assistance of one to two persons with all activities of daily living, including bed mobility, transfers, personal hygiene and toileting. The assessment documented the resident had impaired range of motion to one side of the lower extremity and was at risk for the development of pressure ulcers and had no pressure ulcers. The care plan, dated 01/21/15 and last updated on 03/29/16, documented the resident required assistance with activities of daily living related to weakness and a recent [MEDICAL CONDITION]. Interventions included staff were to assist the resident to reposition and turn in bed and perform weekly skin inspections. The care plan also documented the resident was incontinent of bladder, and staff were to check the resident every two hours and as required for incontinence. On 04/04/16 at 4:15 p.m. to 5:30 p.m., the resident was observed sitting in a Geri chair in the living area outside the assisted dining room. At 5:30 p.m., she was observed to receive help with the evening meal while continuing to sit in the Geri chair. At 6:25 p.m., staff assisted the resident to her room from the dining room, still seated in the Geri chair, where she remained until 7:15 p.m. During this time no staff were observed to assist the resident with repositioning while in the Geri chair. At 7:15 p.m., CNAs #1 and #3 entered the resident's room with a mechanical lift. They were asked what care the resident needed. They stated the resident was incontinent of bowel and bladder, and unable to recognize or verbalize her needs, so

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F 0282 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) she was to be checked for incontinence at least every two hours and incontinent care provided to keep her skin clean. They stated she needed to be repositioned from side to side every one to two hours, and heels were to be floated utilizing pillows so there was no pressure on the heels. They stated it was important to do these things so residents did not develop pressure ulcers. The CNAs assisted the resident from the Geri chir to the bed, utilizing a mechanical lift, after which CNA #3 assisted with positioning the resident to her side, while CNA #1 removed the incontinent brief from the resident, which was observed to be heavily soiled with urine and feces. CNA#1 cleansed the resident's soiled perineum and buttocks and applied a clean incontinent brief. The CNAs then repositioned the resident to her right side and adjusted the pillows and covers. The CNAs were asked what care the resident had received since they had arrived at 3:00 p.m. They stated they had provided no care for the resident since arriving at 3:00 p.m. They stated the resident had been up in the Geri chair since noon to eat lunch in the dining room, and no staff had checked the resident for incontinence or provided assistance with repositioning since that time. They stated the staff working prior had not had time to lay the resident down after lunch to provide any personal care or repositioning. They stated they had been busy assisting other residents with personal care and assisting residents up for the evening meal since arriving at 3:00 p.m. They stated they were aware of the resident's care needs, which included checking for incontinence and incontinent care provided every two hours, as well as repositioning the resident every one to two hours due the presence of a pressure ulcer on the coccyx. 4. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly assessment, dated 08/26/16, documented the resident was severely impaired in cognition, required extensive assistance with transfers and toileting, utilized a wheelchair for mobility, was frequently incontinent of urine and always incontinent of bowel. The resident's care plan, last revised on 03/24/16, documented the resident was incontinent of bladder due to cognitive loss and general debility. Interventions included the resident was to be checked frequently and as required for incontinence, incontinent care was to be provided as needed and clothing was to be changed as needed after incontinence episodes. On 04/04/16 at 4:40 p.m., the resident was observed propelling herself in her wheelchair from the lobby area towards hall 400. She stopped at the entrance end of hall 400, next to the meal cart sitting in the hall, talking outloud to herself. During her self conversation, a staff member walked up beside the resident and stood looking at the trays on the meal cart. While the staff member was standing next to the resident, the resident repeatedly stated, I'm about to pee my pants. The staff member walked away from the hallway and disappeared. Immediately after the staff member walked away, a steady stream of urine was observed from under the seat of the resident's wheelchair to form a puddle, which soaked into the carpet and made a wet circle approximately nine to ten inches in diameter. The resident's pants were visibly wet. The resident sat in the the lobby area for 25 minutes, during which time at least six staff members walked past or talked to the resident without taking the resident to her room to provide incontinent care. At 5:03 p.m., LPN #4 assisted the resident to her room and incontinent care was provided. On 04/06/16 at 2:55 p.m., CNA #3 was asked about the resident remaining in wet clothing for 25 minutes in the common areas of the facility. The CNA stated the resident should have been cleaned and changed immediately.
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, it was determined the facility failed to provide: a) assistance with showers/baths for two (#8 and #9) of seven sampled residents who required assistance with activities of daily living and b) timely assistance with eating for two (#1 and #24) of seven sampled residents who required assistance with activities of daily living and c) timely assistance with incontinent care for two (#5 and #6) of four sampled residents who required assistance with toileting/incontinent care. The facility identified 16 residents needing assistance with eating, 52 residents needing assistance with toileting/incontinent care and all 85 residents residing in the facility needed assistance with bathing. Findings: 1. Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An annual assessment, dated 03/03/16, documented the resident was cognitively intact and required extensive assistance with eating. The resident's care plan, last updated on 03/25/16, documented, .Focus .(Resident name deleted) has a potential for altered nutrition as result of impaired chewing/swallowing with risks for aspiration,[MEDICAL CONDITION] cough . Interventions .Regular diet, puree texture, thin liquids .Stay with (Resident name deleted) during meals . On 04/04/06 at 4:35 p.m., the hall meal cart was observed at the beginning of hall 400. At 4:45 p.m., a staff member began delivering meal trays to rooms on hall 400. At 5:13 p.m., a staff member was observed to remove the meal tray for resident #1 from the meal cart and take the tray into the resident's room and return to the hallway. The surveyor went into the resident's room at this time and observed the covered tray sitting on the over-the-bed table. At 5:43 p.m., one hour and 8 minutes after the meal trays were delivered to the hall, a certified nurse aide (CNA) was observed to enter the resident's room. The surveyor knocked and entered the resident's room as the CNA was lifting the first bite of pureed green beans to the resident's mouth. The surveyor asked the CNA to return the tray to the kitchen and obtain a new plate of hot food for the resident. The surveyor accompanied the CNA to the dining room and asked the dietary staff to obtain the temperature of the food on the tray. The temperatures of the resident's food was as follows: ~ pureed goulash was 80 degrees Fahrenheit (F), ~ pureed green beans was 82 degrees F, and ~ pureed bread was 80 degrees F. The dietary manager came out of the kitchen and stated, I know the food was hot when it was delivered to the hall. At 5:48 p.m., one hour and 13 minutes after the meal trays had been delivered the to 400 hall, a new plate of hot food was obtained and the CNA returned to the resident's room and fed her the hot food. 2. Resident #6 was admitted on [DATE] with [DIAGNOSES REDACTED]. A quarterly assessment, dated 08/26/16, documented the resident was severely impaired in cognition, required extensive assistance with transfers and toileting, utilized a wheelchair for mobility, was frequently incontinent of urine and always incontinent of bowel. The resident's care plan, last revised on 03/24/16, documented, .Focus .bladder incontinence r/t (related to) cognitive loss and general debility . Interventions .INCONTINENT: Check the resident frequently and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes . On 04/04/16 at 4:40 p.m., the resident was observed propelling herself in her wheelchair from the lobby area towards hall 400. She stopped at the entrance end of hall 400, next to the meal cart sitting in the hall, talking outloud to herself. During her self conversation, a staff member walked up beside the resident and stood looking at the trays on the meal cart. While the staff member was standing next to the resident, the resident repeatedly stated, I'm about to pee my pants. The staff member walked away from the hallway and disappeared. Immediately after the staff member walked away, a steady stream of urine was observed from under the seat of the resident's wheelchair to form a puddle, which soaked into the carpet and made a wet circle approximately nine to ten inches in diameter. The resident's pants were visibly wet. A second resident was sitting in a wheelchair directly behind her as this was occurring. When the resident was incontinent of urine, the second resident looked up at the surveyor and pointed to the stream of urine coming from the resident's chair. The resident continued to sit there, in her wheelchair talking to herself, during which time a staff member came, moved the

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F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) meal cart and began delivering meal trays at 4:45 p.m. At 4:47 p.m., the resident propelled herself behind the nurse's station area in the front lobby. While the resident was behind the nurse's station area, a total of three different staff members were observed in the same area and within vision of the resident's soiled garment. One of these staff members got down on their knees at the resident's eye level and spoke with her, then left, without alerting any other staff the resident's soiled garment. At 4:55 p.m., the resident propelled herself from the nurse's station area to the entrance area of the dining room. A CNA bent down to the resident's eye level and asked her if she wanted to go into the dining room or wanted a cup of coffee, then went on, without alerting staff of the resident's soiled garment or assisting the resident to her room to clean and change her clothing. At 4:57 p.m., another staff member came over and spoke with the resident and then went on, again not alerting any staff of the resident's soiled garment. At 5:03 p.m., the resident was observed to speak with another surveyor, who could not understand her and asked a sixth different staff member to see what the resident was trying to ask. This sixth staff member immediately went to the resident and was observed to push her towards the 300 hall. At 5:15 p.m., the resident was brought into the dining room wearing a different pair of clean, dry pants. On 04/06/16 at 2:55 p.m., CNA #3 was asked about the resident remaining in wet clothing for 25 minutes in the common areas of the facility. The CNA stated the resident should have been cleaned and changed immediately when staff noticed the resident's garment was soiled. 3. Resident #8 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Medicare 14-day assessment dated [DATE], documented the resident was cognitively intact and dependent upon staff for bathing with two person physical assist. The care plan, dated 04/01/16, documented the resident required assistance with the performance of activities of daily living (ADL) related to impaired mobility, fatigue and weakness after hospitalization for pancreatitis. The care plan documented the resident had the option of when to bathe and what kind of bath to take, with scheduled days suggested, but had the option to change as she chose. An interview was conducted with resident on 04/04/16 at 4:30 p.m. The resident was asked about bathing. The resident stated she had asked for a shower the day before and was told she could not get one because there was not enough staff available to help. She was asked when she had last received a shower. She stated it had been six days since she had received a shower. She further stated the facility did not have enough help. She stated there was only one CNA on the hall she resided on to help with her needs. The facility identified 25 residents residing on the 200 hall. An interview was conducted with the resident on 04/06/16 at 2:55 p.m. She was asked if she had received any bed type baths since she had been at the facility. She stated when she had been incontinent that staff cleansed only the parts of her body which had been soiled. 4. Resident #9 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Medicare 14-day assessment, dated 03/21/16, documented the resident was cognitively intact and was dependent on staff for bathing with a two person physical assist. The care plan, dated 04/05/16, documented the resident had an ADL self performance deficit related to a recent hip replacement. The care plan also documented the resident had the option of when to bathe and what kind of bath to take, with scheduled days suggested, but had the option to change as he chose. An interview was conducted with the resident on 04/04/16 at 6:15 p.m. The resident was asked about bathing. He stated it had been over a week since he had received a shower. He was asked how often he would like to have a shower. He said he would like one every day or at least every other day. He said he was scheduled to receive a shower three times a week, however he did not receive them because there was not enough staff. He stated there was only one CNA on the hall. The facility identified 25 residents residing on the 200 hall. An interview was conducted with licensed practical nurse (LPN) #1 on 04/06/16 at 2:15 p.m. She was asked if the residents on her hall received three showers a week. She stated the residents sometimes received a wash up or a bed type bath in place of a shower. She stated they also had a type of no rinse product they used to cleanse the residents. The surveyor informed her that some of the residents stated they had not received a shower in six or more days. She stated the residents always got cleansed at least three times a week. An interview was conducted with the resident on 04/06/16 at 2:40 p.m. He was asked if he had received any bed type baths since he had been at the facility. He stated no. He stated he had been at the facility for about thirty days and had received four showers since he had been admitted . He was asked if he had specifically asked for a shower. He stated he had asked four or five times in the last two weeks for a shower and was told, I can't get to you today because I'm by myself. 5. Resident #5 was readmitted to the facility on [DATE] following hospitalization for surgical repair of a fracture to the left femur. Other [DIAGNOSES REDACTED]. A reentry assessment, dated 03/02/16, documented the resident displayed severe cognitive impairment and required extensive assistance of one to two persons with all activities of daily living, including bed mobility, transfers, personal hygiene and toileting. The care plan, dated 01/21/15 and last updated on 03/29/16, documented the resident required assistance with activities of daily living related to weakness and a recent [MEDICAL CONDITION]. The care plan documented the resident was incontinent of bladder, and staff were to check the resident every two hours and as required for incontinence. On 04/04/16 at 4:15 p.m. to 5:30 p.m., the resident was observed sitting in a Geri chair in the living area outside the assisted dining room. At 5:30 p.m., she was observed to receive help with the evening meal while continuing to sit in the Geri chair. At 6:25 p.m., staff assisted the resident to her room from the dining room, still seated in the Geri chair, where she remained until 7:15 p.m. During this time no staff were observed to assist the resident with repositioning while in the Geri chair. At 7:15 p.m., CNAs #1 and #3 entered the resident's room with a mechanical lift. They were asked what care the resident needed. They stated the resident was incontinent of bowel and bladder, and unable to recognize or verbalize her needs, so she was to be checked for incontinence at least every two hours and incontinent care provided to keep her skin clean. They stated she needed to be repositioned from side to side every one to two hours, and heels were to be floated utilizing pillows so there was no pressure on the heels. They stated it was important to do these things so residents did not develop pressure ulcers. The CNAs assisted the resident from the Geri chair to the bed, utilizing a mechanical lift. CNA #3 assisted with positioning the resident to her side, and CNA #1 then removed the incontinent brief from the resident, which was observed to be heavily soiled with urine and feces. They cleansed the resident's buttocks and perineum, and then applied a clean brief and repositioned the resident onto her left side. The CNAs were asked what care the resident had received since they had arrived at 3:00 p.m. They stated they had provided no care for the resident since arriving at 3:00 p.m. They stated the resident had been up in the Geri chair since noon to eat lunch in the dining room, and no staff had checked the resident for incontinence or provided assistance with repositioning since that time. They stated the staff working prior had not had time to lay the resident down after lunch to provide any personal care or repositioning. They stated they had been busy assisting other residents with personal care and assisting residents up for the evening meal since arriving at 3:00 p.m. They stated they were aware the resident needed to be checked for incontinence and incontinent care provided every two hours, as well as repositioning the resident every one to two hours due the presence of a pressure ulcer on the coccyx. The CNAs were asked what care the resident had received since they had arrived at 3:00 p.m. They stated they had provided no care for the resident since arriving at 3:00 p.m. They stated the resident had been up in the Geri chair since noon to eat lunch in the dining room, and no staff had checked the resident for incontinence or provided assistance with repositioning since that time. They stated the staff working prior had not had time to lay the resident down after lunch to provide any personal care or repositioning. They stated they had been busy assisting other residents with personal care and assisting residents up for the evening meal since arriving at 3:00 p.m. They stated they were aware the resident needed to be checked for incontinence and incontinent care provided every two hours, as well as repositioning the resident every one to two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375508	A. BUILDING _____ B. WING _____	04/06/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSE MANOR NURSING CENTER	1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804

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 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) hours due the presence of a pressure ulcer on the coccyx. 6. On 04/04/16 at 5:10 p.m., resident #24 was observed seated in her wheelchair at a table in the dining area for residents needing assistance with eating, with her plate of food on the table. The resident made no attempts to eat her food, and staff was observed assisting another resident seated at her table. From 5:10 to 5:45 p.m., the resident sat in her wheelchair at the table asleep, with no assistance with eating provided by staff. At 5:45 p.m., thirty five minutes after the meal had been served to the resident, LPN #2 awoke the resident and started to feed her. The surveyor asked the LPN to obtain another plate of food for the resident, and asked dietary staff to obtain the temperature of the food on the plate that had been taken. The meat dish, which was goulash, was 108 degrees F and vegetable dish, which was green beans, was 91 degrees F. Dietary staff stated the food had been at correct holding temperatures when served to the resident, but no staff had assisted the resident, who needed assistance with eating, to eat at the time the meal was served.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined the facility failed to: a) provide interventions according to the resident's needs to prevent the development of an avoidable stage 3 pressure ulcer for one resident (#5), b) identify the presence of a pressure ulcer prior to developing into a stage 3 and failed to identify the breakdown of the right heel for one resident (#5), c) provide interventions according to the resident's needs to prevent the development of an avoidable stage 2 pressure ulcer for one resident (#12), and d) provide interventions to prevent the worsening of a stage 3 pressure ulcer for one resident (#5) and the worsening of a stage 2 to a stage 3 pressure ulcer for one (#12) of six sampled residents with pressure ulcers. The facility's failure to provide interventions according to the residents' needs resulted in harm with the development and worsening of avoidable stage 3 pressure ulcers for two (#5 and #12) of six sampled residents with pressure ulcers. The facility identified nine residents with pressure ulcers. The facility also failed to: e) provide interventions to prevent the development of a stage one pressure ulcer; and accurately assess and identify the presence of a stage one pressure ulcer for one (#5) of six sampled residents with pressure ulcers. These deficient practices had the potential to affect 48 residents identified by the facility who were at high risk for the development of pressure ulcers. Findings: 1. Resident #5 was readmitted to the facility on [DATE] following hospitalization for surgical repair of a fracture to the left femur. Other [DIAGNOSES REDACTED]. The reentry assessment, dated 03/02/16, documented the resident displayed severe cognitive impairment and required extensive assistance of one to two persons with all activities of daily living, including bed mobility, transfers, personal hygiene and toileting. The assessment documented the resident had impaired range of motion to one side of the lower extremity and was at risk for the development of pressure ulcers, but had no pressure ulcers. The care plan, dated 01/21/15 and last updated on 03/29/16, documented the resident required assistance with activities of daily living related to weakness and a recent [MEDICAL CONDITION]. Interventions included staff was to assist the resident to reposition and turn in bed and perform weekly skin inspections. The care plan also documented the resident was incontinent of bladder, and staff were to check the resident every two hours and as required for incontinence. The admission summary progress note, dated 03/02/16, documented the resident returned to the facility with multiple bruises and scabs to wrists, elbows, forearms, feet and toes, and no pressure ulcers. The 'Braden Scale for Predicting Pressure Sore Risk', dated 03/02/16, documented the resident was high risk for the development of pressure ulcers. The assessment documented the resident's ability to respond to pressure-related discomfort was very limited; the degree to which skin was exposed to moisture was occasional; the degree of physical activity was limited to being confined to bed, and the resident was completely immobile with abilities to change and control body position. An initial plan of care, dated 03/02/16, documented interventions to include: ~ check every two hours for wetness and soiling of undergarments, ~ assist with turning and repositioning to meet the resident's needs and use pillows as needed to float heels and for positioning, ~ perform head to toe skin assessment and ~ keep skin clean and free from irritating substances and provide incontinent care as needed. On 03/08/16, a skin evaluation by licensed practical nurse (LPN) #2, documented no open areas/skin issues were noted and the resident continued to be at high risk for skin breakdown. A physician's orders [REDACTED]. There was no documentation of any changes to the resident's skin. On 03/15/16, the 'Braden Scale for Predicting Pressure Sore Risk' documented the resident remained at high risk for the development of pressure ulcers. The assessment documented the degree of physical activity was limited to being chairfast, and the resident's ability to change and control body position was very limited, meaning the resident made only slight changes in body position and was unable to make frequent or significant changes independently. On 03/17/16, a skin/wound progress note and 'Weekly Skin at Risk Evaluation' documented a skin evaluation was completed with no documentation of the presence of a pressure ulcer. On 03/18/16, a skin/wound progress note documented the presence of an open area to the coccyx, stage 3, with 75% pink/red granulation tissue and 25% slough, 2.0 centimeter (cm) length x 2.5 cm width x 0.3 cm depth with no drainage or odor. There was no prior documentation of altered skin integrity prior to the development of the stage 3 pressure ulcer. an order for [REDACTED]. On 03/25/15, a wound note documented the presence of an open area to the coccyx, stage 3, 2.5 cm length x 2.4 cm width x 0.3 cm depth with no drainage or odor. The length of the pressure ulcer had worsened from the prior week. On 04/04/16 at 4:15 p.m., the resident was observed sitting in a Geri chair in the living area outside the assisted dining room. The resident was observed to receive help with the evening meal at 5:30, continuing to sit in the Geri chair and without being repositioned. At 6:25 p.m., the resident was assisted to her room from the dining room, still seated in the Geri chair. At 7:15 p.m., the resident was assisted from the Geri chair to the bed utilizing a mechanical lift. CNAs (certified nurse aides) #1 and #3 removed the incontinent brief from the resident, which was observed to be heavily soiled with urine and feces. The lower edge of the dressing, which was intact over the coccyx, was soiled with feces. The resident's buttocks were observed to be dark pink. The CNAs did not notify the nurse of the soiled dressing. The CNAs cleansed the resident's soiled perineum and buttocks, applied a clean incontinent brief, repositioned the resident to her left side and adjusted the pillows and covers. The CNAs used the same gloves throughout the entire time. The CNAs were asked what care the resident had received since they had arrived at 3:00 p.m. They stated they had provided no care for the resident since arriving at 3:00 p.m. They stated the resident had been up in the Geri chair since noon to eat lunch in the dining room, and no staff had checked the resident for incontinence or provided any type of repositioning since that time. They stated the staff working prior had not had time to lay the resident down after lunch to provide any personal care or repositioning. They stated they had been busy assisting other residents with personal care and assisting residents up for the evening meal since arriving at 3:00 p.m. They stated they were aware the resident needed to be checked for incontinence and incontinent care provided every two hours, as well as repositioning the resident every one to two hours due the presence of a pressure ulcer on the coccyx. They were asked what care the resident needed. They stated the resident was incontinent of bowel and bladder, and unable to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSE MANOR NURSING CENTER	1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 5) recognize or verbalize her needs, so she was to be checked for incontinence at least every two hours and incontinent care provided to keep her skin clean. They stated she needed to be repositioned from side to side every one to two hours, and heels were to be floated utilizing pillows so there was no pressure on the heels. They stated it was important to do these things so residents did not develop pressure ulcers. On 04/05/16, a skin/wound progress note documented the presence of an open area to the coccyx, stage 3, with 75% slough, 3.1 cm length x 2.6 cm width x 0.3 cm depth with no drainage or odor. The pressure ulcer had worsened, increasing in length and width from the prior week. The physician was notified of the worsening of the pressure ulcer and treatment orders changed to Santyl ointment (used for [MEDICATION NAME] slough in a wound) to be used daily and as needed. The resident's skin was observed on 04/05/16 at 10:45 a.m., with LPN #2 and CNAs #5 and #6. The pressure ulcer was observed to be the size as measured earlier in the day, as above. Heels were observed to be dark pink. The right heel was a darker pink with a purple color to the outer edge of the heel. There was no documentation of the discoloration to the heels in the resident's record or on the skin assessment that had been completed earlier in the day. At 2:30 p.m., LPN #2 was asked if she had observed the resident's heels as part of the skin assessment completed earlier in the day. She stated she had observed the heels, and although they were a darker pink, they had blanched. At 2:35 p.m., the surveyor and LPN #2 observed the resident's heels. The left heel was a dark pink color. The right heel was a darker pink with a purple color to the outer edge of the right heel. The LPN was asked if the discolored heels would be considered to be pressure related and she stated yes. She stated they should be considered as a stage one pressure ulcer to the right heel. 2. Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The nursing admission assessment and a weekly skin evaluation, dated 01/13/16, documented the resident had no pressure areas/open wounds. The care plan, initiated on 01/13/16, documented, .Focus .has Potential for skin breakdown and/or pressure ulcers r/t (related to) Braden <(less than) 18 . Goal .prevent any new breakdown, or reoccurrence of closed/resolved pressure ulcers . Interventions .Draw sheets to bed to reduce friction .encourage/assist in turning and repositioning every two hours .moisture barrier after each incontinence episode .Pressure relieving cushion in wheelchair or geri chair unless contraindicated .Use pillows while positioned in bed or a geri chair if applicable to reduce pressure to bony prominences . The admission assessment, dated 01/20/16, documented the resident had moderately impaired cognition, was frequently incontinent of urine, was always incontinent of bowel and required extensive two person assistance for bed mobility, transfers, toileting and hygiene. The assessment documented the resident was at risk for pressure ulcers, had no pressure ulcers, venous/arterial ulcers or other skin conditions at the time of admission. A wound assessment, dated 02/01/16, documented the resident had a stage 2 pressure ulcer to the right (rt) buttock with an onset date of 02/01/16. The wound measured 1 cm in length (L) x 0.4 cm in width (W) x < (less than) 0.2 cm in depth (D). The wound bed had pink/red granulation tissue present without drainage or odor present. Wound care orders were to apply Triad (a topical paste used for the treatment of [REDACTED]. The resident's care plan, updated 02/01/16, documented, .Focus .has a stage 3 pressure ulcer to her right buttocks near her coccyx . Goal .wound will not deteriorate, will be free from infection, and will show signs of healing . Interventions .keep skin clean and dry .lift sheet .low air loss mattress .pressure reducing cushion in w/c (wheelchair) .3/5/16- cleanse rt. buttock with NSS (normal sterile saline), pat dry, apply [MEDICATION NAME], cover with bordered foam dressing, change Q (every) day and prn (as needed) until resolved . A wound assessment, dated 02/08/16, documented the resident's pressure ulcer to the rt buttock had increased to a stage 3 which measured 1 cm L x 0.4 cm W x <0.2 cm D. The condition of the wound bed had worsened to include the presence of slough without drainage or odor. Wound care orders remained the same. The resident's care plan, dated 02/10/16, documented, .Focus .has an ADL Self Care Performance Deficit r/t right AKA, weakness, fatigue . Interventions .BED MOBILITY .requires X2 staff participation to reposition and turn in bed . On 02/13/16, the resident was sent to the emergency room for evaluation as per physician's orders [REDACTED]. A nursing readmission assessment, dated 02/15/16, documented the resident had an open area to the coccyx with no drainage. Wound assessments, dated 02/16/16 and 02/23/16, documented the resident's stage 3 pressure ulcer to the rt buttock had increased to 1 cm L x 1 cm W x <0.2cm D. The wound bed continued to have slough present without drainage or odor. Wound care orders changed to Magic Butt Paste to rt buttock every shift and Hydraguard cream to be left at bedside for application after each incontinent episode with the 02/16/16 assessment. A wound assessment, dated 03/04/16, documented the resident's stage 3 pressure ulcer to the rt buttock had increased to 1.3 cm L x 1.7 cm W x 0.1 cm D. The wound bed had pink/red granulation tissue present at that time without drainage or odor. Wound care orders were changed to cleanse with NSS, pat dry, apply [MEDICATION NAME] and cover with bordered foam pad. A wound assessment, dated 03/08/16, documented the resident's stage 3 pressure ulcer to the rt buttock measured 1.1 cm L x 1.5 cm W x 0.1 cm D. The wound bed continued to have pink/red granulation tissue present without drainage or odor. Wound care orders remained the same. A wound assessment, dated 03/18/16, documented the resident's stage 3 pressure ulcer to the rt buttock measured 1.1 cm L x 1.4 cm W x 0.1 cm D. The wound bed continued to have pink/red granulation tissue present without drainage or odor. Wound care orders remained the same. A wound assessment, dated 03/24/16, documented the resident's stage 3 pressure ulcer to the rt buttock had increased to 1.5 cm L x 1.4 cm W x 0.1 cm D. The wound bed continued to have pink/red granulation tissue present without drainage or odor. Wound care orders remained the same. A wound assessment, dated 03/31/16, documented the resident's stage 3 pressure ulcer to the rt buttock had increased to 2 cm L x 1.5 cm W x 0.1 cm D. The wound bed continued to have pink/red granulation tissue present without drainage or odor. Wound care orders remained the same. On 04/06/16, at 2:00 p.m., the resident had refused to allow the surveyor to observe her wound care. On 04/06/16 at 2:30 p.m., the director of nurses was asked about the resident's pressure ulcer. She stated it was facility acquired. On 04/06/16 at 2:55 p.m., CNA #3 was asked about the resident's care. The CNA stated staff assisted the resident with transfers from bed to recliner and to bedside commode. The CNA stated the resident would wipe herself. The CNA stated the resident would reposition herself in the bed and recliner to redistribute her weight. The resident was observed throughout the day on 04/06/16 sitting either in a wheelchair with her left leg/foot elevated on the recliner or sitting in the recliner with the left leg/foot resting on the extended footrest. The resident was not observed to reposition/redistribute her weight for any length of time.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** Based on observation and interview, it was determined the facility failed to ensure a portable dining steam table was not accessible to one (#28) of one wandering residents observed in the dining area for residents needing assistance with meals. The facility identified two residents who wandered in the dining area for residents needing assistance with meals. Findings: On 04/06/16 at 4:50 p.m., a portable steam stable was observed in the dining area for residents needing assistance with meals. The steam table power cord was plugged into the electrical wall outlet. The temperature settings on the food wells were set at high and medium. The stainless steel surfaces of the unit were hot to touch along the edge and atop the table. These hot surfaces were within reach of any resident sitting in a wheelchair. There were 10 residents sitting in wheelchairs at three tables in the dining area. One of the ten residents, resident #28, was observed propelling himself about the area aimlessly, bumping into other vacant chairs as he propelled. There was no staff observed in the dining area to oversee the hot portable steam table. At 4:55 p.m., dietary staff #1 was asked about the steam table. She stated the dietary staff brought the steam table out to the dining area for residents needing assistance with meals prior to meal service. She stated no dietary staff monitored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) the unit until nursing staff was present in the dining room to assist residents with their meals. She stated meals were usually served beginning at 5:00 p.m. She was asked it the surface area was hot and she stated it was hot to the touch. She was asked if it would be safe for residents to be around the unit and she stated no because it was hot.
F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** 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 the residents' individualized needs. The facility failed to: a) provide interventions according to the resident's needs to prevent the development of an avoidable stage 3 and stage 1 pressure ulcer for one resident (#5), b) provide interventions according to the resident's needs to prevent the development of an avoidable stage 2 pressure ulcer for one resident (#12), and c) provide interventions to prevent the worsening of a stage 3 pressure ulcer for one resident (#5) and the worsening of a stage 2 to a stage 3 pressure ulcer for one (#12) of six sampled residents with pressure ulcers. The facility's failure to provide interventions according to the residents' needs resulted in harm with the development and worsening of avoidable stage 3 pressure ulcers for two (#5 and #12) of six sampled residents with pressure ulcers. The facility identified nine residents with pressure ulcers. These deficient practices had the potential to affect 48 residents identified by the facility who were at high risk for the development of pressure ulcers. Please refer to F314 The facility also failed to provide sufficient nursing staff to provide: d) assistance with showers/baths for two residents (#8 and #9) and e) timely assistance and oversight with eating for three (#1, #24 and #28) of seven sampled residents who required assistance with activities of daily living. f) timely assistance with incontinent care for two (#5 and #6) of four sampled residents who required assistance with toileting/incontinent care. The facility identified 16 residents that needed assistance with eating, 52 residents that needed assistance with toileting/incontinent care and all 85 residents that needed assistance with bathing. Please refer to F312
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined the facility failed to ensure: a) incontinent care was provided in a manner to prevent infection for one (#5) of three residents observed for incontinent care and b) residents did not share food from the same plate for one (#28) during the observation of two meals. The facility identified 52 of 85 residents who received incontinent care and 59 of 85 residents ate independently and/or required only supervision. Findings: 1. Resident #5 was readmitted to the facility on [DATE] following hospitalization for surgical repair of a fracture to the left femur. Other [DIAGNOSES REDACTED]. The reentry assessment, dated 03/02/16, documented the resident displayed severe cognitive impairment and required extensive assistance of one to two persons with all activities of daily living, including bed mobility, transfers, personal hygiene and toileting. The care plan, dated 01/21/15 and last updated on 03/29/16, documented the resident required assistance with activities of daily living related to weakness and a recent hip fracture. The care plan documented the resident was incontinent of bladder, and staff were to check the resident every two hours and as required for incontinence. On 04/04/16 at 7:15 p.m., CNAs (certified nurse aides) #1 and #3 entered the residents room with a mechanical lift. After washing their hands and donning gloves, they assisted the resident from the Geri chair to the bed utilizing a mechanical lift. CNA #3 assisted with positioning the resident to her side, and CNA #1 then removed the incontinent brief from the resident, which was observed to be heavily soiled with urine and feces. CNA #1 cleansed the resident's soiled perineum and buttocks and applied a clean incontinent brief. The CNAs then repositioned the resident to her right side and adjusted the pillows and covers. The CNAs used the same gloved hands throughout the entire time, never washing their hands or changing gloves after they had removed the soiled brief until they were ready to exit the room. During the provision of wound care on 04/05/16 at 10:45 a.m., the resident's incontinent brief was observed to be soiled with urine and feces. CNAs #5 and #6 were observed as they provided incontinent care. The CNAs had assisted the resident into the bed using a mechanical lift, and then removed the residents soiled incontinent brief. They did not wash their hands prior to the provision of care, using the same gloved hands after using the mechanical lift. CNA #6 cleansed the resident's buttocks and anal area, then cleansed the perineal/vaginal area, applied a clean brief and adjusted the covers without washing her hands or changing gloves at any time during the provision of care. On 04/06/16 at 5:00 p.m., the director of nursing was asked about incontinent care. She stated a problem had been identified with improper incontinent care. She stated the CNAs should have washed/cleansed hands and changed gloves after they removed the soiled brief. 2. Resident #28 was admitted to the facility with [DIAGNOSES REDACTED]. A significant change assessment, dated 02/16/16, documented the resident was severely impaired in cognition, required extensive assistance from one to two staff with bed mobility, transfers, toileting and hygiene needs. The assessment further documented the resident required staff supervision for all meals. On 04/04/16 at 5:30 p.m., surveyors touring hall 500 observed a small cart which had two partially eaten plates of food sitting on it. The cart was sat outside room [ROOM NUMBER]. The top shelf contained a plate which was covered with the meal lid. The second shelf contained the left over remains of beef goulash, and green beans on a plate. The partially eaten food was covered with a paper napkin. The spoon and fork which was used by the previous resident sat next to the plate of partially eaten food. Resident #28, who resided in room [ROOM NUMBER], was observed exiting his room in his wheelchair. He stopped in the doorway of his room, removed the paper napkin from the plate of partially eaten food on the second shelf. He was observed to pick up the soiled fork which was sitting on the tray and began to consume the left over meal. The surveyor approached the resident and asked if he had changed his mind and wanted to finish his meal. The resident spoke incomprehensibly, smiled, nodded his head and continued to eat the food. After consuming a majority of the food, he replaced the paper napkin and fork onto the tray and propelled himself down the hall. CNA #1 was observed exiting from a room across the hall. She was asked if resident #28 often changed his mind about his meal once it was removed from his room. She stated, He eats in the dining room for all his meals. She was advised of the observation of the resident eating the left over partially eaten food on the cart left outside his door. She stated she wasn't aware he would do that. She then stated she had been picking up dinner trays, until she stopped to answer another call light. She was asked if she was the only staff working on the hall. She stated she was not and another staff was to float and help her with the hall. She was asked where that person was. She stated they were assisting with other residents in the dining area for residents needing assistance with eating. The CNA was then asked if she was able to cover her hall and do the additional duties effectively.

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ROSE MANOR NURSING CENTER	**1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804**

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F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) The CNA stated, I do the best I can.
F 0498 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **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 certified nurse aides (CNAs) were trained to provided urinary incontinent care in a manner to prevent infection for one (#5) of three residents observed for urinary incontinent care. The facilty identified 52 of 85 residents needing assistance with incontinent care. Findings: Resident #5 was readmitted to the facility on [DATE] following hospitalization for surgical repair of a fracture to the left femur. Other [DIAGNOSES REDACTED]. The reentry assessment, dated 03/02/16, documented the resident displayed severe cognitive impairment and required extensive assistance of one to two persons with all activities of daily living, including bed mobility, transfers, personal hygiene and toileting. The care plan, dated 01/21/15 and last updated on 03/29/16, documented the resident required assistance with activities of daily living related to weakness and a recent [MEDICAL CONDITION]. The care plan documented the resident was incontinent of bladder, and staff were to check the resident every two hours and as required for incontinence. On 04/04/16 at 7:15 p.m., CNAs #1 and #3 entered the residents room with a mechanical lift. After washing their hands and donning gloves, they assisted the resident from the Geri chair to the bed utilizing a mechanical lift. CNA #3 assisted with positioning the resident to her side, and CNA #1 then removed the incontinent brief from the resident, which was observed to be heavily soiled with urine and feces. CNA#1 cleansed the resident's soiled perineum and buttocks and applied a clean incontinent brief. The CNAs then repositioned the resident to her right side and adjusted the pillows and covers. The CNAs used the same gloved hands throughout the entire time, never washing their hands or changing gloves after they had removed the soiled brief until they were ready to exit the room. On 04/06/16 at 5:00 p.m., the director of nursing was asked about incontinent care. She stated a problem had been identified with improper incontinent care. She stated the CNAs should have washed/cleansed hands and changed gloves after they removed the soiled brief.