STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375351	A BUILDING _____ B WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKS EDGE NURSING AND REHABILITATION CENTER	5115 EAST 51ST STREET TULSA, OK 74135

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F 000	INITIAL COMMENTS A recertification survey was conducted on 05/22/16 through 05/26/16. The following abbreviations/symbols may have been used in this text: MDS - minimum data set CVA - cerebral vascular accident CAA - care area assessment MAR - medication administration record TAR - treatment administration record FSBS - finger stick blood sugar DON - director of nursing CNA - certified nurse aide CMA - certified medication aide LPN - licensed practical nurse RN - registered nurse ADON - assistant director of nursing ADL - activities of daily living IJ - immediate jeopardy DC - discontinue BR - bed rail BSR - bed side rail X - times Q - every DM - diabetes mellitus mg - milligrams ml - milliliter OSDH - Oklahoma State Department of Health TV - television BOM - business office manager	F 000		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221		

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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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free from physicial restraints for six (#3, #5, #7, #8, #9, and #19) of six sampled residents who were observed with side rails. This had the potential to affect the 94 residents who resided in the facility and were identified as having a bedrail. Findings:

An application of restraints policy, updated on 08/11/15, documented the facility was restraint free. The policy documented the following equipment and supplies may be utilized: low bed, self releasing seat belt, tray with spring-release device, lap buddy, bed rails, and a defined perimeter mattress. The policy documented to also follow state regulations for the use of restraints in long term care facilities, a pre-restraint assessment must be completed, a family consent must be signed, a physician's order must be obtained, and monthly charting would be completed.

1. Resident #3 was admitted to the facility on 10/20/14 and had diagnoses which included dementia and cerebral accident with right side hemiplegia.

A monthly physician's order, dated November 2014, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

An incident/accident report, dated 08/27/15, documented the resident had been found on the

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floor in her room, lying on her left side parallel to the bed. The report documented there was no injury and neuro checks had been started. The report documented the follow up measures were to do hourly visual checks times 14 days.

A monthly physician's order, dated November 2015, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

An annual assessment, dated 12/01/15, documented the resident was moderately impaired cognitively, required extensive assistance of two staff members for transfers, required supervision to extensive assistance with all other ADLs, had one fall without major injury, and had no restraints.

A monthly physician's order, dated March 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

A monthly nursing summary, dated 03/04/16, documented the resident did not have any restraints.

A significant change assessment, dated 03/09/16, documented the resident was severely impaired cognitively, required extensive assistance of two staff members for transfers, required limited to extensive assistance with all other ADLs, had no falls, and had no restraints.

A care plan review, dated 03/10/16, documented the resident was at risk for a fall related injury as evidenced by, previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented the following

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fall precautions: Evaluate for and supply adaptive equipment or devices as needed, re-evaluate as needed for continued need or safety, and coordinate with appropriate staff to ensure a safe environment.

A fall risk assessment, dated 03/10/16, documented the resident was a high risk for falls.

A monthly physician's order, dated April 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

An incident/accident report, dated 04/12/16, documented the resident had been found hanging halfway out of her bed. The report documented the resident's head had been resting on the floor and her feet and legs were between the bed rail and the mattress. The report documented neuro checks had been started and were within normal limits. The report documented the follow up measures were to do hourly visual checks times 14 days.

A monthly nursing summary, dated 04/14/16, documented the resident had 1/2 bed rails as a restraint.

A monthly physician's order, dated May 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

A monthly nursing summary, dated 05/13/16, documented the resident had bed rails as a restraint.

On 05/23/16 at 10:10 a.m., the resident was observed lying in bed on her back on an air mattress. The resident was alert but unable to

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answer questions appropriately. A half rail was observed in the center of the bed on the right side The other side of the bed was against the wall. There was approximately 3 1/2 inches of space between the bed rail and the air mattress.

On 05/24/16 at 9:35 a.m., the resident was observed lying in bed with her eyes closed. The half rail remained at the center of the bed.

At 2:10 p.m., CNA #6 was asked if she knew why the resident had a bed rail. She stated she had been told it was for turning and repositioning. She stated she was not aware of the resident ever using the bed rail to turn or reposition. She stated the resident would not try to help when care was being provided. CNA #6 was asked if the resident would try to get up without assistance. She stated yes. She stated on several occasions she had found the resident partially sitting up with her legs hanging off the bed in between the bed rail and the mattress.

At 2:15 p.m., CNA #7 was asked if she knew why the resident had a bed rail. She stated she did not know why. She stated the resident had the bed rails when she started working at the facility five months ago. CNA #7 was asked if the resident would try to get up without assistance. She stated yes. She stated she had found the resident sitting on the side of the bed before with her legs between the rail and the mattress.

On 05/24/16 at 3:45 p.m., the resident was observed awake and lying in bed. The half rail remained at the center of the bed. The resident was asked if she used the bed rail to help position herself. She stated no. The resident was asked if she could transfer herself from the bed to the

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F 221	Continued From page 5 chair. She stated yes. 2. Resident #19 was admitted to the facility 12/07/15 and had diagnoses which included left artificial knee joint replacement An admission nursing evaluation, dated 12/07/15, documented the resident was dependent for transfers with the assistance of one staff member. An admission assessment, dated 12/14/15, documented the resident was cognitively intact, required limited assistance of one staff member for transfers, and had experienced a fall at home which resulted in a fracture prior to this admission. A care plan, dated 12/15/15, documented to use half bed rails times two as ordered. The care plan documented the resident was at risk for falls related to previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented to evaluate for and supply adaptive equipment or devices as needed and to re-evaluate as needed for continued need or safety. A fall risk assessment, dated 12/15/16, documented the resident had a score of 7. A score of greater than 10 represented the resident was a high risk for falls. A care plan, updated 12/18/15, documented the resident had fallen in his room with no sustained injuries. The care plan documented the resident would be placed on every hour visual checks. An incident/accident report, dated 01/08/16,	F 221		

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F 221	Continued From page 6 documented the resident had been found sitting on the floor with his head resting against the foot of the bed. The report documented the resident had stated he had gone to the bathroom and fell on the way back to bed. The report documented the resident was disoriented at times and there were no injuries noted from the fall. The report documented the follow up interventions were to provide a toileting schedule times 14 days. A care plan, updated 01/08/16, documented the resident had fallen in his room with no sustained injuries. The care plan documented a toileting schedule would be started. An incident/accident report, dated 01/11/16 at 11:00 p.m., documented the resident had been found on the floor next to his bed face down with his head pointed toward the bathroom door. The left foot was on the floor and the right foot was caught between the bed rail and the bed. There was bruising noted to the bridge of the resident's nose and chin. The report documented neuro checks had been started. A daily skilled nurse' note, dated 01/12/16 at 8:00 a.m., documented the resident's neuro checks remained within normal limits. The note documented the resident's daughter had requested the resident be sent to the emergency room for an evaluation due to the changes in the resident's mental status prior to the fall. The note documented the physician had been notified and the resident had been transferred to the hospital for an evaluation. A facility discharge summary, dated 01/12/16, documented the resident had been discharged from the facility.	F 221		

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A final incident report to the OSDH, dated 01/18/16, documented the resident remained at the hospital with altered mental status. The report documented tests and X-rays done at the hospital had been negative for injuries and the family had chosen to take the resident home when he was discharged from the hospital.

3 Resident #5 was admitted to the facility on 11/18/13 and had diagnoses which included dementia.

An incident/accident report, dated 05/09/15, documented the resident had been found sitting on the floor with her wheelchair turned over and the resident had been unable to explain what happened. The report documented there were no sustained injuries.

An incident/accident report, dated 07/16/15, documented the resident had been found on the floor in her room and no injuries had been sustained.

An annual assessment, dated 10/15/15, documented the resident was severely impaired cognitively, required extensive assistance of one staff member for transfers, and the resident had no falls.

An incident/accident report, dated 04/04/16, documented the resident had been found sitting on the floor on 100 hall next to the linen closet. The report documented there were no sustained injuries.

A quarterly assessment, dated 04/12/16, documented the resident was severely impaired

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F 221	Continued From page 8 cognitively, required extensive assistance of one staff member for transfers, and had one non-injury fall. A care plan review, dated 04/13/16, documented half bed rails times two as ordered. The care plan documented the resident was at risk for falls related to injury as evidenced by previous falls, functional deficits, medication usage, and the use of assistive devices. A fall risk assessment, dated 04/13/16, documented the resident was a high risk for falls. A monthly physician's order, dated May 2016, documented an order for half bed rails times two to enable the resident to turn and reposition. On 05/23/16 at 10:23 a.m., the resident was observed sitting in a wheelchair in the TV lobby area. The resident had some difficulty with speech and word finding. She was smiling and pleasant. The resident's room was observed. The resident had a low bed with a half bed rail on both sides of the bed in the center. 4. Resident #7 was admitted to the facility on 10/12/15 and had diagnoses which included cerebral infarction with left sided weakness A fall risk assessment, dated 04/13/16, documented the resident was a high risk for falls. A care plan review, dated 04/13/16, documented to use 1/2 side rails as an enabler. The care plan documented the resident was at risk for a fall related injury as evidenced by previous falls, functional deficits, decreased safety awareness, and the use of assistive devices. The care plan	F 221		

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documented the resident had sustained a non-injury fall on 10/31/15, 11/12/15, 11/20/15, 11/22/15, and 11/24/15.

A quarterly assessment, dated 04/17/16, documented the resident was moderately impaired cognitively, required extensive assistance with most ADLs, and had no falls.

A monthly physician's order, dated May 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

On 05/24/16 at 4:55 p.m., CNA #5 was asked why the resident had bed rails. She stated because the resident climbed out of bed.

5. Resident #8 was admitted to the facility on 01/19/16 and had diagnoses which included dementia.

A quarterly assessment, dated 04/12/16, documented the resident was severely impaired cognitively, required limited assistance of one staff member for transfers, and had two non-injury falls.

A fall risk assessment, dated 04/13/16, documented the resident was a high risk for falls.

A care plan review, dated 04/13/16, documented 1/2 bed rails time two as ordered. The care plan documented the resident was at risk for a fall related injury as evidenced by previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented the resident had sustained a fall on 01/26/16 that resulted in a bump on the back of her head. The care plan documented the resident had sustained

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a non-injury fall on 02/10/16, 02/18/16, 02/23/16, 02/26/16, 03/01/16, 03/07/16, 03/17/16, 05/06/16, 05/11//16, and 05/12/16.

A monthly physician's order, dated May 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

On 05/24/16, at 9:35 a.m., the resident was observed lying in bed with her eyes closed and the bed rail up. The bed rail was in the middle of the bed with a space at the head of the bed and the foot of the bed.

At 9:35 a.m., LPN #1 was asked why the resident had bed rails. She stated to prevent the resident from falling out of bed.

At 3:40 p.m , CNA #8 was asked why the resident had a bed rail. She stated to keep the resident from falling out of bed. She stated the resident would climb around the rail because the resident thought she could transfer herself, but she was not suppose to.

At 3:43 p.m., RN #2 was asked why the resident had bed rails. She stated the resident used the rail to turn and reposition herself. The RN was asked if the resident had an assessment for the use of bed rails. She stated she had never seen an assessment for bed rails. RN #2 was asked if the resident tried to get out of bed with the rail up. She stated yes.

6. Resident #9 was admitted to the facility on 12/29/14 and had diagnoses which included Alzheimer's disease.

An annual assessment, dated 01/04/16,

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documented the resident was severely impaired cognitively, was independent with transfers, rejected care, and had two non-injury falls

An incident/accident report, dated 01/22/16, documented the resident had been found lying on the floor of her room with no sustained injuries.

An incident/accident report, dated 01/26/16, documented the resident had been found sitting on the floor of her room with her back against her bed. The report documented the resident had some redness on the right side of her head and neuro checks had been started.

An incident/accident report, dated 02/09/16 at 3:15 p.m., documented the resident had been found sitting on the floor in her room. The report documented there were no sustained injuries.

An incident/accident report, dated 02/09/16 at 11:30 p.m., documented the resident had been found lying on the floor in her room on her back and there were no sustained injuries.

A quarterly assessment, dated 03/29/16, documented the resident was severely impaired cognitively, was independent with transfers, had delusions, and had two non-injury falls.

A care plan review, dated 03/30/16, documented the resident was at risk for a fall related injury as evidenced by previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented to use bed rails time two as ordered.

An incident/accident report, dated 05/11/16, documented the resident had been found

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F 221	Continued From page 12 scooting across her bathroom floor. The report documented there were no sustained injuries. On 05/24/16 at 5:30 p.m., the resident was observed lying in bed watching TV. A half bed rail was observed in the middle of the bed, on each side of the bed. On 05/24/16 at 11:30 a.m., the ADON was asked why residents had bed rails. She stated the residents used the bed rails for turning and repositioning. The ADON was asked if the residents had been assessed for the safe use of bed rails. She stated no, there were no assessments on the residents who used bed rails The ADON was asked if there were signed consents for the use of bed rails. She stated no. The ADON was asked how she determined if the use of a bed rail was a safety hazard for a resident. She stated, "I don't know."	F 221		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: On 05/24/16 an Immediate Jeopardy (IJ) situation was determined to exist regarding the facility's failure to ensure bed rails were not an accident hazard for a resident who became	F 323		

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entrapped between the bed rail and the mattress. Resident #3 had been found hanging halfway out of bed with her head resting on the floor. The resident's legs and feet were between the bed rail on the bed and the mattress. The facility continued to use the bed rails after the resident had become entrapped in the bed rail.

On 05/24/16 at 3:25 p.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 3:30 p.m., the administrator was informed of the IJ situation regarding accident hazards. They were informed this placed the facility in an extended survey and a plan of removal was required.

At 5:20 p.m., an acceptable plan of removal was received from the administrator. The plan of removal documented:

"...5/24/16 RE: IMMEDIATE JEOPARDY, RELATED TO [resident name deleted] BEDRAIL INCIDENT 4/12/16

3:30PM NOTIFED [sic] OF IJ REGARDING [resident name deleted]

3:31PM REVIEWED INCIDENT REPORT FROM 4/12/16 AND PHYSCIAN'S ORDERS RELATED TO BR X 1

3.35 WENT ASSESSED BSR ON [resident name deleted]. BEDRAIL ASSESSMENT COMPLETED, NO NEGATIVE EFFECTS NOTED

3:40 OBTAINED ROOM/BED ROSTER,

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F 323	Continued From page 14 CHECKING ALL BEDS IN BUILDING FOR BSR IN USE, SIDE RAIL ASSESSMENTS STARTED ON EVERY RESIDENT IN THE BUILDING (hand written in), to be completed by 5/25/16 3:00 pm. 4:00 IN-SERVICES INITIATED "PROPER USE OF BEDRAILS" FOR 3/11 SHIFT - NURSING DEPT. 4:08pm - MEDICAL DIRECTOR INFORMED OF IJ 4:10PM - NOTIFIED ATTENDING PHYSICIAN, DR. [physician name deleted], OBTAINED DC ORDER FOR (1) BEDRAIL 4:11PM - REMOVED (1) BEDRAIL, WALL ALREADY MARKED FOR APPROPRIATE HT., VISUAL CHECKS STARTED ON [resident name deleted] q 30 min. X 72HOURS, THEN Q HOUR X 4 DAYS 4:12PM - UPDATED CLOSET CARE AND RESIDENT PLAN OF CARE 4:15PM - NOTIFIED RESPONSIBLE PARTY, [name deleted], OF REMOVAL OF BEDRAIL/PHYSICIAN ORDER Note: all nursing staff (Nurses, CMAs, and CNAs) will be in-serviced by 3:00PM BY May 25, 2016 Attachments: 1) Bedrail assessment - 2 pages 2) Telephone order 3) Updated closet care plan 4) Updated plan of care related to bedrail	F 323		

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F 323	Continued From page 15 removal 5) Observation/visual checks..." On 05/24/16 at 5:25 p.m., the resident's room was observed. The resident was out of the room and no bed rails were observed on the resident's bed. Staff were interviewed on 05/25/16 and 05/26/16 in regard to their knowledge of the in-service relating to the proper use of bedrails. Staff interviewed exhibited an understanding on the proper use of bedrails The IJ was removed effective 05/25/16 at 3:15 p.m., when all components of the plan of removal had been completed. The deficient practice remained at no actual harm with a potential for more than minimal harm at a pattern. Based on observation, interview, and record review, it was determined the facility failed to: ~ Ensure bed rails were not an accident hazard for three (#3, 8 and #19) of six sampled residents reviewed for side rails and accident hazards. Residents #3 and #19 experienced falls from the bed with a limb entrapped between the bed rail and the mattress. The facility continued to utilize the bed rails for resident #3. The ADON identified 94 residents who had a bed rail. ~ Ensure hazardous chemicals were secured and not accessible to residents on one (200 Skilled Hall) of seven halls. The facility identified two residents (#5 and #15) who wandered. Findings:	F 323		

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1 Resident #3 was admitted to the facility on 10/20/14 and had diagnoses which included dementia and cerebral vascular accident with right side hemiplegia.

A monthly physician's order, dated November 2014, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

An incident/accident report, dated 08/27/15, documented the resident had been found on the floor in her room, lying on her left side parallel to the bed. The report documented there was no injury and neuro checks had been started. The report documented the follow up measures were to do hourly visual checks times 14 days.

A monthly physician's order, dated November 2015, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

An annual assessment, dated 12/01/15, documented the resident was moderately impaired cognitively, required extensive assistance of two staff members for transfers, required supervision to extensive assistance with all other ADLs, had one fall without major injury, and had no restraints.

A monthly physician's order, dated March 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

A monthly nursing summary, dated 03/04/16, documented the resident did not have any restraints.

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F 323	Continued From page 17 A significant change assessment, dated 03/09/16, documented the resident was severely impaired cognitively, required extensive assistance of two staff members for transfers, required limited to extensive assistance with all other ADLs, had no falls, and had no restraints. A care plan review, dated 03/10/16, documented the resident was at risk for a fall related injury as evidenced by, previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented the following fall precautions: Evaluate for and supply adaptive equipment or devices as needed, re-evaluate as needed for continued need or safety, and coordinate with appropriate staff to ensure a safe environment. A fall risk assessment, dated 03/10/16, documented the resident was a high risk for falls. A monthly physician's order, dated April 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition. An incident/accident report, dated 04/12/16, documented the resident had been found hanging halfway out of her bed. The report documented the resident's head had been resting on the floor and her feet and legs were between the bed rail and the mattress. The report documented neuro checks had been started and were within normal limits. The report documented the follow up measures were to do hourly visual checks times 14 days. A monthly nursing summary, dated 04/14/16, documented the resident had 1/2 bed rails as a restraint.	F 323		

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A monthly physician's order, dated May 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

A monthly nursing summary, dated 05/13/16, documented the resident had bed rails as a restraint.

On 05/23/16 at 10:10 a.m., the resident was observed lying in bed on her back on an air mattress. The resident was alert but unable to answer questions appropriately. A half rail was observed in the center of the bed on the right side. The other side of the bed was against the wall. There was approximately 3 1/2 inches of space between the bed rail and the air mattress.

On 05/24/16 at 9:35 a.m., the resident was observed lying in bed with her eyes closed. The half rail remained at the center of the bed.

On 05/24/16 at 11:30 a.m., the ADON was asked why residents had bed rails. She stated the residents used the bed rails for turning and repositioning. The ADON was asked if the residents had been assessed for the safe use of bed rails. She stated no, there were no assessments on the residents who used bed rails. The ADON was asked how she determined if the use of a bed rail was a safety hazard for a resident. She stated, "I don't know."

At 2:10 p.m., CNA #6 was asked if she knew why the resident had a bed rail. She stated she had been told it was for turning and repositioning. She stated she was not aware of the resident ever using the bed rail to turn or reposition. She stated the resident would not try to help when

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F 323	Continued From page 19 care was being provided. CNA #6 was asked if the resident would try to get up without assistance. She stated yes. She stated on several occasions she had found the resident partially sitting up with her legs hanging off the bed in between the bed rail and the mattress. At 2:15 p m., CNA #7 was asked if she knew why the resident had a bed rail. She stated she did not know why. She stated the resident had the bed rails when she started working at the facility five months ago. CNA #7 was asked if the resident would try to get up without assistance. She stated yes. She stated she had found the resident sitting on the side of the bed before with her legs between the rail and the mattress. On 05/24/16 at 3:45 p.m., the resident was observed awake and lying in bed. The half rail remained at the center of the bed. The resident was asked if she used the bed rail to help position herself She stated no. The resident was asked if she could transfer herself from the bed to the chair. She stated yes. 2. Resident #19 was admitted to the facility on 12/07/15 and had diagnoses which included left artificial knee joint replacement. An admission nursing evaluation, dated 12/07/15, documented the resident was dependent for transfers with the assistance of one staff member. An admission assessment, dated 12/14/15, documented the resident was cognitively intact, required limited assistance of one staff member for transfers, and had experienced a fall at home which resulted in a fracture prior to this	F 323		

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F 323	Continued From page 20 admission A care plan, dated 12/15/15, documented to use half bed rails times two as ordered. The care plan documented the resident was at risk for falls related to previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented to evaluate for and supply adaptive equipment or devices as needed and to re-evaluate as needed for continued need or safety. A fall risk assessment, dated 12/15/16, documented the resident had a score of 7. A score of greater than 10 represented the resident was a high risk for falls. A care plan, updated 12/18/15, documented the resident had fallen in his room with no sustained injuries. The care plan documented the resident would be placed on every hour visual checks. An incident/accident report, dated 01/08/16, documented the resident had been found sitting on the floor with his head resting against the foot of the bed. The report documented the resident had stated he had gone to the bathroom and fell on the way back to bed. The report documented the resident was disoriented at times and there were no injuries noted from the fall. The report documented the follow up interventions were to provide a toileting schedule times 14 days. A care plan, updated 01/08/16, documented the resident had fallen in his room with no sustained injuries. The care plan documented a toileting schedule would be started. An incident/accident report, dated 01/11/16 at	F 323		

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F 323	Continued From page 21 11:00 p m., documented the resident had been found on the floor next to his bed face down with his head pointed toward the bathroom door. The left foot was on the floor and the right foot was caught between the bed rail and the bed. There was bruising noted to the bridge of the resident's nose and chin. The report documented neuro checks had been started. A daily skilled nurse' note, dated 01/12/16 at 8:00 a.m., documented the resident's neuro checks remained within normal limits. The note documented the resident's daughter had requested the resident be sent to the emergency room for an evaluation due to the changes in the resident's mental status prior to the fall. The note documented the physician had been notified and the resident had been transferred to the hospital for an evaluation. A facility discharge summary, dated 01/12/16, documented the resident had been discharged from the facility. A final incident report to the OSDH, dated 01/18/16, documented the resident remained at the hospital with altered mental status. The report documented tests and X-rays done at the hospital had been negative for injuries and the family had chosen to take the resident home when he was discharged from the hospital. 3. Resident #8 was admitted to the facility on 01/19/16 and had diagnoses which included dementia. A quarterly assessment, dated 04/12/16, documented the resident was severely impaired cognitively, required limited assistance of one	F 323		

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staff member for transfers, and had two non-injury falls.

A fall risk assessment, dated 04/13/16, documented the resident was a high risk for falls.

A care plan review, dated 04/13/16, documented 1/2 bed rails time two as ordered. The care plan documented the resident was at risk for a fall related injury as evidenced by previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented the resident had sustained a fall on 01/26/16 that resulted in a bump on the back of her head. The care plan documented the resident had sustained a non-injury fall on 02/10/16, 02/18/16, 02/23/16, 02/26/16, 03/01/16, 03/07/16, 03/17/16, 05/06/16, 05/11//16, and 05/12/16.

A monthly physician's order, dated May 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

On 05/24/16, at 9:35 a.m., the resident was observed lying in bed with her eyes closed and the bed rail up.

At 9:35 a.m., LPN #1 was asked why the resident had bed rails She stated to prevent the resident from falling out of bed.

At 3:40 p.m., CNA #8 was asked why the resident had a bed rail. She stated to keep the resident from falling out of bed. She stated the resident would climb around the rail because the resident thought she could transfer herself, but she was not suppose to.

At 3:43 p.m., RN #2 was asked why the resident

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had bed rails. She stated the resident used the rail to turn and reposition herself. The RN was asked if the resident had an assessment for the use of bed rails. She stated she had never seen an assessment for bed rails. RN #2 was asked if the resident tried to get out of bed with the rail up. She stated yes.

4. On 05/22/16 at 5:00 p.m., during the entrance tour of the facility, the hopper room door on the skilled 200 hall was observed to be unlocked A key was observed hanging on the wall next to the door. The hopper room contained a one gallon container of Sani-Care Lemon Quat disinfectant. The container was open and had two tubes from the opening of the container to a device on the wall. No residents were observed in the area. The skilled 200 hall only had two residents who resided in the same room on this hall. Their room was at the beginning of the hallway by the nurse's station. All of the other rooms on this hallway were used for offices.

On 05/22/16 at 5:25 p.m., CMA #3 was asked if there were any residents who would wander into other rooms. She stated she had not noticed any residents who wandered on this side (West side) of the facility. She stated there were some residents who wandered on the other side (East side) of the facility.

At 5:30 p.m., the DON was asked if there were any residents who wandered in the facility. She stated yes there were two, resident #5 and resident #15. She stated they would pick items up from other rooms, but she did not think they would eat or drink anything they found. The DON was asked if she was aware of any residents eating or drinking anything harmful. She stated

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no. The DON was asked how she ensured residents were safe from chemicals. She stated the doors to those rooms were kept locked. The DON was shown the hopper room on the skilled 200 hall. She stated the door should always be locked, that is why there is a key hanging here The DON locked the door. The DON was asked if she was aware of any residents who had been found in the hopper room. She stated, "I have been here many years and there has never been a resident found in the hopper room."

On 05/23/16 at 9:00 a.m., the hopper room on the skilled 200 hall was observed to be unlocked. No wandering or unattended residents were observed on the hallway. The surveyors were placed in the office directly across the hall from the hopper room. The hopper room was observed by the surveyors throughout the day

At 10:00 a.m., the hopper room door remained unlocked. No residents were observed in the area.

At 10:25 a.m., the hopper room door remained unlocked. No residents were observed in the area.

At 11:30 a.m., the hopper room door remained unlocked. No residents were observed in the area.

At 1:55 p.m., The hopper room door was locked.

On 05/24/16 at 8:10 a.m., the hopper room door was observed to be unlocked. No residents were observed in the area.

At 8:30 a.m., the DON was observed checking

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F 323	Continued From page 25 the hopper room door. She stated she did not know who was leaving the door unlocked. She locked the door and stated she was going to have maintenance change the lock on the door to a lock that stayed locked.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		

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F 431	Continued From page 26 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to: ~ ensure tuberculin vials were dated after opening in two of three medication rooms observed. ~ sign and date narcotic reconciliation sheets between each off-going and on-coming shift for six (#100 hall, #200 hall, #300 hall, #500 hall, #600 hall and #700 hall) of six resident hallways This had the potential to affect the 57 residents who were identified by the ADON who had an order for a narcotic medication. Findings: A facility storage and expiration dating of drugs policy, dated 06/06/09, documented, "...Once any drug is opened, the Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications..." A tuberculin solution manufacturer's recommendation insert, documented, "...Once entered, vial should be discarded after 30 days " A facility narcotic count policy, undated, documented, "...One R.N. or one L.P.N. or CMA going off-duty and one R.N. or one L.P.N. or CMA coming on duty must count and justify accuracy of narcotics supply for each individual patient at the change of shift...After the supply is counted and justified, each nurse must record the date and his/her signature verifying that the count is	F 431		

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F 431	Continued From page 27 correct.. " On 05/24/16 at 11:30 a.m., three vials of tuberculin solution were observed open and undated in the center medication room refrigerator. On 05/24/16 at 11:35 a.m., one vial of tuberculin solution was observed open and undated in the west medication room refrigerator. On 05/24/16 at 11:40 a.m , LPN #2 was asked what the procedure was when a new vial of tuberculin solution was opened. LPN #2 stated once a vial of TB solution was opened, it was to be dated and was good for 30 days. On 05/25/16 at 4:35 p.m., LPN #3 was asked what the procedure was when a new vial of TB solution was opened. LPN #3 stated as soon as a vial was opened, it was to be dated. The LPN stated once opened, the TB solution was good for 30 days LPN #3 was asked who was responsible for ensuring vials were dated when opened. She stated it was the nurses' responsibility. On 05/25/16 the narcotic count sheets were observed for the following hallways: At 3:15 p.m., 100 hall narcotic count sheets, dated May 2016, documented, 103 blanks out of 144 opportunities for a signature. At 3:10 p.m., 200 hall narcotic count sheets, dated May 2016, documented, 143 blanks out of 144 opportunities for a signature. At 4:35 p.m., 300 hall narcotic count sheets,	F 431		

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	375351	A BUILDING _____ B WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKS EDGE NURSING AND REHABILITATION CENTER	5115 EAST 51ST STREET TULSA, OK 74135

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F 431	Continued From page 28 dated May 2016, documented, 109 blanks out of 144 opportunities for a signature. At 4:40 p.m., 500 hall narcotic count sheets, dated May 2016, documented, 116 blanks out of 144 opportunities for a signature. At 4:45 p.m., 600 hall narcotic count sheets, dated May 2016, documented, 102 blanks out of 144 opportunities for a signature. At 4:50 p.m., 700 hall narcotic count sheets, dated May 2016, documented, 135 blanks out of 144 opportunities for a signature. A random check of narcotics was conducted. No discrepancies were noted regarding narcotic counts. On 05/24/16, at 8:15 a.m., CMA #2 was asked how often narcotics were counted. She stated with each shift change. On 05/24/16, at 8:25 a.m., CMA #2 was asked how often narcotics were counted. She stated narcotics were counted with the night shift nurse going off duty and in between shifts. CMA #2 stated a narcotic count was conducted anytime the narcotic keys were exchanged. On 05/25/16, at 2:00 p.m., the ADON was asked when narcotics should be counted. She stated narcotics should be counted between shifts. The ADON was asked when the narcotic count sheets should be signed She stated the narcotic count sheets should be signed by the off going and on coming staff members to verify the narcotic count was correct at the beginning and end of the shift.	F 431		

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F 431	Continued From page 29 On 05/26/16 at 10:16 a.m., the ADON was asked what the procedure was when a new vial of TB solution was opened. The ADON stated the nurse who opened the vial of medication was responsible for dating the vial.	F 431		
F 503 SS=E	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to calibrate six of six glucometers used to obtain	F 503		

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F 503	Continued From page 30	F 503		

FSBS checks. This had the potential to affect four (#3, #8, #13, and #16) of four sampled residents who were receiving FSBS checks. The ADON identified 30 residents who resided in the facility who received FSBS checks. Findings:

A glucometer policy, dated 05/17/07, documented, "...The glucometer log will be filled out by the charge nurse @ each desk on the 11-7 shift...The charge nurse on the 7-3 shift should check the log daily to see that it has been done. If not, the 7 - 3 charge nurse needs to do the controls...Please follow directions and make sure you use proper solution. Fill all information on the log..."

On 05/24/16, at 10:55 a.m., the east hallway glucometer calibration log, dated May 2016, contained 32 blanks out of 96 opportunities for a signature.

On 05/24/16, at 11:00 a.m., the west hallway glucometer calibration log, dated May 2016, contained 30 blanks out of 96 opportunities for a signature.

On 05/24/16, at 11:10 a.m., the center hallway glucometer calibration log, dated May 2016, contained 86 blanks out of 96 opportunities for a signature.

1. Resident #3 was admitted to the facility on 12/15/14 and had diagnoses which included DM.

A significant change assessment, dated 03/09/16, documented the resident was severely impaired cognitively, required limited to extensive assistance with ADLs, and had received an insulin injection seven days out of the seven day

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F 503	Continued From page 31 look back period. A monthly physician's order, dated May 2016, documented to obtain a FSBS check before meals and at bedtime. On 05/24/16 at 9:35 a.m., the resident was observed lying in bed with her eyes closed. 2. Resident #8 was admitted to the facility on 01/19/16 and had diagnoses which included DM. A quarterly assessment, dated 04/12/16, documented the resident was severely impaired cognitively, required limited to moderate assistance with ADLs, and had received an insulin injection seven days out of the seven day look back period. A monthly physician's order, dated May 2016, documented to obtain a FSBS check before meals and at bedtime On 05/23/16, at 9:08 a.m., resident #8 was observed lying in bed and covered with a blanket. 3. Resident #13 was admitted to the facility on 02/05/16 and had diagnoses which included DM. An admission assessment, dated 02/12/16, documented the resident was cognitively intact, required limited assistance with most ADLs, and received an insulin injection seven days out of the seven day look back period. A physician's order, dated May 2016, documented to obtain a FSBS before meals and at bedtime.	F 503		

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F 503	Continued From page 32 On 05/25/16 at 5:00 p.m., the resident was observed sitting up in his wheelchair in the lobby. 4. Resident #16 was admitted to the facility on 04/04/16 and had diagnoses which included DM. An admission assessment, dated 04/12/16, documented, the resident was severely impaired cognitively, required limited assistance with most ADLs, and received an insulin injection seven days out of the seven day look back period. A physician's order, dated May 2016, documented an order to obtain FSBS checks before meals and at bedtime. On 05/24/16 at 11:15 a.m., LPN #1 was asked who was responsible for calibrating the glucometers. She stated the night shift nurse was to calibrate the glucometer and document the results in the log book. LPN #1 was asked what the process was if the log book contained no documentation that the glucometers had been calibrated. She stated she would calibrate the glucometer before obtaining scheduled FSBS checks. On 05/24/16 at 2:25 p.m., the ADON was asked who was responsible for calibrating the glucometers. She stated the night shift nurse was responsible for calibrating the glucometers and documenting the results in the log book. On 05/25/16 at 11:30 a.m., resident #16 was observed sitting in the main lobby accompanied by visitors.	F 503		

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LL000	Initial Comments A recertification survey was conducted on 05/22/16 through 05/26/16. The following abbreviations/symbols may have been used in this text: MDS - minimum data set CVA - cerebral vascular accident CAA - care area assessment MAR - medication administration record TAR - treatment administration record FSBS - finger stick blood sugar DON - director of nursing CNA - certified nurse aide CMA - certified medication aide LPN - licensed practical nurse RN - registered nurse ADON - assistant director of nursing ADL - activities of daily living IJ - immediate jeopardy DC - discontinue BR - bed rail BSR - bed side rail X - times Q - every DM - diabetes mellitus mg - milligrams ml - milliliter OSDH - Oklahoma State Department of Health TV - television BOM - business office manager	LL000		
LL354	310:675-7-21.(a) SEX OR VIOLENT OFFENDER STATUS Determination of status. A facility subject to the provisions of this Chapter shall determine whether the following individuals have registered pursuant to the Sex Offenders Registration Act or the Mary Rippy Violent Crime Offenders	LL354		

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LL354	Continued From page 1 Registration Act: (1) An applicant for admission or participation, (2) A resident, client or participant of a facility subject to the provisions of this Chapter, and (3) All employees of facilities subject to the provisions of this Chapter, in addition to the required criminal arrest check in 63 O.S §1-1950.1 and 63 O.S. §1-1950.8 (relating to criminal arrest checks) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record view, it was determined the facility failed to obtain sex offender registry checks within three days of admission for four (#7, #8, #10, and #16) of four sampled residents. The BOM identified 78 new admissions to the facility in the last four months. Findings: 1. Resident #7 was admitted to the facility on 10/12/15 and had diagnoses which included cerebral infarction. A quarterly assessment, dated 04/17/16, documented the resident was moderately impaired cognitively and required extensive assistance with most ADL's. On 05/25/16 at 10:15 a.m., resident #7's sex offender registry check was reviewed. The sex offender registry check, undated, documented the resident's status was clear. On 05/25/16 at 2:30 p.m., resident #7 was	LL354		

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LL354	Continued From page 2 observed resting in bed. 2. Resident #10 was admitted to the facility on 01/08/16 and had diagnoses which included peripheral neuropathy. A quarterly assessment, dated 04/18/16, documented the resident was cognitively intact and required minimal to limited assistance with most ADL's. On 05/23/16 at 1:05 p.m., resident #10 was observed in the dining room eating lunch. On 05/25/16 at 10:15 a.m., resident #10's sex offender registry check was reviewed. The sex offender registry check, undated, documented the resident's status was clear. 3. Resident #8 was admitted to the facility on 01/19/16 and had diagnoses which included DM. A quarterly assessment, dated 04/12/16, documented the resident was cognitively intact and required limited to moderate assistance with ADLs. On 5/23/16 at 9:08 a.m., resident #8 was observed lying in bed covered by a blanket. On 05/25/16 at 10:15 a.m., resident #8's sex offender registry check was reviewed. The sex offender registry check, undated, documented the resident's status was clear. 4. Resident #16 was admitted to the facility on 04/04/16 and had diagnoses which included DM. An admission assessment, dated 04/12/16, documented, the resident was severely impaired	LL354		

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LL354	Continued From page 3 cognitively and required limited assistance with most ADL's. On 05/25/16 at 10:15 a.m., resident #16's sex offender registry check was reviewed. The sex offender registry check, undated, documented the resident's status was clear. On 05/25/16 at 10:30 a.m., the BOM was asked when resident sex offender checks were done. She stated she did the sex offender checks within two days of a resident's admission to the facility. The BOM stated there were no dates for the sampled residents' sex offender checks so she could not say when the checks had been completed. On 05/25/16 at 11:30 a.m., resident #16 was observed sitting up in the main lobby accompanied by visitors.	LL354		
LL803	310:675-7-15.1.(c)(3) GENERAL STORAGE The facility shall provide general storage as follows: (3) Residents shall not have access to storage areas for cleaning agents, bleaches, insecticides or any other dangerous, poisonous or flammable substances. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure hazardous chemicals were secured and not accessible to residents on one (200 Skilled	LL803		

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LL803	Continued From page 4 Hall) of seven halls. The facility identified two residents (#5 and #15) who wandered. Findings: On 05/22/16 at 5:00 p.m , during the entrance tour of the facility, the hopper room door on the skilled 200 hall was observed to be unlocked. A key was observed hanging on the wall next to the door. The hopper room contained a one gallon container of Sani-Care Lemon Quat disinfectant. The container was open and had two tubes from the opening of the container to a device on the wall. No residents were observed in the area. The skilled 200 hall only had two residents who resided in the same room on this hall. Their room was at the beginning of the hallway by the nurse's station. All of the other rooms on this hallway were used for offices. On 05/22/16 at 5:25 p.m., CMA #3 was asked if there were any residents who would wander into other rooms. She stated she had not noticed any residents who wandered on this side (West side) of the facility. She stated there were some residents who wandered on the other side (East side) of the facility. At 5:30 p.m., the DON was asked if there were any residents who wandered in the facility. She stated yes there were two, resident #5 and resident #15. She stated they would pick items up from other rooms, but she did not think they would eat or drink anything they found. The DON was asked if she was aware of any residents eating or drinking anything harmful. She stated no. The DON was asked how she ensured residents were safe from chemicals. She stated the doors to those rooms were kept locked. The DON was shown the hopper room on the skilled	LL803		

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LL803	Continued From page 5 200 hall. She stated the door should always be locked, that is why there is a key hanging here. The DON locked the door. The DON was asked if she was aware of any residents who had been found in the hopper room. She stated, "I have been here many years and there has never been a resident found in the hopper room." On 05/23/16 at 9:00 a.m., the hopper room on the skilled 200 hall was observed to be unlocked. No wandering or unattended residents were observed on the hallway. The surveyors were placed in the office directly across the hall from the hopper room. The hopper room was observed by the surveyors throughout the day. At 10:00 a.m., the hopper room door remained unlocked No residents were observed in the area. At 10:25 a.m., the hopper room door remained unlocked. No residents were observed in the area. At 11:30 a.m., the hopper room door remained unlocked. No residents were observed in the area. At 1:55 p.m., The hopper room door was locked. On 05/24/16 at 8:10 a.m., the hopper room door was observed to be unlocked. No residents were observed in the area. At 8:30 a.m., the DON was observed checking the hopper room door. She stated she did not know who was leaving the door unlocked. She locked the door and stated she was going to have maintenance change the lock on the door to a lock that stayed locked.	LL803		

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LL835	310:675-9-6.1(d) RESTRAINTS FOR MEDICAL SYMPTOMS (d) When restraints are required for the resident's medical symptoms, the nursing staff shall ensure that physical and chemical restraints are administered only in accordance with the resident's care plan and under the following circumstances. (1) When restraints are used to prevent falling, or for the purpose of positioning the resident, the resident and resident's representative shall be informed of the risk and benefits, and written consent shall be obtained. (2) Restraints may be applied only on a physician's written order and shall identify the type and reason for the restraint. The physician shall also specify the period of time, and the circumstances under which the restraint may be applied. (3) Alternative measures to the use of restraints shall be evaluated prior to their use. Circumstances requiring the restraints, and alternative measures, shall be re-evaluated and documented in the clinical record every thirty days. (4) A restrained resident shall have the restraints released every two hours for at least ten minutes; and the resident shall be repositioned, exercised, or provided range of motion and toileted as necessary. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free from physicial restraints for six (#3, #5, #7, #8, #9, and #19) of	LL835		

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LL835	Continued From page 7 six sampled residents who were observed with side rails This had the potential to affect the 94 residents who resided in the facility and were identified as having a bedrail. Findings: An application of restraints policy, updated on 08/11/15, documented the facility was restraint free. The policy documented the following equipment and supplies may be utilized: low bed, self releasing seat belt, tray with spring-release device, lap buddy, bed rails, and a defined perimeter mattress. The policy documented to also follow state regulations for the use of restraints in long term care facilities, a pre-restraint assessment must be completed, a family consent must be signed, a physician's order must be obtained, and monthly charting would be completed. 1. Resident #3 was admitted to the facility on 10/20/14 and had diagnoses which included dementia and cerebral accident with right side hemiplegia A monthly physician's order, dated November 2014, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition. An incident/accident report, dated 08/27/15, documented the resident had been found on the floor in her room, lying on her left side parallel to the bed. The report documented there was no injury and neuro checks had been started. The report documented the follow up measures were to do hourly visual checks times 14 days. A monthly physician's order, dated November 2015, documented an order for 1/2 bed rails times two to enable the resident to turn and	LL835		

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LL835	Continued From page 8 reposition. An annual assessment, dated 12/01/15, documented the resident was moderately impaired cognitively, required extensive assistance of two staff members for transfers, required supervision to extensive assistance with all other ADLs, had one fall without major injury, and had no restraints. A monthly physician's order, dated March 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition. A monthly nursing summary, dated 03/04/16, documented the resident did not have any restraints. A significant change assessment, dated 03/09/16, documented the resident was severely impaired cognitively, required extensive assistance of two staff members for transfers, required limited to extensive assistance with all other ADLs, had no falls, and had no restraints. A care plan review, dated 03/10/16, documented the resident was at risk for a fall related injury as evidenced by, previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented the following fall precautions: Evaluate for and supply adaptive equipment or devices as needed, re-evaluate as needed for continued need or safety, and coordinate with appropriate staff to ensure a safe environment. A fall risk assessment, dated 03/10/16, documented the resident was a high risk for falls. A monthly physician's order, dated April 2016,	LL835		

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	NH7219	A BUILDING _____ B WING _____	05/26/2016

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LL835	Continued From page 9	LL835		

documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

An incident/accident report, dated 04/12/16, documented the resident had been found hanging halfway out of her bed. The report documented the resident's head had been resting on the floor and her feet and legs were between the bed rail and the mattress. The report documented neuro checks had been started and were within normal limits. The report documented the follow up measures were to do hourly visual checks times 14 days.

A monthly nursing summary, dated 04/14/16, documented the resident had 1/2 bed rails as a restraint.

A monthly physician's order, dated May 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition.

A monthly nursing summary, dated 05/13/16, documented the resident had bed rails as a restraint.

On 05/23/16 at 10:10 a.m., the resident was observed lying in bed on her back on an air mattress. The resident was alert but unable to answer questions appropriately. A half rail was observed in the center of the bed on the right side. The other side of the bed was against the wall. There was approximately 3 1/2 inches of space between the bed rail and the air mattress.

On 05/24/16 at 9:35 a.m., the resident was observed lying in bed with her eyes closed. The half rail remained at the center of the bed.

At 2:10 p.m., CNA #6 was asked if she knew why

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LL835	Continued From page 10	LL835		

the resident had a bed rail. She stated she had been told it was for turning and repositioning. She stated she was not aware of the resident ever using the bed rail to turn or reposition. She stated the resident would not try to help when care was being provided. CNA #6 was asked if the resident would try to get up without assistance. She stated yes. She stated on several occasions she had found the resident partially sitting up with her legs hanging off the bed in between the bed rail and the mattress.

At 2:15 p.m., CNA #7 was asked if she knew why the resident had a bed rail. She stated she did not know why. She stated the resident had the bed rails when she started working at the facility five months ago. CNA #7 was asked if the resident would try to get up without assistance. She stated yes. She stated she had found the resident sitting on the side of the bed before with her legs between the rail and the mattress.

On 05/24/16 at 3:45 p.m., the resident was observed awake and lying in bed. The half rail remained at the center of the bed. The resident was asked if she used the bed rail to help position herself. She stated no. The resident was asked if she could transfer herself from the bed to the chair. She stated yes.

2. Resident #19 was admitted to the facility 12/07/15 and had diagnoses which included left artificial knee joint replacement.

An admission nursing evaluation, dated 12/07/15, documented the resident was dependent for transfers with the assistance of one staff member.

An admission assessment, dated 12/14/15,

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LL835	Continued From page 11	LL835		

documented the resident was cognitively intact, required limited assistance of one staff member for transfers, and had experienced a fall at home which resulted in a fracture prior to this admission.

A care plan, dated 12/15/15, documented to use half bed rails times two as ordered. The care plan documented the resident was at risk for falls related to previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented to evaluate for and supply adaptive equipment or devices as needed and to re-evaluate as needed for continued need or safety.

A fall risk assessment, dated 12/15/16, documented the resident had a score of 7. A score of greater than 10 represented the resident was a high risk for falls.

A care plan, updated 12/18/15, documented the resident had fallen in his room with no sustained injuries. The care plan documented the resident would be placed on every hour visual checks.

An incident/accident report, dated 01/08/16, documented the resident had been found sitting on the floor with his head resting against the foot of the bed. The report documented the resident had stated he had gone to the bathroom and fell on the way back to bed. The report documented the resident was disoriented at times and there were no injuries noted from the fall. The report documented the follow up interventions were to provide a toileting schedule times 14 days.

A care plan, updated 01/08/16, documented the resident had fallen in his room with no sustained injuries. The care plan documented a toileting

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LL835	Continued From page 12 schedule would be started. An incident/accident report, dated 01/11/16 at 11:00 p m., documented the resident had been found on the floor next to his bed face down with his head pointed toward the bathroom door. The left foot was on the floor and the right foot was caught between the bed rail and the bed. There was bruising noted to the bridge of the resident's nose and chin. The report documented neuro checks had been started. A daily skilled nurse' note, dated 01/12/16 at 8:00 a.m , documented the resident's neuro checks remained within normal limits. The note documented the resident's daughter had requested the resident be sent to the emergency room for an evaluation due to the changes in the resident's mental status prior to the fall The note documented the physician had been notified and the resident had been transferred to the hospital for an evaluation. A facility discharge summary, dated 01/12/16, documented the resident had been discharged from the facility. A final incident report to the OSDH, dated 01/18/16, documented the resident remained at the hospital with altered mental status. The report documented tests and X-rays done at the hospital had been negative for injuries and the family had chosen to take the resident home when he was discharged from the hospital. 3. Resident #5 was admitted to the facility on 11/18/13 and had diagnoses which included dementia. An incident/accident report, dated 05/09/15,	LL835		

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LL835	Continued From page 13 documented the resident had been found sitting on the floor with her wheelchair turned over and the resident had been unable to explain what happened. The report documented there were no sustained injuries. An incident/accident report, dated 07/16/15, documented the resident had been found on the floor in her room and no injuries had been sustained An annual assessment, dated 10/15/15, documented the resident was severely impaired cognitively, required extensive assistance of one staff member for transfers, and the resident had no falls. An incident/accident report, dated 04/04/16, documented the resident had been found sitting on the floor on 100 hall next to the linen closet. The report documented there were no sustained injuries. A quarterly assessment, dated 04/12/16, documented the resident was severely impaired cognitively, required extensive assistance of one staff member for transfers, and had one non-injury fall. A care plan review, dated 04/13/16, documented half bed rails times two as ordered. The care plan documented the resident was at risk for falls related to injury as evidenced by previous falls, functional deficits, medication usage, and the use of assistive devices. A fall risk assessment, dated 04/13/16, documented the resident was a high risk for falls. A monthly physician's order, dated May 2016,	LL835		

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LL835	Continued From page 14 documented an order for half bed rails times two to enable the resident to turn and reposition. On 05/23/16 at 10.23 a.m., the resident was observed sitting in a wheelchair in the TV lobby area. The resident had some difficulty with speech and word finding. She was smiling and pleasant. The resident's room was observed. The resident had a low bed with a half bed rail on both sides of the bed in the center. 4. Resident #7 was admitted to the facility on 10/12/15 and had diagnoses which included cerebral infarction with left sided weakness. A fall risk assessment, dated 04/13/16, documented the resident was a high risk for falls. A care plan review, dated 04/13/16, documented to use 1/2 side rails as an enabler. The care plan documented the resident was at risk for a fall related injury as evidenced by previous falls, functional deficits, decreased safety awareness, and the use of assistive devices. The care plan documented the resident had sustained a non-injury fall on 10/31/15, 11/12/15, 11/20/15, 11/22/15, and 11/24/15. A quarterly assessment, dated 04/17/16, documented the resident was moderately impaired cognitively, required extensive assistance with most ADLs, and had no falls. A monthly physician's order, dated May 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition. On 05/24/16 at 4:55 p.m., CNA #5 was asked why the resident had bed rails. She stated because the resident climbed out of bed.	LL835		

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LL835	Continued From page 15 5. Resident #8 was admitted to the facility on 01/19/16 and had diagnoses which included dementia. A quarterly assessment, dated 04/12/16, documented the resident was severely impaired cognitively, required limited assistance of one staff member for transfers, and had two non-injury falls. A fall risk assessment, dated 04/13/16, documented the resident was a high risk for falls. A care plan review, dated 04/13/16, documented 1/2 bed rails time two as ordered. The care plan documented the resident was at risk for a fall related injury as evidenced by previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented the resident had sustained a fall on 01/26/16 that resulted in a bump on the back of her head. The care plan documented the resident had sustained a non-injury fall on 02/10/16, 02/18/16, 02/23/16, 02/26/16, 03/01/16, 03/07/16, 03/17/16, 05/06/16, 05/11//16, and 05/12/16. A monthly physician's order, dated May 2016, documented an order for 1/2 bed rails times two to enable the resident to turn and reposition. On 05/24/16, at 9:35 a.m., the resident was observed lying in bed with her eyes closed and the bed rail up. The bed rail was in the middle of the bed with a space at the head of the bed and the foot of the bed. At 9:35 a.m., LPN #1 was asked why the resident had bed rails. She stated to prevent the resident from falling out of bed.	LL835		

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At 3:40 p.m., CNA #8 was asked why the resident had a bed rail. She stated to keep the resident from falling out of bed. She stated the resident would climb around the rail because the resident thought she could transfer herself, but she was not suppose to.

At 3:43 p.m., RN #2 was asked why the resident had bed rails. She stated the resident used the rail to turn and reposition herself. The RN was asked if the resident had an assessment for the use of bed rails. She stated she had never seen an assessment for bed rails. RN #2 was asked if the resident tried to get out of bed with the rail up. She stated yes.

6. Resident #9 was admitted to the facility on 12/29/14 and had diagnoses which included Alzheimer's disease.

An annual assessment, dated 01/04/16, documented the resident was severely impaired cognitively, was independent with transfers, rejected care, and had two non-injury falls.

An incident/accident report, dated 01/22/16, documented the resident had been found lying on the floor of her room with no sustained injuries.

An incident/accident report, dated 01/26/16, documented the resident had been found sitting on the floor of her room with her back against her bed. The report documented the resident had some redness on the right side of her head and neuro checks had been started.

An incident/accident report, dated 02/09/16 at 3:15 p.m., documented the resident had been found sitting on the floor in her room. The report

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LL835	Continued From page 17 documented there were no sustained injuries. An incident/accident report, dated 02/09/16 at 11:30 p.m., documented the resident had been found lying on the floor in her room on her back and there were no sustained injuries. A quarterly assessment, dated 03/29/16, documented the resident was severely impaired cognitively, was independent with transfers, had delusions, and had two non-injury falls. A care plan review, dated 03/30/16, documented the resident was at risk for a fall related injury as evidenced by previous falls, functional deficits, medication usage, and the use of assistive devices. The care plan documented to use bed rails time two as ordered. An incident/accident report, dated 05/11/16, documented the resident had been found scooting across her bathroom floor. The report documented there were no sustained injuries. On 05/24/16 at 5:30 p.m., the resident was observed lying in bed watching TV. A half bed rail was observed in the middle of the bed, on each side of the bed. On 05/24/16 at 11:30 a.m., the ADON was asked why residents had bed rails. She stated the residents used the bed rails for turning and repositioning. The ADON was asked if the residents had been assessed for the safe use of bed rails. She stated no, there were no assessments on the residents who used bed rails. The ADON was asked if there were signed consents for the use of bed rails. She stated no The ADON was asked how she determined if the use of a bed rail was a safety hazard for a	LL835		

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LL835	Continued From page 18 resident. She stated, "I don't know."	LL835		
LL837	310:675-9-8.1(a) CLINICAL LABORATORY The facility shall provide, or obtain, clinical laboratory services to meet the resident's needs. The facility shall be responsible for the quality and timeliness of the services. If the facility provides clinical laboratory services, the services shall meet the applicable conditions of the services furnished by independent laboratories. If the facility provides blood bank and transfusion services, it shall meet the applicable conditions for independent laboratories and hospitals. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to calibrate six of six glucometers used to obtain FSBS checks. This had the potential to affect four (#3, #8, #13, and #16) of four sampled residents who were receiving FSBS checks. The ADON identified 30 residents who resided in the facility who received FSBS checks. Findings: A glucometer policy, dated 05/17/07, documented, ".. The glucometer log will be filled out by the charge nurse @ each desk on the 11-7 shift...The charge nurse on the 7-3 shift should check the log daily to see that it has been done. If not, the 7 - 3 charge nurse needs to do the controls...Please follow directions and make sure you use proper solution. Fill all information on the log..."	LL837		

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LL837	Continued From page 19 On 05/24/16, at 10:55 a.m., the east hallway glucometer calibration log, dated May 2016, contained 32 blanks out of 96 opportunities for a signature. On 05/24/16, at 11:00 a.m., the west hallway glucometer calibration log, dated May 2016, contained 30 blanks out of 96 opportunities for a signature. On 05/24/16, at 11.10 a.m., the center hallway glucometer calibration log, dated May 2016, contained 86 blanks out of 96 opportunities for a signature. 1. Resident #3 was admitted to the facility on 12/15/14 and had diagnoses which included DM. A significant change assessment, dated 03/09/16, documented the resident was severely impaired cognitively, required limited to extensive assistance with ADLs, and had received an insulin injection seven days out of the seven day look back period. A monthly physician's order, dated May 2016, documented to obtain a FSBS check before meals and at bedtime. On 05/24/16 at 9:35 a.m., the resident was observed lying in bed with her eyes closed. 2. Resident #8 was admitted to the facility on 01/19/16 and had diagnoses which included DM. A quarterly assessment, dated 04/12/16, documented the resident was severely impaired cognitively, required limited to moderate assistance with ADLs, and had received an	LL837		

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LL837	Continued From page 20 insulin injection seven days out of the seven day look back period. A monthly physician's order, dated May 2016, documented to obtain a FSBS check before meals and at bedtime. On 05/23/16, at 9:08 a.m., resident #8 was observed lying in bed and covered with a blanket. 3. Resident #13 was admitted to the facility on 02/05/16 and had diagnoses which included DM. An admission assessment, dated 02/12/16, documented the resident was cognitively intact, required limited assistance with most ADLs, and received an insulin injection seven days out of the seven day look back period. A physician's order, dated May 2016, documented to obtain a FSBS before meals and at bedtime. On 05/25/16 at 5:00 p.m., the resident was observed sitting up in his wheelchair in the lobby. 4. Resident #16 was admitted to the facility on 04/04/16 and had diagnoses which included DM. An admission assessment, dated 04/12/16, documented, the resident was severely impaired cognitively, required limited assistance with most ADLs, and received an insulin injection seven days out of the seven day look back period. A physician's order, dated May 2016, documented an order to obtain FSBS checks before meals and at bedtime. On 05/24/16 at 11:15 a.m., LPN #1 was asked	LL837		

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LL837	Continued From page 21 who was responsible for calibrating the glucometers. She stated the night shift nurse was to calibrate the glucometer and document the results in the log book. LPN #1 was asked what the process was if the log book contained no documentation that the glucometers had been calibrated. She stated she would calibrate the glucometer before obtaining scheduled FSBS checks. On 05/24/16 at 2:25 p.m., the ADON was asked who was responsible for calibrating the glucometers. She stated the night shift nurse was responsible for calibrating the glucometers and documenting the results in the log book. On 05/25/16 at 11:30 a.m., resident #16 was observed sitting in the main lobby accompanied by visitors	LL837		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKS EDGE NURSING AND REHABILITATION CENTER	**5115 EAST 51ST STREET TULSA, OK 74135**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The findings on this Statement of Deficiencies demonstrate non-compliance with Title 42, Code of Regulations, §483.70(a) Life safety from fire. The requirement is not met as evidenced by the facility's failure to meet the National Fire Protection Association code(s) cited. K3 - Building - 0101 K6 - Plan Approval - Unknown K7 - Surveyed Under - 2000 Existing K8 - S/NF TYPE OF CONSTRUCTION: Type V (000), One story all wood frame construction. The facility had a complete automatic sprinkler system.	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke resistant ceiling and walls in a manner that would retard the spread of smoke to adjacent areas in the event of fire. This practice could affect 51 of 51 residents who currently resided in the facility as identified by the administrator on 05/25/16. The facility had	K 029		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375351	A. BUILDING **01 - PARK S EDGE** B. WING _____	**05/25/2016**

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K 029	Continued From page 1 a census of 96 residents. Findings: 1. During a tour of the facility on 05/25/16 from 8:00 a.m. to 12:00 p.m., the following observations were made: a. The mechanical closet, located on 100 hall, contained two gas-fired furnaces and a hot water heater. There was an unsealed penetration in the wall associated with a wire. b. The mechanical closet, located on 200 hall, contained a gas-fired water heater. There were two unsealed penetrations in the wall around the conduit. c. The mechanical closet, located in the housekeeper closet on the rehabilitation wing, contained a gas-fired furnace and a water heater. A piece of sheet rock had falling out of the ceiling leaving a hole exposed to the attic space above. d. The mechanical closet, located on 500 hall, contained two gas-fired furnaces and a hot water heater. There was an unsealed penetration in the wall associated with a wire. 2. The maintenance supervisor was present during the entire tour of the facility on 05/25/16 and acknowledged the unsealed penetrations. NFPA Standard: Hazardous areas shall be safeguarded by a fire barrier of one hour fire resistance rating or provided with an automatic sprinkler system, doors shall have closer and positive latches. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. NFPA 101, 19.3.2.1	K 029		

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