PRINTED: 06/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
1		375351	B WING		05/	05/26/2016	
	PROVIDER OR SUPPLIER EDGE NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET TULSA, OK 74135			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	rs	F O	00			
	A recertification su 05/22/16 through 0	rvey was conducted on 5/26/16.					
	been used in this te MDS - minimum da CVA - cerebral vaso CAA - care area as	ata set cular accident sessment administration record ministration record blood sugar ursing se aide dication aide ctical nurse se irector of nursing aily living ardy					
	mg - milligrams ml - milliliter OSDH - Oklahoma TV - television BOM - business off 483.13(a) RIGHT T PHYSICAL RESTR	State Department of Health ice manager O BE FREE FROM AINTS	F 22	21			
ADORATORY	physical restraints in discipline or conver treat the resident's	e right to be free from any mposed for purposes of hience, and not required to medical symptoms. ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		375351	B WING	S		05/26/2016	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZII 5115 EAST 51ST STREET TULSA, OK 74135	P CODE		
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F 221	Continued From pa	age 1	F 2	221			
	by: Based on observareview, it was deterore residents we restraints for six (# six sampled residents who residents who residents who residentified as having. An application of reconstruction of reconstruction of reconstruction of reconstruction of reconstruction. An application of reconstruction o	ation, interview, and record armined the facility failed to were free from physicial fa, #5, #7, #8, #9, and #19) of ents who were observed with did the potential to affect the 94 ded in the facility and were grained a bedrail. Findings: Destraints policy, updated on a ted the facility was restraint becomented the following oplies may be utilized: low bed, belt, tray with spring-release bed rails, and a defined so. The policy documented to egulations for the use of the erm care facilities, a sessent must be completed, a set be signed, a physician's ained, and monthly charting ed. Is admitted to the facility on diagnoses which included abral accident with right side on the resident to turn and the resident to turn and the report, dated 08/27/15,					
		esident had been found on the		1			

	DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		375351	B WING	B WING		05/26/2016		
	PROVIDER OR SUPPLIED EDGE NURSING AN	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 5115 EAST 51ST STREET TULSA, OK 74135	CODE			
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F 221	floor in her room, the bed. The report he bed. The report injury and neuro or report documented to do hourly visua. A monthly physicial 2015, documented times two to enable reposition. An annual assess documented the rimpaired cognitive assistance of two required supervisial other ADLs, hall other residented and or the residented the restraints. A significant change documented the restraints. A significant change documented the restraints. A care plan review the resident was a evidenced by, premedication usage	lying on her left side parallel to ort documented there was no shecks had been started. The d the follow up measures were a checks times 14 days. In the follow up measures were a checks times 14 days. In the follow up measures were a checks times 14 days. In the follow up measures were a checks times 14 days. In the follow up measures were a checks times 14 days. In the follow up measures were a checks times 14 days. In the follow up measures were a checks times 14 days. In the follow up measures were a checks times 14 days. In the follow up measures were a checks times 12 bed rails times two dent to turn and reposition. In the follow up measures were a checks times for 1/2 bed rails times two dent to turn and reposition. In the follow up measures were a checks times 12/2 bed rails times two dent to turn and reposition. In the follow up measures were a checks times 12/2 bed rails times two dent to turn and reposition. In the follow up measures were a checks times 12/2 bed rails times two dent to turn and reposition. In the follow up measures were a checks times 12/2 bed rails times two dent to turn and reposition. In the follow up measures were a checks times 12/2 bed rails times two dent to turn and reposition. In the follow up measures were a checks times 12/2 bed rails times two dent to turn and reposition. In the follow up measures were a checks times 12/2 bed rails times two dent to turn and reposition. In the follow up measures were a checks times 12/2 bed rails times two dent to turn and reposition to turn and rep	F 2					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		•	(X3) DATE SURVEY COMPLETED	
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F 221	equipment or device needed for continue coordinate with apprention and the residual and her feet and the mattress. Checks had been stilling to continue to enable the residual and the mattress.	age 3 valuate for and supply adaptive es as needed, re-evaluate as ed need or safety, and propriate staff to ensure a safe ent, dated 03/10/16, sident was a high risk for falls. In's order, dated April 2016, ther for 1/2 bed rails times two ent to turn and reposition. In report, dated 04/12/16, sident had been found hanging bed. The report documented had been resting on the floor gs were between the bed rail The report documented neuro tarted and were within normal locumented the follow up do hourly visual checks times	F 2	221			
	documented the restraint.	summary, dated 04/14/16, sident had 1/2 bed rails as a					
	documented an ord	n's order, dated May 2016, ler for 1/2 bed rails times two ent to turn and reposition.					
		summary, dated 05/13/16, sident had bed rails as a					
	observed lying in be	10 a.m., the resident was ed on her back on an air dent was alert but unable to					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIENT EDGE NURSING AN	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (5115 EAST 51ST STREET TULSA, OK 74135		
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F 221	answer questions observed in the consider of the other single. The other single wall. There was a space between the conserved lying in half rail remained. At 2:10 p.m., CNA the resident had a been told it was for She stated she was ever using the bed stated the resident care was being provided the resident would assistance. She is several occasions partially sitting up bed in between the At 2:15 p.m., CNA the resident had a not know why. She bed rails when she five months ago. resident would try She stated yes. So resident sitting on her legs between the conserved awake a remained at the conserved awake a remained at the conserved awake a remained at the conserved several states. She states the states of th	appropriately. A half rail was enter of the bed on the right de of the bed was against the approximately 3 1/2 inches of the bed rail and the air mattress. 35 a.m., the resident was bed with her eyes closed. The at the center of the bed. 36 was asked if she knew why bed rail. She stated she had are turning and repositioning. The as not aware of the resident derivation and reposition. She to would not try to help when ovided. CNA #6 was asked if try to get up without with her legs hanging off the debed rail and the mattress. 37 was asked if she knew why bed rail. She stated on she had found the resident with her legs hanging off the debed rail and the mattress. 38 a.m., the resident had the estarted working at the facility CNA #7 was asked if the to get up without assistance, he stated she had found the the side of the bed before with the rail and the mattress. 39 a.m., the resident was and lying in bed. The half rail enter of the bed. The resident used the bed rail to help position d no. The resident was asked are herself from the bed to the	F 22			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING				(X3) DATE SURVEY COMPLETED	
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F 221	An admission nursi documented the restransfers with the asmember. An admission assess documented the restransfers with the asmember. An admission assess documented the restrequired limited assess for transfers, and hawhich resulted in a admission. A care plan, dated half bed rails times plan documented the related to previous medication usage, a devices. The care plor and supply adaptive and supply a	es. as admitted to the facility iagnoses which included left eplacement ag evaluation, dated 12/07/15, sident was dependent for ssistance of one staff assment, dated 12/14/15, sident was cognitively intact, istance of one staff member ad experienced a fall at home fracture prior to this 12/15/15, documented to use two as ordered. The care are resident was at risk for falls falls, functional deficits, and the use of assistive colan documented to evaluate ative equipment or devices as valuate as needed for rafety. and, dated 12/15/16, sident had a score of 7. A on 10 represented the resident alls. dd 12/18/15, documented the	F 2					
	resident had fallen i injuries. The care p would be placed on	n his room with no sustained plan documented the resident every hour visual checks. t report, dated 01/08/16,						

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE 5115 EAST 51ST STREET TULSA, OK 74135	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 221	documented the re on the floor with hi of the bed. The re had stated he had on the way back to the resident was dwere no injuries no documented the for provide a toileting. A care plan, update resident had fallen injuries. The care schedule would be An incident/accide 11:00 p.m., docum found on the floor his head pointed to left foot was on the caught between the was bruising noted nose and chin. The checks had been so A daily skilled nurs a.m., documented the requested the resident's mental so documented the plate resident's mental so documented the plate resident had be for an evaluation. A facility discharge	esident had been found sitting is head resting against the foot port documented the resident gone to the bathroom and fell bed. The report documented isoriented at times and there of the from the fall. The report allow up interventions were to schedule times 14 days. The report documented the in his room with no sustained plan documented a toileting started. The report, dated 01/11/16 at ented the resident had been next to his bed face down with the power of the foot and the right foot was the bed rail and the bed. There is to the bridge of the resident's the report documented neuro	F 2	221			

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		l ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		375351	B WING		Q	3/26/2016		
	PROVIDER OR SUPPLIE EDGE NURSING AN	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 5115 EAST 51ST STREET TULSA, OK 74135				
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F 221	the hospital with a report documente hospital had been family had choser when he was disconsisted and the manual assess documented the resident had been family had choser when he was disconsisted and the manual assess documented the resident had been floor in her room a sustained. An incident/accide documented the resident had been floor in her room a sustained. An annual assess documented the recognitively, requires staff member for the floor on 10 falls. An incident/accide documented the recognitively is required to the floor on 10 falls.	cort to the OSDH, dated ented the resident remained at altered mental status. The difference difference and X-rays done at the negative for injuries and the notate the resident home harged from the hospital. The difference are also done at the negative for injuries and the notate the resident home harged from the hospital. The difference are also done and interest the second of the facility on diagnoses which included enterest the difference and interest the second of the	F 2	21				
		esident was severely impaired						

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE 5115 EAST 51ST STREET TULSA, OK 74135			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 221	staff member for to non-injury fall. A care plan review half bed rails times plan documented related to injury as functional deficits, of assistive devices. A fall risk assessm documented the residual documented an or to enable the residual commented and or to enable the resident speech and word in pleasant. The resident had a both sides of the best of the best of the pleasant	ed extensive assistance of one ransfers, and had one ansfers, and had one ansfers, and had one at the care the resident was at risk for falls evidenced by previous falls, medication usage, and the use s. Inent, dated 04/13/16, esident was a high risk for falls. In sorder, dated May 2016, der for half bed rails times two lent to turn and reposition. In a wheelchair in the TV lobby thad some difficulty with finding. She was smiling and ident's room was observed.	F 2	221			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING				(X3) DATE SURVEY COMPLETED	
		375351	B WING	B WING		05/26/2016	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 115 EAST 51ST STREET ULSA, OK 74135		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	Continued From pa		F 2	21			
		sident had sustained a 0/31/15, 11/12/15, 11/20/15, 4/15.	Parameters and the second				
	documented the re impaired cognitivel	ment, dated 04/17/16, sident was moderately y, required extensive sst ADLs, and had no falls.					
	documented an ord	n's order, dated May 2016, der for 1/2 bed rails times two ent to turn and reposition.					
	why the resident ha	5 p.m., CNA #5 was asked ad bed rails. She stated ant climbed out of bed.					
		s admitted to the facility on liagnoses which included	***************************************				
	documented the re cognitively, require	ment, dated 04/12/16, sident was severely impaired d limited assistance of one ansfers, and had two					
		ent, dated 04/13/16, sident was a high risk for falls.	**************************************				
	1/2 bed rails time to documented the re related injury as ev functional deficits, of assistive devices the resident had su resulted in a bump	dated 04/13/16, documented wo as ordered. The care plan sident was at risk for a fall idenced by previous falls, medication usage, and the use s. The care plan documented istained a fall on 01/26/16 that on the back of her head. The ited the resident had sustained					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	375351	B WING		0:	05/26/2016	
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND R	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 5115 EAST 51ST STREET TULSA, OK 74135			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
O2/26/16, O3/01/16, O5/11//16, and O5/12 A monthly physician's documented an order to enable the resider. On O5/24/16, at 9:35 observed lying in bed the bed rail up. The the bed with a space the foot of the bed. At 9:35 a.m., LPN #1 had bed rails. She served from falling out of bewould climb around thought she could train not suppose to. At 3:43 p.m., RN #2 had bed rails. She served from falling out of bewould climb around thought she could train thought she could train thought she she could train to turn and repose asked if the resident use of bed rails. She an assessment for bothe resident tried to get the stated yes. 6. Resident #9 was a server was a s	2/10/16, 02/18/16, 02/23/16, 03/07/16, 03/17/16, 05/06/16, /16. s order, dated May 2016, er for 1/2 bed rails times two on to turn and reposition. a.m., the resident was d with her eyes closed and bed rail was in the middle of at the head of the bed and was asked why the resident tated to prevent the resident d. She stated the resident d. She stated the resident the rail because the resident the rail because the resident tated the resident was asked why the resident the rail because the resident the rail because the resident tated the resident used the ition herself. The RN was had an assessment for the estated she had never seen ed rails. RN #2 was asked if get out of bed with the rail up.	F 22	21			

375351 B WING 05/2	05/26/2016	
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET TULSA, OK 74135		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221 Continued From page 11 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		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL A BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		375351	B WING		0	5/26/2016	
	PROVIDER OR SUPPLIER EDGE NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 5115 EAST 51ST STREET TULSA, OK 74135			
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F 323	On 05/24/16 at 5:30 observed lying in be was observed in the side of the bed. On 05/24/16 at 11:3 why residents had be residents used the repositioning. The residents had been bed rails. She state assessments on the rails The ADON was ask use of a bed rail waresident. She state 483.25(h) FREE OF HAZARDS/SUPER' The facility must en environment remain as is possible; and	r bathroom floor. The report were no sustained injuries. O p.m., the resident was ed watching TV. A half bed rail e middle of the bed, on each seed rails. She stated the bed rails for turning and ADON was asked if the assessed for the safe use of ed no, there were no e residents who used bed as asked if there were signed as asfety hazard for a d, "I don't know."	F 2				
	This REQUIREMENthy: On 05/24/16 an Imsituation was deterrifacility's failure to er	NT is not met as evidenced mediate Jeopardy (IJ) mined to exist regarding the asure bed rails were not an a resident who became					

	ENT OF DEFICIENCIES IN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUI A BUILD		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER EDGE NURSING AND	REHABILITATION CENTER		511	REET ADDRESS, CITY, STATE, ZIP CODE 15 EAST 51ST STREET ILSA, OK 74135		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Resident #3 had be of bed with her hear resident's legs and on the bed and the continued to use the had become entrary. On 05/24/16 at 3:25 Department of Hear verified the existent At 3:30 p.m., the active IJ situation regardered informed this extended survey ar required. At 5:20 p.m., an acreceived from the arremoval documenter. "5/24/16 RE: IMM RELATED TO [resident name deleases at 18.31 PM REVIEWE 4/12/16 AND PHYSTO BR X 1 3:35 WENT ASSES deleted]. BEDRAIL COMPLETED, NO NOTED	the bed rail and the mattress. Seen found hanging halfway out and resting on the floor. The feet were between the bed rail mattress. The facility is bed rails after the resident oped in the bed rail. 5 p.m., the Oklahoma State of the IJ situation. dministrator was informed of the IJ situation. dministrator was informed of the IJ situation. dministrator was informed of the facility in an of a plan of removal was of the facility in an of a plan of removal was of the facility in an of the decimal strator. The plan of the facility in an of the plan of	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	IN USE, SIDE RAIL ON EVERY RESID written in), to be co 4:00 IN-SERVICES OF BEDRAILS" FO DEPT. 4:08pm - MEDICAL IJ 4:10PM - NOTIFIEI DR. [physician nam ORDER FOR (1) B 4:11PM - REMOVE ALREADY MARKE VISUAL CHECKS (deleted) q 30 min.) X 4 DAYS 4:12PM - UPDATE RESIDENT PLAN (0) 4:15PM - NOTIFIEI [name deleted], OF BEDRAIL/PHYSICI Note: all nursing st CNAs) will be in-se 2016 Attachments:	EDS IN BUILDING FOR BSR ASSESSMENTS STARTED ENT IN THE BUILDING (hand impleted by 5/25/16 3:00 pm. SINITIATED "PROPER USE OR 3/11 SHIFT - NURSING DIRECTOR INFORMED OF DIRECTOR INFORMED OF DIRECTOR INFORMED DC EDRAIL ED (1) BEDRAIL, WALL D FOR APPROPRIATE HT., STARTED ON [resident name of the company	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l ` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		375351	B WING_		05	5/26/2016	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 5115 EAST 51ST STREET TULSA, OK 74135			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	removal 5) Observation On 05/24/16 at 5:2 was observed. The and no bed rails we bed. Staff were interview in regard to their kr relating to the prop interviewed exhibite proper use of bedra The IJ was remove p.m., when all com had been complete remained at no act more than minimal Based on observat review, it was deter Ensure bed rails for three (#3, 8 and reviewed for side ra Residents #3 and # bed with a limb ent and the mattress. the bed rails for res 94 residents who h Ensure hazardou not accessible to re Hall) of seven halls	n/visual checks" 5 p.m., the resident's room resident was out of the room ere observed on the resident's room ere observed on the in-service er use of bedrails. Staff red an understanding on the ealls room ere of the plan of removal ed. The deficient practice room ere of the plan of removal ed. The deficient practice room ere of the plan of removal end. The deficient practice room ere of the plan of removal end. The facility failed to: were not an accident hazard resident hazard accident hazards. Figure 19 experienced falls from the rapped between the bed rail. The facility continued to utilize sident #3. The ADON identified	F 32	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		375351	B WING		05	/26/2016	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET TULSA, OK 74135			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		ILD BE	(X5) COMPLETION DATE	
F 323	10/20/14 and had dementia and cere right side hemiples. A monthly physicia 2014, documented times two to enable reposition. An incident/accide documented the refloor in her room, I the bed. The reposinjury and neuro concept documented to do hourly visual. A monthly physicia 2015, documented times two to enable reposition. An annual assessing documented the resimpaired cognitive assistance of two required supervisical other ADLs, had and had no restrain to enable the residual of the res	as admitted to the facility on diagnoses which included abral vascular accident with gia. In's order, dated November of an order for 1/2 bed rails at the resident to turn and ant report, dated 08/27/15, asident had been found on the ying on her left side parallel to be the documented there was no necks had been started. The did the follow up measures were checks times 14 days. In's order, dated November of an order for 1/2 bed rails are the resident to turn and the resident was moderately by, required extensive staff members for transfers, on to extensive assistance with did one fall without major injury,	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		375351	B WING		05	3/26/2016	
	PROVIDER OR SUPPLIED EDGE NURSING AN	R REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 5115 EAST 51ST STREET TULSA, OK 74135			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	A significant chan documented the resident was a evidenced by, premedication usage devices. The care fall precautions: Equipment or devineeded for continucoordinate with apenvironment. A fall risk assessing documented the resident was a evidenced by, premedication usage devices. The care fall precautions: Equipment or devineeded for continucoordinate with apenvironment. A fall risk assessing documented the resident and the resident and the resident and the mattress. Checks had been limits. The report measures were to 14 days. A monthly nursing	ge assessment, dated 03/09/16, esident was severely impaired ed extensive assistance of two transfers, required limited to noe with all other ADLs, had no	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		375351	B WING			05/	26/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 5115 EAST 51ST STREET TULSA, OK 74135	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
·	A monthly physicial documented an or to enable the residual documented the residual documented the restraint. On 05/23/16 at 10 observed lying in the mattress. The restraints observed in the cestide. The other situal. There was a space between the On 05/24/16 at 9:3 observed lying in the half rail remained. On 05/24/16 at 11 why residents had residents used the repositioning. The residents had been bed rails. She sta						
	if the use of a bed resident. She stat At 2:10 p.m., CNA the resident had a been told it was fo	was asked how she determined rail was a safety hazard for a ed, "I don't know." #6 was asked if she knew why bed rail. She stated she had r turning and repositioning. as not aware of the resident					
	ever using the bed	Is not aware of the resident I rail to turn or reposition. She It would not try to help when					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		375351	B WING			05/	26/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 5115 EAST 51ST STREET TULSA, OK 74135	, CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 323	the resident would assistance. She s several occasions partially sitting up to bed in between the At 2:15 p m., CNA the resident had a not know why. She bed rails when she five months ago. Or resident would try She stated yes. So resident sitting on ther legs between the On 05/24/16 at 3:4 observed awake a remained at the cewas asked if she underself. She stated if she could transfer chair. She stated in the state of the s	byided. CNA #6 was asked if try to get up without tated yes. She stated on she had found the resident with her legs hanging off the bed rail and the mattress. #7 was asked if she knew why bed rail. She stated she did e stated the resident had the estarted working at the facility CNA #7 was asked if the to get up without assistance. The stated she had found the the side of the bed before with the rail and the mattress. 5 p.m., the resident was and lying in bed. The half rail anter of the bed. The resident sed the bed rail to help position do no. The resident was asked or herself from the bed to the yes. as admitted to the facility on diagnoses which included left	F3	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		375351	B WING_		05	/26/2016	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET TULSA, OK 74135			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	half bed rails times plan documented the related to previous medication usage, devices. The care for and supply adapted and to recontinued need or a continued need or a fall risk assessmed documented the rescore of greater that was a high risk for a care plan, update resident had fallen injuries. The care plan would be placed on the floor with his of the bed. The rephad stated he had an on the way back to the resident was diswere no injuries not documented the follower provide a toileting and a care plan, update resident had fallen injuries. The care pschedule would be schedule would be	12/15/15, documented to use two as ordered. The care he resident was at risk for falls falls, functional deficits, and the use of assistive plan documented to evaluate otive equipment or devices as valuate as needed for safety. Lent, dated 12/15/16, sident had a score of 7. A an 10 represented the resident falls. Led 12/18/15, documented the in his room with no sustained plan documented the resident of every hour visual checks. Let report, dated 01/08/16, sident had been found sitting is head resting against the foot port documented the resident gone to the bathroom and fell bed. The report documented soriented at times and there the from the fall. The report low up interventions were to exchedule times 14 days. Let 01/08/16, documented the in his room with no sustained plan documented a toileting	F 32	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		375351	B WING		0!	5/26/2016
	PROVIDER OR SUPPLIER	O REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 5115 EAST 51ST STREET TULSA, OK 74135		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	found on the floor his head pointed to left foot was on the caught between the was bruising noted nose and chin. The checks had been to be a more a.m., documented remained within noted the resident's mental adocumented the part of an evaluation. A facility discharge documented the resident had be for an evaluation. A facility discharge documented the refrom the facility. A final incident report documented hospital with a report documented hospital with a report documented hospital had been family had chosen when he was discidented.	nented the resident had been next to his bed face down with oward the bathroom door. The effoor and the right foot was he bed rail and the bed. There do to the bridge of the resident's he report documented neuro started. Se' note, dated 01/12/16 at 8:00 the resident's neuro checks ormal limits. The note esident's daughter had dent be sent to the emergency ation due to the changes in the status prior to the fall. The note hysician had been notified and een transferred to the hospital esident had been discharged fort to the OSDH, dated anted the resident remained at litered mental status. The dot tests and X-rays done at the negative for injuries and the to take the resident home harged from the hospital.	F 3:	23		
	documented the re	ment, dated 04/12/16, esident was severely impaired				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		375351	B WING			05/	26/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 115 EAST 51ST STREET ULSA, OK 74135		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	non-injury falls. A fall risk assessm documented the reduced the residual time of documented the residual fall for assistive devices the resident had suresulted in a bump care plan documented in a bump care plan documented an on-injury fall on 02/26/16, 03/01/16, and 05/11//16, and 05/11//16, and 05/11//16, and 05/11//16, and 05/11//16, at 9:30 observed lying in the bed rail up. At 9:35 a.m., LPN had bed rails She from falling out of 1 would climb around thought she could not suppose to.	ransfers, and had two nent, dated 04/13/16, esident was a high risk for falls. If, dated 04/13/16, documented two as ordered. The care plan esident was at risk for a fall videnced by previous falls, medication usage, and the use s. The care plan documented ustained a fall on 01/26/16 that to on the back of her head. The neted the resident had sustained 02/10/16, 02/18/16, 02/23/16, 6, 03/07/16, 03/17/16, 05/06/16, 12/16. In's order, dated May 2016, der for 1/2 bed rails times two ent to turn and reposition. 35 a.m., the resident was ed with her eyes closed and #1 was asked why the resident e stated to prevent the resident	F3	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		375351	B WING			05	/26/2016	
	PROVIDER OR SUPPLIER EDGE NURSING AND	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET TULSA, OK 74135					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	had bed rails. She rail to turn and report asked if the resider use of bed rails. So an assessment for the resident tried to She stated yes. 4. On 05/22/16 at tour of the facility, to skilled 200 hall was key was observed bedoor. The hopper of container of Sani-Container was at the beginning station. All of the owere used for office of the facility. She residents who wand of the facility. She residents who wand side) of the facility. At 5:30 p.m., the Dany residents who wand side) of the facility. At 5:30 p.m., the Dany residents who wand side) of the facility. She resident #15. She up from other room would eat or drink a was asked if she w	stated the resident used the position herself. The RN was not had an assessment for the he stated she had never seen bed rails. RN #2 was asked if get out of bed with the rail up. 5:00 p.m., during the entrance he hopper room door on the sobserved to be unlocked. A manging on the wall next to the room contained a one gallon care Lemon Quat disinfectant, open and had two tubes from container to a device on the were observed in the area. I only had two residents who is room on this hall. Their room ig of the hallway by the nurse's ther rooms on this hallway	F 3	323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		375351	B WING_		0:	5/26/2016	
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 5115 EAST 51ST STREET TULSA, OK 74135			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETION DATE		
F 323	residents were saft the doors to those DON was shown the 200 hall. She state locked, that is why The DON locked the if she was aware of found in the hoppe been here many year esident found in On 05/23/16 at 9:0 skilled 200 hall was wandering or unatt observed on the haplaced in the office the hopper room. observed by the sunlocked. No residence. At 10:00 a.m., the unlocked. No residence. At 11:30 a.m., the unlocked. No residence. At 11:30 a.m., the locked. No residence. At 11:55 p.m., The homosory of the area.	asked how she ensured to from chemicals. She stated rooms were kept locked. The ne hopper room on the skilled to the door should always be there is a key hanging here ne door. The DON was asked from any residents who had been to room. She stated, "I have the hopper room." Or a.m., the hopper room on the state of the hopper room door remained dents were observed in the hopper room door remained dents were observed in the hopper room door remained dents were observed in the hopper room door was locked. Or a.m., the hopper room door was locked. Or a.m., the hopper room door was locked. No residents were	F 32	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l ` ′	LTIPLE CONSTRUCTION DING	(X3)	(X3) DATE SURVEY COMPLETED			
		375351	B WING	B WING		05/26/2016			
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 5115 EAST 51ST STREET TULSA, OK 74135	ODE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
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.			323					
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS		F 4	431					
	a licensed pharmad of records of receip controlled drugs in accurate reconcilia records are in orde	mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically							
	labeled in accordar professional princip appropriate access	als used in the facility must be not with currently accepted ples, and include the ory and cautionary e expiration date when							
	facility must store a locked compartment	State and Federal laws, the all drugs and biologicals in the nts under proper temperature it only authorized personnel to keys.							
	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distri	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the hinimal and a missing dose can							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		375351	B WING	B WING			26/2016	
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER				51	REET ADDRESS, CITY, STATE, ZIP CODE 15 EAST 51ST STREET JLSA, OK 74135			
(X4) ID PREFIX TAG				×	N BE RIATE	(X5) COMPLETION DATE		
F 431	Continued From p	-	 F2	31				
	by: Based on observative review, it was dete	eNT is not met as evidenced ation, interview, and record armined the facility failed to: n vials were dated after three medication rooms		***************************************				
	between each off- six (#100 hall, #20 #600 hall and #700 This had the poter who were identified	grootic reconciliation sheets going and on-coming shift for 0 hall, #300 hall, #500 hall, 0 hall) of six resident hallways utial to affect the 57 residents d by the ADON who had an expedication. Findings:						
	policy, dated 06/06 drug is opened, the manufacturer/supp expiration dates fo	nd expiration dating of drugs id/09, documented, "Once any e Facility should follow olier guidelines with respect to r opened medications"						
	A facility narcotic of documented, "Of going off-duty and coming on duty mut of narcotics supply	on manufacturer's insert, documented, "Once d be discarded after 30 days " ount policy, undated, ne R.N. or one L.P.N. or CMA one R.N. or one L.P.N. or CMA ust count and justify accuracy of for each individual patient atAfter the supply is counted						
		nurse must record the date						

1			
375351 B WING	05/26/2016		
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET TULSA, OK 74135	,		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE PROVIDER'S PLAN OF CORRECTION SHOULD PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE PROVIDER'S PLAN OF CORRECTION SHOULD PROVIDER'S PLAN OF CORRECTION SH	BE COMPLETION		
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. 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,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
	375351		B WING			05/26/2016		
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE 5115 EAST 51ST STREET TULSA, OK 74135	E, ZIP CODE			
(X4) ID PREFIX TAG				PROVIDER'S PLAN (IX (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE	
F 431	dated May 2016, do 144 opportunities for At 4:40 p.m., 500 h dated May 2016, do 144 opportunities for At 4:45 p.m., 600 h dated May 2016, do 144 opportunities for At 4:50 p.m., 700 h dated May 2016, do 144 opportunities for A random check of discrepancies were counts. On 05/24/16, at 8:1 how often narcotics with each shift chair on 05/24/16, at 8:2 how often narcotics narcotics were counting off duty and it stated a narcotic counter the narcotic keys when narcotics should be ADON was asked with should be signed sheets should be scoming staff members.	commented, 109 blanks out of or a signature. all narcotic count sheets, ocumented, 116 blanks out of or a signature. all narcotic count sheets, ocumented, 102 blanks out of or a signature. all narcotic count sheets, ocumented, 135 blanks out of or a signature. all narcotic sount sheets, ocumented, 135 blanks out of or a signature. narcotics was conducted. No enoted regarding narcotic 5 a.m., CMA #2 was asked a were counted. She stated ange. 55 a.m., CMA #2 was asked a were counted. She stated onted with the night shift nurse on between shifts. CMA #2 ount was conducted anytime	F 4	131				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
	375351		B WING		05/26/2016		
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER				5115	EET ADDRESS, CITY, STATE, ZIP CODE BEAST 51ST STREET LSA, OK 74135		
(X4) ID PREFIX TAG				×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE	
F 431	Continued From pa	age 29	F 4	31			
	what the procedure solution was opened nurse who opened responsible for dat	•					
	REFERRED, AGR	AB SVCS - FAC PROVIDED, EEMENT	F 5	03			
	the services must r	es its own laboratory services, meet the applicable boratories specified in part 493					
,	services, it must m	boratories specified in Part					
	testing to another la laboratory must be specialties and sub	ooses to refer specimens for aboratory, the referral certified in the appropriate especialties of services in e requirements of part 493 of					
	on site, it must hav these services from	not provide laboratory services e an agreement to obtain n a laboratory that meets the nents of part 493 of this					
	by: Based on observa review, it was deter	NT is not met as evidenced tion, interview, and record mined the facility failed to glucometers used to obtain					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
375351		B WING		05/	26/2016			
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER				5115 EA	ADDRESS, CITY, STATE, ZIP CODE ST 51ST STREET , OK 74135	•		
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 503	FSBS checks. The four (#3, #8, #13, a residents who were ADON identified 30 facility who received A glucometer policy documented, " The out by the charge of shift The charge of shift The charge of shift The charge of shift Please for you use proper sollog" On 05/24/16, at 10 glucometer calibrate contained 32 blanks signature. On 05/24/16, at 11 glucometer calibrate contained 30 blanks signature. On 05/24/16, at 11 glucometer calibrate contained 30 blanks signature. 1. Resident #3 was 12/15/14 and had of the recognitively, require assistance with AD	is had the potential to affect and #16) of four sampled e receiving FSBS checks. The 0 residents who resided in the ed FSBS checks. Findings:	F 5	03				

NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET TULSA, OK 74135	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
PARKS EDGE NURSING AND REHABILITATION CENTER DATE SUMMARY STATEMENT OF DEFICIENCIES 11 SAST SIST SIREET TULSA, OK 74135 10 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OCORRECTIVA GETON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (Inc.) CONSTRUCTION OF		375351		B WING			05/26/2016		
FREFIX TAG REGULATORY OR I SC IDENTIFYING INFORMATION) F 503 Continued From page 31					5115 EAST 51ST STREET				
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 02/06/16 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,	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	COMPLETION			
at bedtime.	F 503	look back period. A monthly physicial documented to obtime als and at bedtii. On 05/24/16 at 9:3 observed lying in b. Resident #8 wa 01/19/16 and had of the recognitively, require assistance with AD insulin injection ser look back period. A monthly physicial documented to obtime als and at bedtii. On 05/23/16, at 9:0 observed lying in b. Resident #13 w 02/05/16 and had of the received an insulin seven day look back. A physician's order documented to obtime als and all obtime as received an insulin seven day look back.	n's order, dated May 2016, tain a FSBS check before me. 5 a.m., the resident was seed with her eyes closed. s admitted to the facility on diagnoses which included DM. ment, dated 04/12/16, tesident was severely impaired dimited to moderate blus, and had received an even days out of the seven day n's order, dated May 2016, tain a FSBS check before me 8 a.m., resident #8 was ted and covered with a blanket. as admitted to the facility on diagnoses which included DM. tessment, dated 02/12/16, tesident was cognitively intact, sistance with most ADLs, and injection seven days out of the tex period.	F 5					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
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	NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 115 EAST 51ST STREET ULSA, OK 74135	-	i	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE	
F 503	On 05/25/16 at 5:00 observed sitting up 4. Resident #16 wa 04/04/16 and had d An admission assess documented, the recognitively, required ADLs, and received days out of the seve days out of the se	o p.m., the resident was in his wheelchair in the lobby. It is admitted to the facility on it is admitted to the facility on it is admitted to the facility on it is admitted DM. It is sident was severely impaired it imited assistance with most is an insulin injection seven en day look back period. I dated May 2016, the to obtain FSBS checks to bedtime. I sam., LPN #1 was asked as for calibrating the stated the night shift nurse glucometer and document is book. LPN #1 was asked the sit is the log book contained that the glucometers had been the she would calibrate the obtaining scheduled FSBS.	F 5	03				

PRINTED: 06/15/2016 FORM APPROVED Oklahoma State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING _ B WING NH7219 05/26/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5115 EAST 51ST STREET** PARKS EDGE NURSING AND REHABILITATION **TULSA, OK 74135** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) LL000 Initial Comments LL000 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

Oklahoma State Department of Health

STATUS

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

the Mary Rippy Violent Crime Offenders

LL354 310:675-7-21.(a) SEX OR VIOLENT OFFENDER

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

BOM - business office manager

TITLE

(X6) DATE

LL354

FORM APPROVED Oklahoma State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A BUILDING _ B WING NH7219 05/26/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET PARKS EDGE NURSING AND REHABILITATION **TULSA, OK 74135** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) LL354 | Continued From page 1 LL354 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: 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.

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On 05/25/16 at 2:30 p.m., resident #7 was

D8RL11

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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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1 ' ′	E CONSTRUCTION		E SURVEY PLETED	
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LL354	most ADL's. On 05/25/16 at 10:1 offender registry chroffender registry chresident's status was on 05/25/16 at 10:3 when resident sex of She stated she did two days of a resident the BOM stated the sampled residents' could not say when completed.	uired limited assistance with a same, resident #16's sexeck was reviewed. The seeck, undated, documented is clear. 30 a.m., the BOM was asked offender checks were done the sex offender checks went's admission to the facilities were no dates for the sex offender checks so should be sexed the checks had been as a same and a.m., resident #16 was in the main lobby	ex I the ed e. ithin iity.			
LL803	The facility shall profollows: (3) Residents shall areas for cleaning a or any other danger substances. This Rule is not me Based on observation review, it was determined to the standard out of the standar	as evidenced by: on, interview, and record mined the facility failed to chemicals were secured an	les ble			

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STATE FORM

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION	COMPLETED		
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LL803	residents (#5 and #Findings: On 05/22/16 at 5:00 tour of the facility, the skilled 200 hall was key was observed he door. The hopper recontainer of Sani-Container was the opening of the owall. No residents was at the beginning station. All of the owere used for office On 05/22/16 at 5:28 there were any residents who wand of the facility. She is residents who wand of the facility. At 5:30 p.m., the Don was asked if she was asked if she was asked if she was asked if she was eating or drinking and. The DON was residents were safe	The facility identified two (15) who wandered. O p.m, during the entrance he hopper room door on the observed to be unlocked. A hanging on the wall next to the oom contained a one gallon are Lemon Quat disinfectant, open and had two tubes from container to a device on the were observed in the area, only had two residents who e room on this hall. Their room g of the hallway by the nurse's ther rooms on this hallway	LL803			

PRINTED: 06/15/2016 FORM APPROVED Oklahoma State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED. A BUILDING _ B WING NH7219 05/26/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5115 EAST 51ST STREET** PARKS EDGE NURSING AND REHABILITATION **TULSA, OK 74135** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) LL803 Continued From page 5 LL803 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

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observed in the area.

lock that stayed locked.

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

Oklahoma State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING _ B WING NH7219 05/26/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5115 EAST 51ST STREET** PARKS EDGE NURSING AND REHABILITATION **TULSA, OK 74135** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) LL835 310:675-9-6.1(d) RESTRAINTS FOR MEDICAL LL835 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 davs. (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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
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LL835	Continued From pa	age 7	LL835			
	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:					
	08/11/15, documen free. The policy do equipment and sup self releasing seat device, lap buddy, perimeter mattress also follow state represtraints in long te pre-restraint assess family consent must order must be obta would be complete. 1. Resident #3 was	sment must be completed, a st be signed, a physician's ined, and monthly charting d.				
	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/accider documented the refloor in her room, ly the bed. The report injury and neuro chreport documented to do hourly visual of A monthly physician 2015, documented	nt report, dated 08/27/15, sident had been found on the ring on her left side parallel to t documented there was no ecks had been started. The the follow up measures were checks times 14 days. n's order, dated November an order for 1/2 bed rails at the resident to turn and				

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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,

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wall. There was approximately 3 1/2 inches of space between the bed rail and the air mattress.

At 2.10 p.m., CNA #6 was asked if she knew why

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
1		NH7219	B WING		05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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	been told it was for She stated she was ever using the bed stated the resident care was being protente resident would tassistance. She stated several occasions apartially sitting up where the At 2:15 p.m., CNA the resident had a tout know why. She bed rails when she five months ago.	bed rail. She stated she had turning and repositioning. It is not aware of the resident rail to turn or reposition. She would not try to help when wided. CNA #6 was asked if try to get up without atted yes. She stated on she had found the resident with her legs hanging off the bed rail and the mattress. For was asked if she knew why bed rail. She stated she did stated the resident had the started working at the facility NA #7 was asked if the oget up without assistance.				
	She stated yes. She resident sitting on the her legs between the On 05/24/16 at 3:45 observed awake an remained at the cerwas asked if she usherself. She stated if she could transfer chair. She stated years and the could transfer chair. She stated years are stated years and the stated years are stated if she could transfer chair. She stated years are stated years and the stated years are stated in the stated years are stated years. An admission nursing documented the restransfers with the asymmetric member.	e stated she had found the ne side of the bed before with e rail and the mattress. 5 p.m., the resident was d lying in bed. The half rail ner of the bed. The resident sed the bed rail to help position no. The resident was asked herself from the bed to the es. as admitted to the facility iagnoses which included left				

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STATEMENT OF DEFICIENCIES (X1) PROVI

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		TULSA, C	K 74135		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETE HE APPROPRIATE DATE
LL835	Continued From pa	nge 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.				
	documented the re-	ent, dated 12/15/16, sident had a score of 7. A an 10 represented the resident 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.				
	documented the re- on the floor with his of the bed. The rep had stated he had g on the way back to the resident was dis- were no injuries no documented the fol provide a toileting s	at report, dated 01/08/16, sident had been found sitting to head resting against the foot cort documented the resident gone to the bathroom and fell bed. The report documented soriented at times and there ted from the fall. The report flow up interventions were to schedule times 14 days.			
	resident had fallen	in his room with no sustained plan documented a toileting			

Oklahoma State Department of Health

PRINTED: 06/15/2016 FORM APPROVED Oklahoma State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED. A BUILDING _ B WING NH7219 05/26/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5115 EAST 51ST STREET** PARKS EDGE NURSING AND REHABILITATION **TULSA, OK 74135** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) LL835 | Continued From page 12 LL835 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.

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dementia.

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

An incident/accident report, dated 05/09/15,

Oklahoma State Department of Health
STATEMENT OF DEFICIENCIES (X1) PROVID

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A BUILDING		COM	PLETED
		NH7219	B WING		05/	26/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS CITY	STATE, ZIP CODE		
		5115 FAS	ST 51ST STR			
PARKS	EDGE NURSING AND	REHABILITATION	OK 74135	· ·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
LL835	Continued From pa	nge 13	LL835		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	documented the reson the floor with he the resident had be	sident had been found sitting r wheelchair turned over and een unable to explain what port documented there were no				
	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.					
	documented the rescognitively, required	nent, dated 04/12/16, sident was severely impaired d extensive assistance of one ansfers, and had one				
	half bed rails times plan documented the related to injury as a	dated 04/13/16, documented two as ordered. The care ne resident was at risk for falls evidenced by previous falls, medication usage, and the use s.				
	A fall risk assessmented the res	ent, dated 04/13/16, sident was a high risk for falls.				
	A monthly physician	n's order, dated May 2016,				

PRINTED: 06/15/2016 FORM APPROVED Oklahoma State Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A BUILDING B WING NH7219 05/26/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5115 EAST 51ST STREET** PARKS EDGE NURSING AND REHABILITATION **TULSA, OK 74135** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) LL835 Continued From page 14 LL835 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.

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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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		NH7219	B WING		05/2	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PARKS I	EDGE NURSING AND	REHABILITATION 5115 EAS TULSA, O	T 51ST STR K 74135	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
LL835	Continued From page 15		LL835			
	 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.					
	documented an ord	e's order, dated May 2016, er for 1/2 bed rails times two ent to turn and reposition.				
	observed lying in be the bed rail up. The	5 a.m., the resident was ed with her eyes closed and be bed rail was in the middle of e at the head of the bed and				
		1 was asked why the resident stated to prevent the resident ed.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		NH7219		B WING		05/	26/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PARKS I	EDGE NURSING AND	REHABILITATION	5115 EAS TULSA, O	T 51ST STR	EET		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY	S FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMA	TION)	TAG	CROSS-REFERENCED TO 1 DEFICIENCE		DATE
LL835	Continued From page 16		LL835				
	had a bed rail. She from falling out of b would climb around	#8 was asked why the stated to keep the reed. She stated the retthe rail because the ransfer herself, but sl	esident esident resident				
	had bed rails. She rail to turn and repo asked if the residen use of bed rails. Shan assessment for	was asked why the stated the resident us sition herself. The Ret had an assessment as tated she had new bed rails. RN #2 was get out of bed with the	sed the RN was t for the ver seen s asked if				
		s admitted to the facil iagnoses which inclu e.					
,	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.						
,	documented the res	t report, dated 01/22/ sident had been found n with no sustained in	d lying on				
	documented the reson the floor of her robed. The report doc	t report, dated 01/26/sident had been found bom with her back agoumented the residence right side of her he been started.	d sitting gainst her l nt had				
	3:15 p.m., documer	t report, dated 02/09/ ited the resident had floor in her room. Th	been				

Oklahoma State Department of Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
	NH7219		B WING		05/2	26/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PARKS E	PARKS EDGE NURSING AND REHABILITATION 5115 EAS			EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
LL835	Continued From page 17		LL835			
	documented there	were no sustained injuries.				
	11:30 p.m., docume	nt report, dated 02/09/16 at ented the resident had been loor in her room on her back 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.					
	documented the res	ot report, dated 05/11/16, sident had been found bathroom floor. The report were no sustained injuries.				
	observed lying in be) p.m., the resident was ed watching TV. A half bed rail e middle of the bed, on each				
	why residents had a residents used the repositioning. The residents had been bed rails. She state assessments on the rails. The ADON was asked to the use the ADON was asked to the state of the use the ADON was asked to the test of the	30 a.m., the ADON was asked bed rails. She stated the bed rails for turning and ADON was asked if the assessed for the safe use of ed no, there were no e residents who used bed as asked if there were signed e of bed rails. She stated no ked how she determined if the is a safety hazard for a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		NH7219	B WING		05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PARKS I	EDGE NURSING AND	REHABILITATION 5115 EAS TULSA, O	T 51ST STR K 74135	EET		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
LL835	Continued From pa	ge 18	LL835			
	resident. She state	d, "I don't know."				
LL837	310:675-9-8.1(a) C	LINICAL LABORATORY	LL837			
	laboratory services The facility shall be and timeliness of th provides clinical lab shall meet the appli services furnished the facility provides services, it shall me	to meet the resident's needs. responsible for the quality e services. If the facility coratory services, the services cable conditions of the blood bank and transfusion set the applicable conditions oratories and hospitals.				
	review, it was deternicalibrate six of six grade FSBS checks. This four (#3, #8, #13, and residents who were ADON identified 30 facility who received A glucometer policy documented, " The out by the charge not shift The charge not check the log daily if not, the 7 - 3 char controls Please follows:	on, interview, and record mined the facility failed to ducometers used to obtain that the potential to affect and #16) of four sampled receiving FSBS checks. The residents who resided in the diffSBS checks. Findings:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
7412124	or contraction	IDENTIFICATION NOMBER	A BUILDING 		JOHN EETED	
		NH7219	B WING		05/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PARKS I	EDGE NURSING AND	REHABILITATION 5115 EAS TULSA, C	T 51ST STR K 74135	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
LL837	Continued From pa	age 19	LL837			
	glucometer calibrat	:55 a.m., the east hallway tion log, dated May 2016, s out of 96 opportunities for a				
	glucometer calibrat	00 a.m., the west hallway ion log, dated May 2016, s out of 96 opportunities for a				
	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.					
		s admitted to the facility on liagnoses 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.					
		5 a.m., the resident was ed with her eyes closed.				
		s admitted to the facility on liagnoses which included DM.				
	documented the rescognitively, required	ment, dated 04/12/16, sident was severely impaired d limited to moderate Ls, and had received an				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,		NH7219	B WING		05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PARKS I	EDGE NURSING AND	REHABILITATION 5115 EAS	T 51ST STR K 74135	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
LL837	Continued From pa	ge 20	LL837			
	insulin injection sev look back period.	en days out of the seven day				
ı		n's order, dated May 2016, ain a FSBS check before ne.				
		8 a.m., resident #8 was ed and covered with a blanket.				
		as admitted to the facility on iagnoses which included DM.	<u> </u> 			<u>. </u>
	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, documented to obta at bedtime.	dated May 2016, ain a FSBS before meals and				
		p.m., the resident was in his wheelchair in the lobby.			١	
		as admitted to the facility on iagnoses which included DM.				
	documented, the re cognitively, required ADLs, and received	ssment, dated 04/12/16, sident was severely impaired I limited assistance with most an insulin injection seven en day look back period.				
	A physician's order, documented an order, before meals and at	der to obtain FSBS checks				
	On 05/24/16 at 11:1	5 a.m., LPN #1 was asked				

PRINTED: 06/15/2016 **FORM APPROVED**

Oklahoma State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A BUILDING B WING_ NH7219 05/26/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET PARKS EDGE NURSING AND REHABILITATION TULSA, OK 74135 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) LL837 Continued From page 21 LL837 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - PARK S EDGE		(X3) DATE SURVEY COMPLETED		
		375351	B WING			05/	25/2016
	PROVIDER OR SUPPLIER EDGE NURSING AND	REHABILITATION CENTER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 115 EAST 51ST STREET ULSA, OK 74135	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K	000			:
K 029 SS=E	demonstrate non-co of Regulations, §48 The requirement is facility's failure to me Protection Associated K3 - Building - 010 K6 - Plan Approval K7 - Surveyed Under K8 - S/NF TYPE OF CONSTRISTORY all wood frame a complete automa NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 prothe approved automoption is used, the other spaces by sm doors. Doors are sefield-applied protect 48 inches from the permitted. 19.3.2 This STANDARD is Based on observated facility failed to mai and walls in a mann spread of smoke to fire. This practice of who currently reside by the administratory.	- Unknown er - 2000 Existing RUCTION: Type V (000), One e construction. The facility had itic sprinkler system. FETY CODE STANDARD construction (with o hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are 2.1 s not met as evidenced by: tion and staff interview, the ntain smoke resistant ceiling her that would retard the adjacent areas in the event of could affect 51 of 51 residents ed in the facility as identified r on 05/25/16. The facility had		029			
LABORATORY	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION - PARK S EDGE		E SURVEY IPLETED
		375351	B. WING			05/	25/2016
	PROVIDER OR SUPPLIER EDGE NURSING AND	REHABILITATION CENTER		511	EET ADDRESS, CITY, STATE, ZIP CODE 5 EAST 51ST STREET _SA, OK 74135	1 33	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 029	8:00 a.m. to 12:00 observations were a. The mechanical contained two gasheater. There was wall associated with b. The mechanical contained a gas-fire two unsealed peneronduit. c. The mechanical housekeeper close contained a gas-fire A piece of sheet rolleaving a hole exportained two gasheater. There was wall associated with 2. The maintenant during the entire to and acknowledged NFPA Standard: H safeguarded by a file	the facility on 05/25/16 from p.m., the following made: closet, located on 100 hall, fired furnaces and a hot water an unsealed penetration in the n a wire. closet, located on 200 hall, ed water heater. There were trations in the wall around the ton the rehabilitation wing, ed furnace and a water heater. ck had falling out of the ceiling used to the attic space above. closet, located on 500 hall, fired furnaces and a hot water an unsealed penetration in the	KC	129			
	sprinkler system, do positive latches. We used, the areas sha	oors shall have closer and /here the sprinkler option is all be separated from other esisting partitions and doors.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING 01 - PARK S EDGE	(X3) DATE SURVEY COMPLETED			
		375351	B. WING		05/25/2016			
NAME OF PROVIDER OR SUPPLIER PARKS EDGE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5115 EAST 51ST STREET TULSA, OK 74135				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLETION			
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