



Oklahoma State Department of Health
Creating a State of Health

December 30, 2019

License Number: AL5541

Mr. Greg Guyman, Administrator
Teal Creek Assisted Living & Memory Care
13501 N Bryant Ave
Edmond, OK 73013

RE: Survey Event ID: OPMV11

Dear Mr. Guyman:

On **October 17, 2019**, agents from our office concluded a State Licensure survey with complaints at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved

Board of Health

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compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,



 Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Teal Creek Assisted Living & Memory Care
Address: 13501 N Bryant Ave
City, State, Zip: Edmond, OK 73013
Provider #: AL5541
Complaint #: 54084
Investigation Date(s): 10/09/19, 10/10/19, 10/14/19 through 10/17/19

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to ensure proper water temperatures were available.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/09/2019 at 8:45 a.m.

A sample of enter number residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0701 for details.

An investigation specific to hot water temperatures was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script, reading "Melissa Swaim RN", is written over a horizontal line.

Melissa Swaim RN

Date report completed: 10/21/2019

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Teal Creek Assisted Living and Memory Care
Address: 13501 N Bryant Ave
City, State, Zip: Edmond, OK 73013
Provider #: AL5541
Complaint #: 54495
Investigation Date(s): 10/09/19, 10/10/19, 10/14/19 through 10/17/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care according to residents' contracts, and failed to notify families regarding changes in condition.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/09/2019 at 8:45 a.m.

A sample of 4 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1512, C1951 and C0522 for details.

An investigation specific to resident care, resident contracts and family notification of changes in resident conditions was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink that reads "Melissa Swaim RN". The signature is written in a cursive style and is positioned above the printed name.

Melissa Swaim RN

Date report completed: 10/23/2019

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Teal Creek Assisted Living & Memory Care
Address: 13501 N Bryant Ave
City, State, Zip: Edmond, OK 73013
Provider #: AL5541
Complaint #: 54501
Investigation Date(s): 10/09/19, 10/10/19, 10/14/19 through 10/17/19

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered by qualified staff.	US

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/09/2019 at 8:45 a.m.

A sample of 4 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to insulin administration was conducted.

On 10/14/19 insulin dependent resident records were reviewed. One resident listed in the complaint was not diagnosed as an insulin dependent diabetic. There was no documentation about finger-stick blood sugars (FSBS) or insulin administration injections on the electronic medication administration record (eMAR) completed by the staff member mentioned in the complaint.

On 10/15/19 two different medication administration technicians (MATs) were asked separately about FSBS and insulin administration. They both stated they were not allowed to perform FSBS or administer insulin injections.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation 1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, reading "Melissa Swaim RN", is written over a horizontal line.

Melissa Swaim RN

Date report completed: 10/23/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/17/2019
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY C.			STREET ADDRESS, CITY, STATE, ZIP CODE 13501 N BRYANT AVE EDMOND, OK 73013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments A re-licensure survey was conducted 10/09/19, 10/10/19, and 10/14/19 through 10/17/19. Complaints OK00054084, OK00054495, and OK00054501 were investigated in conjunction with this survey. Resident census was 65. The following deficient practices were cited.	N 000			
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure long term care aides (LTCA) had annual performance/skills completed by a nurse for 4 (#3, 4, 8 and #12) of 8 employees who had been employed for more than a year. This failed practice resulted in the potential of more than minimal harm at a pattern. Findings:	N1105			

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/17/2019
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N1105	Continued From page 1 On 10/10/19 at 3:23 p.m., LTCA/certified medication aide (CMA)/employee #8 was asked if an annual performance review was completed to evaluate her LTCA skills. LTCA/CMA/employee #8 stated a licensed nurse did not observe the performance of her skills. At 3:45 p.m. LTCA/employee #4 was asked if an annual performance review was completed to evaluate her LTCA skills. She stated a licensed nurse did not observe the performance of her skills. At 4:00 p.m. LTCA/CMA/employee #3 was asked if an annual performance review was completed to evaluate her skills. She stated a licensed nurse did not observe the performance of her skills. On 10/14/19 at 4:00 p.m., licensed practical nurse/director of nursing (LPN/DON) stated the signature on all of the nurse aide skills performance checklists were hers and not the employees. The LPN/DON had not observed the annual LTCA's skills review for employee #3, 4, 8, or #12.	N1105			
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance	N1442			

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N1442	Continued From page 2 competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a nurse had reviewed: a. Certified medication aide (CMA) skills for 4 (#3, 6, 8, and #14) of 8 CMA's were validated prior to administering medication; and b. CMA annual performance reviews were completed for 2 (#3 and #8) of 3 sampled CMAs who had been employed for more than a year. These failed practices resulted in the potential for more than minimal harm at a pattern. Findings: On 10/10/19 at 3:23 p.m., long term care aide/certified medication aide (LTCA/CMA)/employee #8 was asked if an annual performance review or skill validation was completed on her before she administered medications. She stated a couple of weeks after employed another CMA observed her performance of some medication administration skills. At 3:45 p.m., LTCA/CMA/employee #3 was asked if an annual performance review or skill validation was completed on her before she administered medications. She stated no nurse or staff member observed her performance of skills or had evaluated her prior to her first medication administration or performance of medication administration annually.	N1442			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/17/2019
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY C.			STREET ADDRESS, CITY, STATE, ZIP CODE 13501 N BRYANT AVE EDMOND, OK 73013		
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N1442	Continued From page 3 On 10/14/19 at 9:27 a.m., LTC/CMA/employee #6 was asked a skill validation was completed on her prior to her first medication administration. She stated no nurse or staff member observed her performance of skills upon hire or had evaluated her performance of medication administration since. At 10:30 a.m., there was no annual medication administration performance review or skills validation for employee #14. At 4:00 p.m., licensed practical nurse/director of nursing (LPN/DON) stated the signature on all of the certified medication aide skills performance checklists were hers on the employee signature lines and not the employees' signatures. She further stated the new CMAs were trained by other CMAs on the center's electronic medication administration record.	N1442			
C 000	INITIAL COMMENTS A re-licensure survey was conducted 10/09/19, 10/10/19, and 10/14/19 through 10/17/19. Complaints OK00054084, OK00054495, and OK00054501 were investigated in conjunction with this survey. Resident census was 65. The following deficient practices were cited.	C 000			
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter;	C 522			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/17/2019
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C 522	Continued From page 4 and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure: a. A significant change assessment was completed promptly after a change in the resident's condition for 3 (#8, 15 and #16) of 10 sampled residents which affected more than one area of the residents' health status; and b. An annual comprehensive assessment was completed for 1 (#17) of 11 sampled residents. This failed practice resulted in actual harm at a pattern. Findings: RESIDENT #8 Resident #8 moved into the center on 08/16/18 with diagnoses that included cellulitis of his right leg, ecchymosis, and gout. On 03/26/19, resident #8 admitted to a rehabilitation facility for treatment of his dislocated right hip/right femur fracture repair. The home health certification period and plan of care was documented to be from 05/20/19 to 07/18/19 with diagnoses to include include a displaced intertrochanter closed fracture right femur, unstageable bilateral pressure ulcers to both heels, and generalized muscle weakness. A progress note for resident #8, dated 07/21/19, documented he declined after returning in May	C 522			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/17/2019
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C 522	Continued From page 5 2019. Employee #10 stated resident #8 declined after returning in May from his dislocated hip/fractured femur repair and was unable to stand and required a two-person assist for transfers, assistance with mobility, assistance with toileting, and a decline with mentation. The home health plan of care for resident #8, dated 07/23/19, documented the primary diagnosis as a stage III pressure ulcer of the right heel. The secondary diagnoses to include cellulitis of the right lower limb, a stage III pressure ulcer of the left heel, cellulitis of the left lower limb, a non-pressure chronic ulcer on other part of left foot with unspecified severity, and a methicillin susceptible Staphylococcus wound infection. On 10/15/19, at 1:25 p.m., the LPN stated there was no significant change assessment completed for resident #8 and no complete comprehensive assessment in the center for resident #8. On 10/16/19, at 1:10 p.m., employee #10 stated resident #8 declined after returning in May from his dislocated hip/fractured femur repair and was unable to stand and required a two-person assist for transfers, assistance with mobility, assistance with toileting, and a decline with mentation. RESIDENT #15 Resident #15 moved into the center 05/01/18 with diagnoses to include dementia with Lewy body, Parkinson's disease, Alzheimer's disease, and type 2 diabetes. A progress note for resident #15, dated 01/23/19, documented the resident had returned from the hospital.	C 522			

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C 522	Continued From page 6 The progress note, dated 02/19/19, documented the resident was discharged from speech therapy and hospice services were reinstated after an attempt to help him regain swallowing strength and tone. The progress note, dated 03/22/19, documented a recent weight change related to his decline after a hospital stay and diet change to nectar thick liquids/puree diet. A physicians home health note resident #15, dated 07/24/19, documented the resident had a significant decline in regards to his dementia, Parkinsonism, and overall well-being. RESIDENT #16 Resident #16 moved into the center 06/17/19 with diagnoses to include dementia with behaviors, anxiety and hypertension. A physician's progress note for resident #16, dated 09/05/19, documented, continue with nursing and staff involvement for hydration and assistance with personal care. A progress note, dated 09/21/19, documented a large fluid filled blister to the right heel. On 10/15/19 at 3:24 p.m. a long term care aide stated resident #16 declined over the last couple of months from walking to a wheelchair (self propel) to staff assist with wheelchair. The decline affected their ability to bear weight, mobility, and toileting. The resident required 2 person assist with transfers and toileting. At 3:52 p.m., the LPN/DON stated significant change assessments had not been completed for	C 522			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/17/2019
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C 522	Continued From page 7 residents #8, 15, and #16. RESIDENT #17 Resident #17 moved into the center 07/20/18 with diagnoses that included glaucoma and chronic kidney disease. There was no annual comprehensive assessment for resident #17. On 10/15/19 at 3:47 p.m., the LPN/DON stated resident #17's annual comprehensive assessment had not been completed, was not in the computer, nor in resident #17's chart.	C 522			
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure comprehensive assessments were signed by the resident or residents' representative and registered nurse for 8 (#1 through #8) of 8 sampled residents. This failed practice had the widespread potential for more than minimal harm. Findings: Residents #1 through #8 comprehensive assessments did not contain a signature to	C 543			

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C 543	Continued From page 8 indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 10/17/19 at 11: 31 a.m. the licensed practical nurse/director of nursing stated they did not print out assessments for signatures.	C 543			
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to provide hot water to their residents for bathing for 2 (#11 and #17) of 10 sampled residents who relied on the centers hot water temperatures to take a hot shower. This failed practice resulted in the potential of more than minimal harm at a pattern. Findings: Temperature logs for resident rooms throughout the center documented: June 2019 hot water temperatures ranged from	C 701			

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NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY C.			STREET ADDRESS, CITY, STATE, ZIP CODE 13501 N BRYANT AVE EDMOND, OK 73013		
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C 701	Continued From page 9 100 degrees Fahrenheit (F) to 104.2 degrees F; and July 2019 hot water temperatures ranged from 100 degrees F to 105 degrees F. An invoice, dated 07/16/19, documented an inspection for a hot water tank for error codes and snaked room, and a blower motor kit. August 2019 hot water temperature logs ranged from 98 degrees F to 103.1 degrees F; September 2019 hot water temperature logs ranged from 104.2 degrees F to 111.3 degrees F. On 10/10/19 at 10:26 a.m., hot water temperatures were obtained throughout the center with the attendance of the administrator. The hot water ranged from 101.1 degrees F to 106.1 degrees F. At 10:45 a.m., the administrator stated it was their goal for hot water temperatures to be 110 degrees F. On 10/14/19 at 11:00 a.m., a resident was asked about complaints or concerns. The resident stated the water never got hot and had to turn the heater all the way up to take a shower. The resident stated the center had been informed, but was only told the water heater was on the opposite side of the building. Their hot water temperature was 97 degrees F. Another resident had complained to the center about not having hot water for shower/bathing. They were told to run the hot water for 15 minutes prior to shower, but the water still failed to get hot.	C 701			

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C 701	Continued From page 10 An undated Resident Bill of Rights documented the resident had the right to exercise individual rights that do not infringe upon the rights or safety of others, to voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of retaliation and to have a safe and homelike environment.	C 701			
C 911 SS=H	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure nurse supervision and intervention was provided for 3 (#8, #15, #16) of 4 residents with current skin breakdown. The center failed to assess residents and their wounds; develop care plan interventions and implement the interventions; and evaluate the care plan interventions for effectiveness. This deficient practice resulted in actual harm at a pattern. Findings: RESIDENT #8	C 911			



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C 911	Continued From page 12 The center provided no progress notes or any documentation for the period 05/20/19 through 07/15/19 assessing resident #8's pressure ulcers, treatment of wounds or response to treatment. There was no indication a licensed nurse from the center observed, monitored, or participated in the care of resident #8's wounds. On 06/13/19, the care plan for resident #8 was revised and documented the resident would maintain independence for toileting and dressing and continue to be mobile with a walker. Resident #8 actually required assistance with toileting, dressing, transfers and was mobile only by wheelchair. A progress noted dated 7/21/19 documented the "resident now unable to stand and requires 2 person assist for transfers. This decline was not addressed on the center's plan of care. On 06/14/19, a wound care clinic consultation note documented resident #8 had two unstageable full-thickness pressure wounds (right and left heel) with eschar present, and also one full-thickness pressure wound to left heel. On 07/15/19, a home health note documented resident #8 was found to be unresponsive, his breathing pattern remarkably changed, with an odor from the lower extremity wounds. The LPN was notified that resident #8 was lethargic and hard to arouse. There was no documentation the LPN or RN assessed the resident or that staff had identified an odor and notified the nurse. On 07/15/19, resident #8 was transported to the hospital for mental status changes and concern specific to odor of the wounds. The resident's mental status had declined from "fairly sharp" to confused.	C 911			

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C 911	Continued From page 13 On 07/21/19, resident #8 was readmitted to the center. On 07/23/19, the home health plan of care documented resident #8 had a stage 3 pressure ulcer of right heel; a stage 3 pressure ulcer of left heel; cellulitis of right lower limb, cellulitis of left lower limb, non-pressure chronic ulcer of left foot with unspecified severity and Methicillin susceptible staphylococcus wound infection. The home health plan of care for the certification period 07/23/19 to 09/20/19 documented resident #8 was to focus on energy conserving measures including frequent rest periods, small frequent meals, avoid large meals/overeating and controlling stress. The resident was to elevate feet above level of the heart as frequently as possible and avoid added sodium. None of these interventions were included on the center's plan of care and there was no plan of care specific to prevention of skin breakdown or treatment of developed wounds. On 9/21/19, a home health note documented resident #8 had developed a new wound described as "a stage III." The wound was identified on the right lateral malleolous, a venous ulcer, open, full thickness with a musty odor, measuring 1.2 centimeters (cm) x 1.8 cm x 0.5 cm, and a large amount of serosanguineous drainage. At this point, resident #8 had existing wounds that were not healing and a new wound was identified. On 10/15/19, at 6:02 p.m., the LPN/DON stated she last observed the wounds on 10/14/19 and stated the wounds were to the residents bilateral heels. The LPN/DON stated the resident had no other wounds, which was not accurate. The	C 911			

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C 911	Continued From page 14 resident had a new wound on the right lateral malleolous. The LPN/DON stated she could not describe the pressure wounds because she was not assessing or documenting them clinically when observing them. The LPN/DON provided no documentation the resident's wounds were being assessed and monitored for response to treatment. There was no documentation of the size or status of the wounds. The LPN/DON stated the resident did not have a special mattress to decrease pressure, bed rails were not padded and no heel boots were provided to reduce pressure on the resident's heels. The LPN/DON stated she was not aware there were three guardrails on resident #8's bed. The LPN/DON also stated there were no assessments or accurate care plan available for resident #8. On 05/20/19, the home health plan documented the resident was to "float heels." On 06/20/19 and 6/28/19, the wound care clinic ordered resident to have heel lift boots for bilateral heels. On 10/16/19 at 11:00a.m., resident #8 was observed to have 3 guardrails present on the bed, there was no padding observed, no pressure reducing mattress was on the bed and the resident was observed to not have on heel boots or have heels elevated off the foot rest while sitting up in the recliner. The use of bedrails was not included on the center's plan of care. At 11:07 a.m., an observation of resident #8's right lateral ankle was made. The wound had a tan wound bed, was approximately 1 inch by 1 inch, with a moderate amount of serosanguineous drainage. A wound to the right heel was observed and had a tan and black wound bed, was approximately 4 inches by 2	C 911			

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C 911	Continued From page 15 inches, and had a moderate amount of serous drainage. The home health nurse was present and stated there was an approximately 2 inch by 2 inch wound to the left heel with a tan wound bed with a moderate amount of serosanguineous drainage under a dressing. The home health nurse stated the right lateral ankle wound seemed necrotic and did not appear to be healing. At 1:16 p.m., employee #10 stated resident #8 declined after returning to the center in May (05/20/19) from his dislocated hip/fractured femur/repair and was unable to stand, required a two-person assist for transfers, assistance with mobility and toileting, and had a decline with mentation. At 1:25 p.m., the LPN stated there was no significant change assessment completed since the resident returned to the center after he broke his hip. No documentation was provided by the center that the resident was being assessed or monitored or that treatments performed by home health were being provided as ordered. There was no documentation that interventions were provided by the center to facilitate healing or the physician was notified when new wounds were identified and current wounds were not responding to treatment. The only nurses note provided by the center that identified the resident had wounds was a progress note dated 5/29/19 identifying a wound care clinic would be providing care. On 07/21/19, the center documented the resident had a "dressing to foot" and on 10/04/19, the center documented "resident has pressure wounds on bilateral heels..."	C 911			

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C 911	Continued From page 16 RESIDENT #15 On 05/01/18, Resident #15 was admitted to the center with diagnoses to include dementia with Lewy body, Parkinson's disease, Alzheimer's disease, and type 2 diabetes. The resident did not have an annual comprehensive assessment. One was started but was 95% incomplete. A Care Plan, dated 05/14/19, documented the resident required assistance of one staff for weight bearing or balance assistance. The care plan identified a mechanical lift was used to help with transfers, but staff stated they hadn't been able to use the mechanical lift. On 05/14/19, the care plan was revised and documented the resident was mobile in a wheelchair. However, the resident was observed in a broda chair and could not move freely on their own. The care plan documented during activities of daily living (ADLs) the resident needed weight-bearing or balance assistance from one associate. On 08/06/19, a hospice care plan documented the resident had a wound to the sacrum. On 09/03/19, the hospice care plan documented a stage II pressure ulcer to the resident's sacrum. On 10/15/19, the center provided no documentation of wound assessments, treatments or response to treatment. The center did not have a care plan addressing residents increased need for assistance with ADL's or the pressure ulcer on the resident's sacrum. On 10/15/19, at 4:21p.m., LPN #2 stated it took two people to safely assist the resident with ADL's	C 911			

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C 911	Continued From page 17 and the resident was observed being transferred with two staff. A hospice care plan, dated 08/06/19, documented the resident had a wound to the sacrum. A hospice care plan, dated 09/03/19, documented an alteration in skin integrity: sacrum-stage 2 pressure ulceration. The center did not provide any documentation addressing resident #15's pressure wounds. RESIDENT #16 On 06/17/19, Resident #16 was admitted to the center with diagnoses to include dementia with behaviors, anxiety and hypertension. The resident had edema to the lower extremities. The resident did not have wounds/pressure ulcers on admission. Resident #16 required assistance from staff with toileting, transfers, incontinent care and bathing, but the only assessment available was the admission assessment dated 06/17/19, which was incomplete and a care plan dated 09/27/19. No weights were documented on the assessment. The resident had become dependent on staff for toileting (was no longer independent), was incontinent of both bowel and bladder and required staff assistance for all transfers. The physicians progress notes, dated 08/08/19 and 09/05/19, documented, "...see detailed skin report in chart...continue with nursing and staff involvement for hydration and assistance with personal care..." The nurse was not able to provide any detailed skin reports from the chart.	C 911			

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C 911	Continued From page 18 The nurse was not able to provide any more current documentation from the physician. On 09/14/19, a physicians order documented the center to obtain blood labwork a CBC (a complete blood count) and the order was STAT (urgent, rush, immediately) due to the residents altered mental status. The LPN had no documentation about the resident for the date. The labwork was not completed STAT. The laboratory documented the collection date 09/16/19 and received date 09/16/19. On 9/21/19, a progress note documented a large, draining, fluid filled blister to the resident's right heel. On 09/21/19, the physician ordered a wound treatment for the right outer heal. The treatment was to be completed every day and as needed until healed. Staff documented the resident continued to have skin problems with the heels. On 9/21/19, a progress note documented a large, draining, fluid filled blister to the resident's right heel. On 09/21/19, the physician ordered a wound treatment for the right outer heel. The treatment was to be completed every day and as needed until healed. On 10/04/19, a progress note documented staff reported resident #16 had a "red discoloration and darkened area inside crack of the buttocks." On 10/04/19, the physician ordered "home health to evaluate and treat if indicated for wound care ..." On 10/04/19, a home health care plan	C 911			

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C 911	Continued From page 19 documented the resident was disoriented and lethargic. Diagnoses included a pressure ulcer of contiguous site of back, buttock and hip, unstageable. The wound to the coccyx was documented to have a bed of eschar surrounded by excoriation and bruising. The plan documented a strong recommendation was given to the daughter to get the resident to the wound clinic ASAP (as soon as possible.) Functional limitations included incontinence of both bowel and bladder, endurance, ambulation and dyspnea with minima exertion. The resident was unable to ambulate and at risk for infection due to open wounds. The resident had 2+ pitting edema bilateral lower extremities. On 10/06/19 at 12:04 p.m. the home health registered nurse noted a strong odor and large amount of tan drainage from the wound. On 10/07/19 at 1:014 p.m. during a home health visit, the LPN documented, the resident's oxygen levels dipped into the 80's while the resident was asleep. The home health LPN had two staff turn the resident with a moderate amount of urine in her depends. The wound on the buttocks had a very strong odor. Due to the severity of the wound the home health LPN wanted the resident sent to the emergency room, but LPN #1 stated the resident would go to the wound clinic the next day if there was a cancellation. On 10/07/19, a physician order documented the resident was unable to reposition self due to increased pain to bilateral heels and buttocks. The resident had unstageable pressure ulcer to buttocks and shearing wound to right heel due to inability to transfer self. On 10/08/19, Resident #16 was complaining of	C 911			

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C 911	Continued From page 20 pain. The right ankle wound measured 4 x 4 x 0.1cm. The buttocks pressure ulcer measured 5 x 3 x 3.5cm. and was noted with large amounts of yellow exudate and maceration surround the skin. The wound also had a strong odor. Lab results identified bacterial contamination. The resident was transported to the hospital and admitted for intravenous antibiotics for a wound infection and a blood transfusion for a "very large unstageable decubitus ulcer to coccyx." On 10/15/19 at 3:24 p.m. a long term care aide stated resident #16 declined over the last couple of months from walking to independent use of a wheelchair to requiring staff assistance with wheelchair. The resident had declined from being able to stand and bear weight and toilet self to being only able to bear weight (no endurance) and transfer with 2 staff assistance. The resident was now incontinent of bowel and bladder, required assistance to eat and was bed bound. The center was unable to provide any documentation of resident #16 being assessed and monitored by the centers RN and the care plan did not include interventions being implemented to prevent skin breakdown and facilitate healing of current wound. At 3:52 p.m., the LPN/DON stated significant change assessments had not been completed for residents #8, 15, and #16. There was no documentation provided the RN or either licensed practical nurse (LPN) completed assessments, made observations, monitored implementation of interventions or provided interventions to prevent resident wounds. At 2:08 p.m. the LPN/DON was asked how the care staff were notified of resident changes to	C 911			

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C 911	Continued From page 21 provide care. She provided no documentation, to include care plans, for the care staff to review. The LPN/DON was asked for what the residents' care plan was used. She stated no care plans were printed out for staff to review or use for the care of the residents, she did not update care plans, but deferred to the RN to update the care plans. No care plans were found to be updated or accurately documented the residents' current conditions.	C 911			
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505			

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C1505	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure physician's ordered blood glucose finger stick (FSBS) monitoring and insulin was administered according to the physician's order for 2 (#15 and #18) of 2 sampled residents with a diagnosis of insulin dependent diabetes. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #15 The resident admitted to the center 05/01/18 with diagnoses that included type 2 diabetes mellitus with insulin dependence, and Lewy body dementia. A care plan dated 05/15/18 documented medication interventions to include: ordering and coordinating medications, staff attention while taking medications, physical assistance with taking medications. Review of the September and October 2019 medication administration records (MAR) for resident #15, identified Levemir 10 units were to be administered subcutaneous one time each day at 12:00 p.m. (noon). Finger stick blood sugars (FSBS) were to be completed one time a day at 12:00 p.m. (noon). There was a total of 9 out of 37 days in September and October 2019 where FSBS readings were not documented. The center could not provide documentation that FSBS were performed on the following dates: 09/05/19, 09/09/19, 09/10/19, 09/11/19, 09/12/19, 09/16/19,	C1505		

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NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY C.		STREET ADDRESS, CITY, STATE, ZIP CODE 13501 N BRYANT AVE EDMOND, OK 73013		
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C1505	Continued From page 23 09/17/19, 10/03/19 and 10/07/19. Based on review of the MAR's, during September and October 2019 resident #15 was not administered insulin on the following dates: 09/01/19, 09/05/19, 09/09/19, 09/10/19, 09/11/19, 09/12/19, 09/14/19, 09/16/19, 09/17/19, 10/03/19 and 10/07/19. RESIDENT #18 Resident #18 moved into the center on 06/04/19 with diagnoses that included type 2 diabetes mellitus with hyperglycemia. A care plan for resident #18, dated 06/04/19, documented medication interventions were the resident was to be supported to take all medications safely and as ordered including; ordering and coordinating medications, storage of medications, required daily supervision of medications, supervise/perform blood sugar monitoring three or more times per week, and administration of insulin injections. Resident #18's service agreement included medication administration by a licensed nurse or certified medication aide. A physician's order for resident #18, dated 07/05/19, documented Lantus SoloStar Pen-Injector (used to treat high blood sugar) 100 Units/ML (milliliter) should be administered two times a day. The September 2019 MAR for resident #18 documented the resident was not administered physician ordered insulin 12 of 34 days on the following dates: 09/02/19 p.m., 09/04/19 p.m., 09/05/19, 09/08/19, 09/09/19, 09/12/19, 09/16/19,	C1505		

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C1505	Continued From page 24 09/17/19, 09/18/19, 09/20/19, 09/26/19; and 09/30/19. The October 2019 MAR for resident #18 documented the resident was not administered physician ordered insulin 5 of 8 days on the following dates: 10/03/19, 10/04/19, 10/05/19, 10/06/19; and 10/08/19. On 10/15/19 at 3:21 p.m., the LPN/DON stated she failed to obtain an order for parameters indicating when to notify the physician if the residents blood sugar glucose levels were greater than or less than a specified blood sugar level reading. There was no documentation provided by the center indicating the LPN/DON had communicated to the physician about emergent blood sugar glucose levels/FSBS of for resident #18. On 10/15/19 at The LPN/DON stated there were no hemoglobin A1C (blood sugar laboratory testing) levels for the insulin dependent diabetic residents requested by the center to evaluate the residents' diabetic management in order to monitor if residents were demonstrating stable diabetes. The LPN/DON stated she had failed to request an order for A1C testing. There was no documentation provided by the center for the missing FSBS, or documentation of why the insulin was not administered according to the doctors' orders the missing insulin administrations POLICY A medication administration policy, dated 01/11/17, documented services being provided meet professional standard of quality and are provided by appropriate qualified persons. The	C1505		

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C1505	Continued From page 25 center maintains the clinical records, including medication and treatment administration, in accordance with accepted professional standards and practices that are complete, accurately documented and readily accessible. The designee will ensure that all licensed nurses/medication trained nursing assistants document the administration of all treatments and/or medications.	C1505			
C1512 SS=H	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;	C1512			

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C1512	Continued From page 26 Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center neglected to provide care and prevent skin breakdown for 1 (#16) of 1 sampled resident who was dependent on the staff for all activities of daily living. This failed practice resulted in actual harm at a pattern. Findings: RESIDENT #16 Resident #16 developed wounds at the center. The resident had hypertension and edema to bilateral lower extremities.	C1512		

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C1512	Continued From page 27 Resident #16 moved into the center on 06/17/19 with diagnoses that included dementia with behaviors, anxiety, and hypertension (HTN). The resident was transferred to memory care within the first 24 hours of her stay due to the resident removed a Wander guard from her wrist and was exit seeking. The resident's assessment and care plan were not updated and accurate with interventions upon her transfer to the memory care unit. A comprehensive assessment for resident #16, dated 06/18/19, documented she was alert and oriented to self and was forgetful with poor judgement; The resident could ambulate well, without assistance, without a device, good strength, good gait, and was weight bearing with full range of motion; The resident required a one person assist with bathing and dressing; The resident was independent with eating, was independent toileting, with bladder incontinence at times and was continent of bowel; The resident preferred a shower and had good ability to communicate; The resident had a history of abnormal behaviors which included agitation, aggressiveness, and elopement risk; The resident had good skin with good turgor; and Skin was clean, dry and intact. There was no significant change assessment available for resident #16. The center's staff was responsible for resident #16's care. She was to receive a shower every Tuesday, Thursday, and Saturday; three times a week by the center's staff.	C1512		

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C1512	Continued From page 28 In the month of September 2019, the resident missed 6 showers (from 09/10/19 to 09/30/19), and there was no documentation provided prior to 09/09/19. In the month of October 2019, the resident missed 2 showers, and was hospitalized on 10/08/19. The staff were required to clean rooms, shower residents, provide toileting, incontinent care, turn residents, provide activities, dress and change residents, go to the dining room to retrieve trays; otherwise, they served residents in the main dining room, fed residents, passed medications, cleaned Broda chairs, wheelchairs, walkers, canes. The shower sheet documentation provided only indicated whether a shower was provided or not; and no notations were made by the long term aides about what they saw or reported to the licensed practical nurse/director of nursing (LPN/DON), except for their phone/text messages, and there was no follow up documentation made by the LPN/DON. The LPN/DON had no documentation about the residents skin. The LPN/DON stated she had not followed up until the residents family and staff complained 10/03/19. During an interview, she described what she saw and smelled, but failed to document an assessment with measurements and condition of wound or document any findings. A physician's progress note for resident #16, dated 08/08/19 and 09/05/19, documented the resident was there for care due to an inability to care for herself independently. The physician documented, "See detailed skin report in chart." The physician documented, "continue with	C1512			

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C1512	Continued From page 29 nursing and staff involvement for hydration and assistance with personal care." There were no skin reports provided by the center. The nurse was not able to provide any detailed skin reports from the chart. The nurse was not able to provide more current documentation from the physician. A physicians order, dated 09/14/19, documented the center to obtain blood labwork a CBC (a complete blood count.) The order was to be completed STAT (urgent, rush, immediately) due to the residents altered mental status. The LPN had no documentation about the resident on the initial date of altered mental status. The labwork was not completed STAT. The laboratory documented the collection date 09/16/19 and received date 09/16/19. The physician's orders for lab was not completed "STAT." During the time the resident had become lethargic, the staff was not providing the care required to care for the residents decline and increased needs and dependence on staff. A progress note, dated 09/21/19, documented a large, draining, fluid filled blister to the right heel. A physician's order, dated 09/21/19, documented, "...cleanse area to right outer heel with normal saline, pat dry, apply triple antibiotic ointment, cover with non-stick pad and wrap with kerlix every day and as needed until healed. An incident report, dated 09/28/19, documented the resident was sitting in a wheelchair in the dining room in the memory care and stood up and fell to the ground sitting on buttocks. There was no assessment documented by a nurse and LPN#2 stated she did not observe the residents	C1512		

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C1512	Continued From page 30 bottom. A progress note, dated 10/04/19 (sic), documented staff reported resident bottom with red discoloration and darkened area inside crack of the buttocks. A physician order, dated 10/04/19, documented, "...home health to evaluate and treat if indicated for wound care..." A home health care plan (485), dated 10/04/19, documented, the resident was disoriented and lethargic (her baseline per center staff) but will follow basic instructions. Diagnoses included pressure ulcer of contiguous site of back, buttock and hip, unstageable. The wound to coccyx had a bed of eschar surrounded by excoriation, bruising and blanchable redness. A strong recommendation was given to the daughter to get the resident to the wound clinic ASAP (as soon as possible.) Functional limitations included incontinence of both bowel and bladder, endurance, ambulation (non-ambulatory) and dyspnea (shortness of breath) with minimal exertion. The resident was unable to ambulate and at risk for infection due to open wounds. The resident had 2+ pitting edema bilateral lower extremities. The resident was total care; depended entirely on another person for grooming, dressing, toileting, bathing; the resident was unable to transfer self and was unable to bear weight or pivot when transferred by another person; the resident was chairfast, not able to to ambulate and was unable to wheel self. The resident was unable to feed self and must be assisted or supervised throughout meal/snack. The resident demonstrated nonverbal pain; guarding and	C1512			