

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER Bartlesville Health and Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 3434 Kentucky Place Bartlesville, OK 74006	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to implement their abuse policy for screening potential employees for the prevention of abuse for three (CNA #1, CNA #7, and LPN #3) of five sampled personnel files reviewed.</p> <p>The administrator identified 64 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy and procedure titled Abuse, Neglect, and Exploitation, dated 10/2022, read in part, .Abuse prevention activities for the prevention of resident abuse .screening of potential employees .</p> <p>1. A Provisional Employment Form and Consent and Release Form, dated 09/27/23, documented CNA #1 affirmed the condition for provisional employment related to a background check.</p> <p>An undated background summary, documented CNA #1 was eligible for employment.</p> <p>There was no documentation when CNA #1 was hired, registry checks were completed, and CNA #1 enrolled for criminal history monitoring under the facility.</p> <p>2. A Provisional Employment Form and Consent and Release Form, dated 11/02/23, documented CNA #7 affirmed the condition for provisional employment related to a background check.</p> <p>An undated background summary, documented CNA #7 was eligible for employment.</p> <p>An employee roster, dated 03/04/24, documented CNA #7 was hired on 11/02/23.</p> <p>There was no documentation when CNA #7 was hired, registry checks were completed and CNA #7 enrolled for criminal history monitoring under the facility.</p> <p>3. A Provisional Employment Form and Consent and Release Form, dated 10/17/23, documented LPN #3 affirmed the condition for provisional employment related to a background check.</p> <p>An undated background summary, documented LPN #3 was eligible for employment.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An employee roster, dated 03/04/24, documented LPN #3 was hired on 10/16/23.</p> <p>There was no documentation registry checks were completed and LPN #3 enrolled for criminal history monitoring under the facility.</p> <p>On 03/06/24 at 9:32 a.m., the administrative assistant was asked about the background checks for CNA #1, CNA #7, and LPN #3. They stated after they received their provisional employment forms and consent to release forms they entered their basic information into the background check system. They stated the system indicated they were eligible for employment so there were no further searches conducted. They stated new registry checks were not completed and the employees were not enrolled for criminal history monitoring with the facility.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to OSDH no later than two hours after the allegation was made for one (#1) of three sampled residents reviewed for abuse.</p> <p>The administrator identified 64 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy and procedure titled Abuse, Neglect, and Exploitation, dated 10/2022, read in part, .Facility reporting .The facility will immediately report all alleged violations involving .abuse .as required by State law . Immediately .within two hours of occurrence .</p> <p>Res #1 had diagnoses which included vascular dementia, communication deficit, history of falls with injury, and cerebellar stroke syndrome.</p> <p>OSDH incident report forms, incident date 02/28/24, documented intital reports of an abuse allegation for Res #1 were made to OSDH on 02/29/24 at 12:32 p.m. and 1:01 p.m. It was documented suspected abuse by CNA #1 was visualized on a video monitoring device in Res #1's room on 02/28/24 at 3:30 a.m. It was documented LPN #3 reported the video appeared to show CNA #1 physically restraining Res #1. It was documented LPN #3 reported the incident to the ADON and was advised to meet the ADON on 02/29/24 at 7:00 a.m. to review the footage. It was documented the ADON reported the incident to the DON on 02/29/24 at 9:30 a.m. It was documented the video footage was reviewed by the DON and the administrator and the police department was called. It was documented Res #1 was assessed by the DON and the ADON for injuries. It was documented no injuries were noted. It was documented CNA #1 was placed on suspension pending further investigation.</p> <p>There was no documentation the initial incident report was reported to OSDH no later than two hours after the allegation was made.</p> <p>On 03/04/24 at 3:37 p.m., the DON was asked what was the protocol for reporting allegations of abuse. They stated they had two hours total to report the incident. They were asked when the initial incident report for Res #1 was submitted to OSDH. They stated the report was not submitted no later than two hours after the incident.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>33148</p> <p>Based on record review and interview, the facility failed to ensure allegations of abuse were thoroughly investigated for two (#1 and #2) of three sampled residents reviewed for abuse.</p> <p>The administrator identified 64 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy and procedure titled Abuse, Neglect, and Exploitation, dated 10/2022, read in part, .Abuse allegation steps .Conduct a thorough investigation .</p> <p>1. Res #1 had diagnoses which included vascular dementia, communication deficit, history of falls with injury, and cerebellar stroke syndrome.</p> <p>A significant change assessment, dated 02/27/24, documented the resident's cognition was severely impaired.</p> <p>OSDH incident report forms, incident date 02/28/24, documented initial reports of an abuse allegation for Res #1 were made to OSDH on 02/29/24 at 12:32 p.m. and 1:01 p.m. It was documented suspected abuse by CNA #1 was visualized on a video monitoring device in Res #1's room on 02/28/24 at 3:30 a.m. It was documented LPN #3 reported the video appeared to show CNA #1 physically restraining Res #1. It was documented LPN #3 reported the incident to the ADON and was advised to meet the ADON on 02/29/24 at 7:00 a.m. to review the footage. It was documented the ADON reported the incident to the DON on 02/29/24 at 9:30 a.m. It was documented the video footage was reviewed by the DON and the administrator and the police department was called. It was documented Res #1 was assessed by the DON and the ADON for injuries. It was documented no injuries were noted. It was documented CNA #1 was placed on suspension pending further investigation.</p> <p>An OSDH incident report, incident date 02/28/24, documented a final report of an abuse allegation for Res #1 was made to OSDH on 03/04/24. It was documented the police conducted an investigation. It was documented CNA #1 was terminated for violating policy.</p> <p>There was no documentation residents or additional staff were interviewed related to the incident.</p> <p>2. Res #2 had diagnoses which included dementia, paranoid personality disorder, iron deficiency anemia, and brain stem stroke.</p> <p>A quarterly resident assessment, dated 12/08/23, documented the resident's cognition was moderately impaired.</p> <p>An OSDH incident report form, incident date 02/29/24, documented an initial report of certain injuries and an abuse allegation for Res #2 were made to OSDH on 02/29/24. It was documented LPN #2 reported scattered bruising to Res #2's chest and upper extremities. It was documented the DON and LPN #3 assessed Res #2 and Res #2 stated a boy had hit them. It was documented Res #2 was not able to state when the incident happened. It was documented the incident was reported to the police.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An OSDH incident report, incident date 02/29/24, documented a final report of certain injuries and an abuse allegation for Res #2 was made to OSDH on 03/04/24. It was documented the police conducted an investigation. It was documented an employee was terminated for violating policy and there was no further action taken.</p> <p>There was no documentation of additional resident or staff interviews related to the incident.</p> <p>On 03/04/24 at 3:27 p.m., the DON was asked if there was additional documentation related to the investigations conducted for Res #1 and Res #2. They stated they did not have additional documentation of interviews conducted with residents or staff. They stated what they submitted to OSDH is what they had. They stated the incidents for Res #1 and Res #2 were discovered around the same time and both residents shared a room. They stated Res #2 stated a boy had hit them and CNA #1 was terminated for violating policy.</p>		