

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2024
NAME OF PROVIDER OR SUPPLIER Checotah Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Southeast 2nd Street Checotah, OK 74426	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure interventions were put in place to protect one (#1) of three residents reviewed for abuse. This had the potential to affect all residents.</p> <p>The DON identified 29 residents who resided in the facility.</p> <p>Findings:</p> <p>Res #2 had diagnoses which included other sexual disorders, recurrent depressive disorders, and anxiety.</p> <p>Res #2's quarterly resident assessment dated , 09/11/24, documented the resident was severely cognitively impaired and wandered four to six days a week.</p> <p>An incident report form, dated 08/09/24, documented Res #2 touched Res #1 inappropriately.</p> <p>A progress note, dated 08/12/24 at 11:18 a.m., documented Res #2 was admitted to a geri-psych facility for inappropriate sexual behaviors.</p> <p>A progress note, dated 08/22/24 at 4:07 p.m., documented Res #2 returned to the facility from the geri-psych facility.</p> <p>The care plan for Res #2 was not updated with interventions to prevent reoccurrence of inappropriate sexual behaviors.</p> <p>Progress notes, dated 08/25/24 between 11:04 a.m. and 1:56 p.m., documented Res #2 had aggressive and inappropriate sexual behaviors and was transferred to a geri-psych facility for treatment.</p> <p>On 10/14/24 at 1:48 p.m., the DON reported the staff knew what to do when Res #2 had inappropriate sexual behaviors, but there wasn't a plan in place to prevent Res #2's behaviors. The DON reported the care plan should have been updated with new interventions to prevent behaviors.</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
---	-------	-----------