

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Sequoyah Manor, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 615 East Redwood Sallisaw, OK 74955	

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>35474</p> <p>Based on record review and interview, the facility failed to ensure residents were free from verbal abuse for one (#5) of five sampled residents reviewed for abuse.</p> <p>The administrator identified 70 residents who resided in the facility.</p> <p>Findings:</p> <p>The Abuse, Neglect, Exploitation General policy, dated 05/05/17, read in parts, .Facility will educate all staff about how to recognize signs of possible abuse .All facility employees .are educated that all alleged or suspected violations involving mistreatment, neglect or abuse .are reported IMMEDIATELY to the Administrator .</p> <p>Resident #5 had diagnoses which included cerebral palsy and unspecified intellectual disabilities.</p> <p>The quarterly assessment, dated 07/05/24, documented the resident was moderately impaired in cognition for daily decision making.</p> <p>Resident #2 had diagnoses which included bipolar disorder.</p> <p>The quarterly assessment, dated 07/29/24, documented the resident was cognitively intact for daily decision making.</p> <p>The Event Report for Resident #2, dated 08/05/24 at 7:38 p.m., read in parts, .Progress Note .Resident witnessed being verbally hateful to other resident in hallway and dining room. Resident was witnessed in dining room and hallways calling other Resident Retarded repeatedly loudly where other residents and staff members can hear. Other resident noted to be visibly upset by this, but resident continues with these remarks. [Physician name withheld] notified and received n/o for Depakote 125mg PO TID r/t behaviors . The progress note was signed by LPN #1.</p> <p>Review of the electronic clinical record for Resident #2 and Resident #5 did not reveal the administrator had been notified of the verbal abuse.</p> <p>Review of the state reportable's did not reveal a report for the incident of verbal abuse by Resident #2 toward Resident #5.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/11/24 at 1:15 p.m., LPN #1 identified the resident who had been called Retarded as Resident #5. LPN #1 stated they had notified the ADON and the physician of the incident. LPN #1 stated they had not completed an incident report, investigated the incident, or report the incident as verbal abuse. LPN #1 stated they should have reported the incident as verbal abuse.</p> <p>On 09/11/24 at 1:20 p.m., the ADON stated they had been notified Resident #2 and Resident #5 were not getting along but had not been notified of the verbal abuse. The ADON stated event report progress notes were reviewed regularly but they were unaware of the verbal abuse documented on 08/05/24.</p> <p>On 09/11/24 at 1:25 p.m., the DON stated they reviewed the event report progress notes weekly but they had not seen the progress note dated 08/05/24. The DON stated the incident should have been investigated as verbal abuse.</p> <p>On 09/11/24 at 1:48 p.m., the administrator stated they had just found out about the incident of verbal abuse for Resident #5. They stated they did not know why the incident had not been reported. The administrator was asked how often the event report progress notes were reviewed. The administrator stated, Not near enough.</p>		

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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>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to implement the abuse policy for one (#5) of five sampled residents reviewed for abuse and failed to develop an abuse policy with appropriate reporting time frames.</p> <p>The administrator identified 70 residents who resided in the facility.</p> <p>Findings:</p> <p>The Abuse, Neglect, Exploitation General policy, dated 05/05/17, read in parts, .Facility will educate all staff about how to recognize signs of possible abuse .All facility employees .are educated that all alleged or suspected violations involving mistreatment, neglect or abuse .are reported IMMEDIATELY to the Administrator .In the event an incident that meets or has the potential to meet one of the definitions stated in the policy on abuse or neglect of an elder is reported to the Administrator or designee, an investigation of the incident will be commenced immediately. The Administrator will contact DHS immediately [sic] and the Oklahoma State Department of Health within 24 hours .Reporting .The DON, Administrator or other designated investigating individual will begin their own internal investigation and notify the OSDH within twenty-four (24) hours of identifying the concern of possible abuse, neglect or exploitation .</p> <p>1. Resident #5 had diagnoses which included cerebral palsy and unspecified intellectual disabilities.</p> <p>The quarterly assessment, dated 07/05/24, documented the resident was moderately impaired in cognition for daily decision making.</p> <p>Resident #2 had diagnoses which included bipolar disorder.</p> <p>The quarterly assessment, dated 07/29/24, documented the resident was cognitively intact for daily decision making.</p> <p>The Event Report for Resident #2, dated 08/05/24 at 7:38 p.m., read in parts, .Progress Note .Resident witnessed being verbally hateful to other resident in hallway and dining room. Resident was witnessed in dining room and hallways calling other Resident Retarded repeatedly loudly where other residents and staff members can hear. Other resident noted to be visibly upset by this, but resident continues with these remarks. [Physician name withheld] notified and received n/o for Depakote 125mg PO TID r/t behaviors . The progress note was signed by LPN #1.</p> <p>Review of the electronic clinical record for Resident #2 and Resident #5 did not reveal the administrator had been notified of the verbal abuse.</p> <p>Review of the state incident reports did not reveal a report for the incident of verbal abuse by Resident #2 toward Resident #5.</p> <p>(continued on next page)</p>		

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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>On 09/11/24 at 1:15 p.m., LPN #1 identified the resident who had been called Retarded as Resident #5. LPN #1 stated they had notified the ADON and the physician of the incident. LPN #1 stated they had not completed an incident report, investigated the incident, or reported the incident as verbal abuse. LPN #1 stated they should have reported the incident as verbal abuse.</p> <p>On 09/11/24 at 1:20 p.m., the ADON stated they had been notified Resident #2 and Resident #5 were not getting along but had not been notified of the verbal abuse.</p> <p>On 09/11/24 at 1:25 p.m., the DON stated the incident should have been investigated as verbal abuse.</p> <p>On 09/11/24 at 1:48 p.m., the administrator stated they had just found out about the incident of verbal abuse for Resident #5. They stated they did not know why the incident had not been reported.</p> <p>2. Review of the abuse policy revealed documentation the facility had 24 hours to notify OSDH of allegations of abuse/neglect.</p> <p>On 09/11/24 at 11:57 a.m., the ADON stated the time frame for reporting allegations of abuse/neglect to OSDH was two hours. The ADON reviewed the facility's abuse policy and stated the policy was approved on 05/05/17 and it documented the facility had 24 hours to report allegations to OSDH.</p> <p>On 09/11/24 at 12:17 p.m., the DON stated the time frame for reporting allegations of abuse/neglect to OSDH was 24 hours. The DON reviewed the facility's abuse policy and stated on page five it documented they had 24 hours to report. They stated the facility's policies were reviewed annually in September but had not been completed for this year yet. They stated the abuse policy needed to be updated.</p> <p>On 09/11/24 at 12:36 p.m., the administrator stated suspected criminal acts were to be reported to OSDH within two hours but allegations of abuse/neglect were to be reported within 24 hours to OSDH. The administrator stated they needed to revise and update the facility's abuse policy.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure comprehensive care plans were person-centered for two (#1 and #2) of four sampled residents whose care plans were reviewed.</p> <p>Findings:</p> <p>The Care Plans, Comprehensive Person-Centered policy, dated December 2016, read in part, .The comprehensive, person-centered care plan will .reflect the resident's expressed wishes regarding care and treatment goals .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change .</p> <p>1. Resident #1 had diagnoses which included Rett's syndrome.</p> <p>The quarterly assessment, dated 07/03/24, documented the resident was severely impaired in cognition for daily decision making.</p> <p>Review of the electronic clinical record, including the care plan, revised 08/29/24, did not reveal resident/resident representative preferences had been documented.</p> <p>On 09/10/24 at 2:08 p.m., dietary aide #1 stated they were aware Resident #1's mother did not want male residents around their loved one. They stated they had heard about the mother's preferences a month or two ago.</p> <p>On 09/10/24 at 2:53 p.m., LPN #1 stated the male residents were redirected from Resident #1 because their mother did not want males interacting with Resident #1.</p> <p>On 09/11/24 at 8:50 a.m., LPN #2 stated Resident #1's mother did not want male residents around them.</p> <p>On 09/11/24 at 11:13 a.m., the MDS coordinator stated they were responsible to update and develop the care plans. They stated shortly after admission to the facility the resident's mother requested staff redirect male residents from interacting with Resident #1. The MDS coordinator stated they had not added the verbalized preference from the resident's representative to the care plan. They stated, I guess I just missed it.</p> <p>On 09/10/24 at 12:17 p.m., the DON stated they randomly reviewed care plans to ensure they had been updated/revised. They stated Resident #1's mother informed the staff they did not want male residents interacting with Resident #1. The DON stated the preference was known by staff before the last care plan meeting and the care plan should have been updated to reflect the current preference.</p> <p>2. Resident #2 had diagnoses which included bipolar disorder.</p> <p>The quarterly assessment, dated 07/29/24, documented the resident did not exhibit behaviors and was cognitively intact for daily decision making.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Event Report for Resident #2, dated 08/05/24 at 7:38 p.m., read in parts, .Progress Note .Resident witnessed being verbally hateful to other resident in hallway and dining room. Resident was witnessed in dining room and hallways calling other Resident Retarded repeatedly loudly where other residents and staff members can hear. Other resident noted to be visibly upset by this, but resident continues with these remarks. [Physician name withheld] notified and received n/o for Depakote 125mg PO TID r/t behaviors .</p> <p>The Care Plan, updated 08/06/24, read in parts, .Problem .Resident has bipolar disease .Goal .Resident will interact appropriately with staff, other residents, and visitors .Approach .depakote administered per order .Do not confront, argue against, or deny resident's thoughts .Refocus when he/she changes the subject in middle of conversation .Reinforce and focus on reality. Use clear, concise terms . The Care Plan did not address what behaviors to monitor for related to the order for Depakote.</p> <p>On 09/11/24 at 1:37 p.m., the MDS coordinator reviewed the care plan for Resident #2 and stated they did not review the clinical record to determine what behaviors a resident had experienced to revise the care plan. They stated they had seen Resident #2 had received a new order for Depakote but had not investigated further to determine if a revision in the care plan for monitoring for specific behavior should have been implemented.</p> <p>On 09/11/24 at 1:59 pm., the DON stated the new order for the Depakote was documented on the care plan for Resident #2 but the care plan should have been updated/ revised to reflect the reasoning for the order and the specific behaviors the staff should monitor for Resident #2.</p>		