STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375173	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoyah Manor, LLC	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to protect residents from abuse for 2 (#8 and #10) of 5 sampled residents reviewed for abuse. The administrator identified 77 residents resided in the facility.Findings: 1.An OSDH incident report form, dated 09/12/25, showed CNA #7 witnessed Resident #12 hit Resident #8 on the top of their head. The report showed Resident #8 was assessed and found to be free of injury. The report showed Resident #12 was placed on 1:1 until sent to ER psych evaluation. The report showed Resident #12 had a BIMS score of 1 indicating they were severely cognitively impaired. The report showed Resident #8 had a BIMS of 12 indicating moderate cognitive impairment.A nursing note, dated 09/13/25 at 7:29 a.m., showed Resident #12 returned to the facility (after ER psych evaluation) on 09/13/25 at 6:00 a.m., and remained on 1:1 supervision.A nursing note, dated 09/16/25 at 3:33 p.m., showed Resident #12 remained on 1:1 until they were transported to a behavioral hospital.2. An OSDH incident report form, dated 12/21/25, showed CNA #6 witnessed Resident #11 knock the glasses off the face of Resident #10. The report showed Resident #10 was assessed and found to be free of injury. The report showed Resident #11 was placed on 1:1 until a geriatric psychiatry evaluation was completed. The report showed Resident #11 had a BIMS of 15 indicating they were cognitively intact. The report showed Resident #10 had an Alzheimer's diagnosis and was unaware of their own actions. The report showed the incident was caught on camera. The report showed Resident #11 was evaluated by psych and moved out of memory care with no new orders.An all-staff in-service provided by the ombudsman, dated 01/07/26, covered abuse, neglect, exploitation, misappropriation, and resident rights.A December 2025 quality assurance and performance improvement meeting showed the agenda covered resident council concerns, resident altercations, and resident behavioral concerns.On 01/14/26 at 3:18 p.m., LPN #3 stated they had never seen Resident #11 be anything, but kind. LPN #3 stated they believed Resident #11 was put in memory care because their family was afraid they would wander. LPN #3 stated Resident #11 was happier outside of memory care and was back to being their usual self. They stated they had abuse and neglect training about a month ago.On 01/14/26 at 3:25 p.m., the DON, with the administrator in the room, stated Resident #11 had some confusion and the family was worried about elopement, so they were originally placed in memory care. The DON stated after the incident, the psych advanced practical registered nurse evaluated the resident and felt like removing Resident #11 from the situation would stop the problem. The DON stated Resident #11 was moved out of memory care and wore WanderGuard.On 01/14/26 at 3:30 p.m., the DON stated Resident #8 was in memory care, but their family wanted them moved out after the incident. The DON stated after an altercation happened, the aggressor was monitored 1:1 until they went to geriatric psychiatry and were treated. The DON stated staff education was completed every time an incident occurred. The DON stated that an activities staff was hired to assist in memory care a few weeks ago, and that staff member was in CNA school.

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