

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2024
NAME OF PROVIDER OR SUPPLIER  Pocola Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Home Street Pocola, OK 74902	

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>33097</p> <p>Based on record review and interview, the facility failed to implement their abuse policy by immediately reporting abuse for two (#1 and #2) of three sampled residents reviewed for abuse.</p> <p>The DON identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>An abuse policy titled POCOLA HEALTH AND REHAB, addendum 08/29/18, read in parts .The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultant, volunteers, .Staff is responsible for identifying, correcting, and intervening in situations in which abuse, neglect, and misappropriation of property are more likely to occur .All alleged violations and/or abuse reported to the charge nurse will be assessed and then reported to the appropriate agencies with a 2 hour timeline. The nurse will also notify the Administrator and Director of Nursing immediately .</p> <p>1. Resident #1 had diagnoses which included diabetes mellitus, morbid obesity, major depressive disorder, anxiety disorder, and schizophrenia.</p> <p>A facility incident report, dated 07/11/24 at 3:15 p.m., documented two nurses were told by resident #1 the aide with black hair called me a motherfucking C-U-N-T. The report documented the two nurses questioned the aides working on the resident hall. Two aides stated they did not here the identified incident regarding the accused third aide, but had heard the third aide call the resident a fat fuck earlier in the day and they informed their supervisor of the verbal abuse. The report documented the nurse immediately reported the incident to the ADON and the DON was made aware and was investigating the incident.</p> <p>A state incident report, dated 07/11/24, documented an allegation of abuse/mistreatment for resident #1. The report documented the see progress notes.</p> <p>A fax confirmation report, dated 07/11/24 at 7:36 p.m., documented a state incident report regarding the abuse allegation for resident #1 was faxed to OSDH.</p> <p>2. Resident #2 had diagnoses which included a fracture of the right tibia, anxiety disorder, dementia, and Alzheimer's Disease.</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>A facility incident report, dated 07/11/24 at 9:30 a.m., documented the nurse was called to the resident's room. The report documented the resident told the nurse that girl threw me in the chair and it hurt my back.</p> <p>A progress note, dated 07/11/24 at 7:30 p.m., documented the incident regarding the resident. The note documented the DON was aware of the incident and was investigating at that time.</p> <p>A state incident report, dated 07/11/24, documented an allegation of abuse/mistreatment for resident #2. The report documented the see progress notes.</p> <p>A fax confirmation report, dated 07/11/24 at 7:38 p.m., documented a state incident report regarding the abuse allegation for resident #2 was faxed to OSDH.</p> <p>On 08/13/24 at 3:15 p.m., the DON stated they were unaware of the incident regarding the allegation of abuse by resident #2 until in the afternoon.</p> <p>On 08/15/24 at 8:45 a.m., the DON was interviewed regarding the incidents for resident #1 and resident #2. The DON stated the staff did not notify them or the administrator of the allegations of abuse and/or neither incident was reported to the OSDH within the two required time frame per facility policy.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to ensure an allegation of abuse was reported within the two hours to OSDH for two (#1 and #2) of three sampled residents reviewed for abuse.</p> <p>The DON identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>An abuse policy titled POCOLA HEALTH AND REHAB, addendum 08/29/18, read in parts .The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultant, volunteers, .Staff is responsible for identifying, correcting, and intervening in situations in which abuse, neglect, and misappropriation of property are more likely to occur .The Administrator and the Director of Nursing are responsible for the initial reporting, investigation of the alleged violations and reporting the results to the proper authorities .All alleged violations and/or abuse reported to the charge nurse will be assessed and then reported to the appropriate agencies with a 2 hour timeline. The nurse will also notify the Administrator and Director of Nursing immediately .</p> <p>1. Resident #1 had diagnoses which included diabetes mellitus, morbid obesity, major depressive disorder, anxiety disorder, and schizophrenia.</p> <p>A facility incident report, dated 07/11/24 at 3:15 p.m., documented two nurses were told by resident #1 the aide with black hair called me a motherfucking C-U-N-T. The report documented the two nurses questioned the aides working on the resident hall. Two aides stated they did not here the identified incident regarding the accused third aide, but had heard the third aide call the resident a fat fuck earlier in the day and they informed their supervisor of the verbal abuse. The report documented the nurse immediately reported the incident to the ADON and the DON was made aware and was investigating the incident.</p> <p>A state incident report, dated 07/11/24, documented an allegation of abuse/mistreatment for resident #1. The report documented the see progress notes.</p> <p>A fax confirmation report, dated 07/11/24 at 7:36 p.m., documented a state incident report regarding the abuse allegation for resident #1 was faxed to OSDH.</p> <p>2. Resident #2 had diagnoses which included a fracture of the right tibia, anxiety disorder, dementia, and Alzheimer's Disease.</p> <p>A facility incident report, dated 07/11/24 at 9:30 a.m., documented the nurse was called to the resident's room. The report documented the resident told the nurse that girl threw me in the chair and it hurt my back.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A progress note, dated 07/11/24 at 7:30 p.m., documented the incident regarding the resident. The note documented the DON was aware of the incident and was investigating at that time.</p> <p>A state incident report, dated 07/11/24, documented an allegation of abuse/mistreatment for resident #2. The report documented the see progress notes.</p> <p>A fax confirmation report, dated 07/11/24 at 7:38 p.m., documented a state incident report regarding the abuse allegation for resident #2 was faxed to OSDH.</p> <p>On 08/13/24 at 2:48 p.m., the DON was interviewed regarding the incidents for resident #1 and resident #2. The DON reviewed the documents regarding the reporting of both incidents. The DON stated neither incident was reported to the OSDH within the two required time frame.</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>33097</p> <p>Based on record review and interview, the facility failed to conduct a thorough abuse investigation for two (#1 and #2) of three residents reviewed for abuse.</p> <p>The DON identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>An abuse policy titled POCOLA HEALTH AND REHAB, addendum 08/29/18, read in parts .The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultant, volunteers, .Staff is responsible for identifying, correcting, and intervening in situations in which abuse, neglect, and misappropriation of property are more likely to occur .The Administrator and the Director of Nursing are responsible for the initial reporting, investigation of the alleged violations and reporting the results to the proper authorities. The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while investigation is in the progress .Staff - to - Resident: Immediately respond to the needs of the injured party. The accused or suspected employee will be immediately suspended pending the investigation .The progress notes, concerning all residents involved should include: assessment of residents involved, who was involved, what happened, what was done, what interventions were used, how did the resident respond to the intervention, what was done to prevent further harm to residents and others. Follow up documentation will continue for 72 hours .</p> <p>1. Resident #1 had diagnoses which included diabetes mellitus, morbid obesity, major depressive disorder, anxiety disorder, and schizophrenia.</p> <p>A facility incident report, dated 07/11/24 at 3:15 p.m., documented two nurses were told by resident #1 the aide with black hair called me a motherfucking C-U-N-T. The report documented the two nurses questioned the aides working on the resident hall. Two aides stated they did not here the identified incident regarding the accused third aide, but had heard the third aide call the resident a fat fuck earlier in the day and they informed their supervisor of the verbal abuse. The report documented the nurse immediately reported the incident to the ADON and the DON was made aware and was investigating the incident.</p> <p>A state incident report, dated 07/11/24, documented an allegation of abuse/mistreatment for resident #1. The report documented the see progress notes.</p> <p>A document titled final investigation for resident #1 regarding incident on 07/11/24 read in parts .Upon my investigation I questioned all the resident on this hall .I spoke with the other staff on the hall that day and their personal statements have been added with this investigation .</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>The DON provided documentation for the completed investigation. There was no statement from the resident. There was one nurse statement provided. There was no statement for the other nurse identified in the incident report. There was no documentation provided regarding the date, time, name, or number of residents interviewed regarding the incident. A statement provided by the CNA who was providing care for the resident at the time of the alleged incident documented a second CNA who assisted with resident care. A statement from the second CNA identified in the room was not provided.</p> <p>2. Resident #2 had diagnoses which included a fracture of the right tibia, anxiety disorder, dementia, and Alzheimer's Disease.</p> <p>A facility incident report, dated 07/11/24 at 9:30 a.m., documented the nurse was called to the resident's room. The report documented the resident told the nurse that girl threw me in the chair and it hurt my back.</p> <p>A progress note, dated 07/11/24 at 7:30 p.m., documented the incident regarding the resident. The note documented the DON was aware of the incident and was investigating at that time.</p> <p>A document titled final investigation for resident #2 regarding incident on 07/11/24 read in parts .Upon my investigation I questioned all the resident on this hall .Spoke with the other staff on the hall that day .</p> <p>The DON provided documentation for the completed investigation. There was no documentation provided regarding the date, time, name, or number of residents interviewed regarding the incident. A document, not dated or timed, documented the resident was was yelling saying she had hit her.</p> <p>On 08/15/24 at 8:45 a.m., the DON was interviewed regarding the incidents for resident #1 and resident #2. The DON stated the investigations were completed together because they were made aware of the incidents at the same time and involved the same staff member. The DON stated there were no documented resident interviews and some staff identified did not have documented interviews.</p>		