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| 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 11/25/2025 |
| 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.

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| (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. (continued on next page) |

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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| F 0600 Level of Harm - Actual harm Residents Affected - Few | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to monitor and prevent sexual abuse for 1 (#1) 1 sampled resident reviewed for abuse. The director of nursing identified 62 residents resided in the facility. Findings: Findings: An undated, Elder Abuse Policy and Procedure, read in part, It is the policy of .to thoroughly investigate all allegations concerning resident abuse .to prevent further abuse .pending an investigation. This facility reserves the right to take whatever actions it, in its sole discretion, deems appropriate to investigate and to prevent possible abuse .Abuse: Any intentional act of one or more of the following .sexual physical, mental/emotional .involuntary seclusion which may be imposed on a resident of this facility by any .or other residents .Abuse is a non-accidental .or sexual abuse, whenever there is impermissible or unjustifiable harmful or offensive contact with the resident .Contact with a resident may constitute abuse even if there is no evidence of physical injury, as long as there has been significant psychological harm. Significant psychological harm has occurred if .the contact intimidates the resident .or the contact subjects the resident to .loss of privacy or personal dignity, and the contact causes noticeable level of .emotional distress .examples .twisting, squeezing, or pinching part of resident's body .sexual molestation .Neglect is when a caregiver fails to provide treatment or services which are necessary to maintain or improve resident's health or safety and this failure results in lack of expected improvements or noticeable deterioration of physical, mental, or emotional condition and jeopardy to health, safety, or welfare . Examples .failure to adequately supervise resident's whereabouts .Battery is touching someone without permission .roughly, or forcing someone to do something they don't want to do. An undated, Abuse Prohibition Training Program, read in part, The abuse prohibition program promotes resident safety and prevents abuse in the long-term care environment. It is designed to give .confidence in the facility's ability to minimize the risk of abuse within the facility. Abuse can be resident to resident .remember .most residents are placed in long term care facilities to provide them with a safe environment. Abuse is serious business. Res #1's EHR, under face sheet, showed them as their own responsible party. Res #1's EHR, under medical diagnosis tab, showed a medical diagnosis, dated 04/15/25, of unspecified dementia, unspecified severity with other behavioral disturbance. Res #2's, EHR, under medical diagnosis tab, showed a medical diagnosis, dated 05/19/25, of hypertension and kidney failure. Res #1's care plan, dated 09/02/25, showed the resident had impaired cognitive function/dementia or impaired thought processes r/t dementia, short term memory loss with behavioral disturbances. Res #1's quarterly MDS, dated [DATE], showed the resident admitted to the facility 03/08/23 and had a BIMS of 03 which indicated a cognitive status of severe impairment. A nursing note, dated 10/05/25, read in part, [Resident #1] was found in another Resident's room [Resident #3], with a [gender withheld] [Resident #2]. Both were on the bed [they] were sitting on the bed, and the [gender withheld] [Resident #2] was lying back on the bed with the zipper of [their] pants open. Separated residents and sent them to their respective rooms. Notified DON. An OSDH form 283, dated 11/10/25, read in part, Allegation of abuse/mistreatment .housekeeper came to this nurse and reported another resident had touched this resident on the breast. Nurse asked both residents, in which the other resident stated [they] did not and that this resident did it to [themselves.] Nurse asked a resident sitting directly next to the incident, in which the resident states, 'I did not see anything, leave me out of it.' This nurse immediately went to DON and cameras were watched to verify incident. A Behavior Note, dated 10/03/25 by LPN #5, read in part, Activities staff came to nurses' desk and stated that [Resident #2] and [Resident #5] were making out in the activities room. [Resident #2] and other [Resident #5] were sitting beside each other and [Resident #2] stated [they] wanted the other [Resident #5] separated. Spoke with staff and [Resident #5] stated [Resident #2] was a 'willing participant.' Residents were separated and will continue to monitor. A Behavior Note, dated 10/04/25 at 11:46 a.m., by LPN #2, read in part, One of our cognitively impaired residents kicked [Resident #2] and [they] turned around and [their] fist up like [they were] going to hit [them.] Staff redirected both residents away from each other. [Resident #2] was reminded that the resident who kicked [them] does not know what [they were] doing due to [their] cognitive status and that if [they] kicked [them] again, [they needed] to step away from [them] and get a staff member. A Behavior Note, dated 10/04/25 at 9:01 p.m., by LPN #4, read in part, CMA notified nurse that [they] could not find [Resident #2] to give evening medications. Looked for [Resident #2] and found [them] in [Resident #3] room lying in bed B with [their] pants unzipped with [Resident #11 sitting on the bed beside [them] Nurse sent residents back to their respective rooms. Called DON to</p> | | |