STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375206	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindsay Nursing & Rehab	1103 West Cherokee Lindsay, OK 73052

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 30875 Based on record review and interview, the facility failed to issue a written grievance decision upon request and to address the grievance in its entirety for one (#4) of one sampled grievance reviewed. Findings: A Grievance Policy and Procedure, not dated, documented, the facility has adopted an internal grievance procedure providing a prompt and equitable resolution or complaints/grievances. A copy of the written summary of the report will also be provided to the resident, if requested, and the original copy will be filed in the Business Office. The investigation and report may include the following: Patient's account of the alleged incident; employees account of the alleged incident; recommendations for corrective action. A Grievance Form, dated 06/12/24, documented, [Staff member #1] was being rude about smokers past the line. He also stated [staff member #1] would push them past the line. Res #4 said if something wasn't done, they will move out though they prefer not too [sic]. Name/Title of person accepting this form: Activity Manager. Nature of resolution: [Staff member #1] was keeping the facility within State regulations regarding smoking to close to an entrance. All smokers are required to be on the correct side of the red line while smoking. Discussed with person filing grievance on: (date) [blank] . The grievance did not address being rude and the grievance did not include the date the grievance was discussed. On 08/05/24 at 11:34 a.m., the administrator was asked about the grievance dated 06/12/24 from Res #4 about staff member #1 being rude. They reported everybody says the same thing that staff member #1 was rude or just blunt. The statements/interviews were requested related to the grievance. They reported they did not have any. They were asked if they completed the portion of the grievance with the date the grievance had been discussed with Res #4. They reported they did not, they reported the activity manager or staff member #1 would have completed that section. They were asked if they provided a written summary of the report to Res #4. They reported they would have just discussed it with them. They were asked if Res #4 requested a copy of the grievance. They reported they did request a copy. They were asked if Res #4 received a copy. They reported they did not give them one, it was their understanding it was an internal document. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/06/24 at 10:15 a.m., the activity manager was asked to review the grievance dated 06/12/24 and was asked if they discussed the grievance with Res #4. They reported they told Res #4 that staff member #1 was following the rules. They were asked if they provided the copy of the grievance to Res #4. They reported Res #4 requested a copy and the administrator informed them they did not have to give Res #4 a copy. They were asked if the portion of the grievance about being rude was addressed in the grievance. They reported it did not address being rude. On 08/07/24 at 12:05 p.m., the corporate consultant was asked if a resident would be allowed to have a copy of a grievance that they filed. They reported they could have a copy.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 30875 Based on record review and interview, the facility failed to conduct a thorough abuse investigation for one (#4) of three sampled residents reviewed for abuse. The Administrator reported 68 residents resided in the facility. Findings: The facility Abuse Policy and Procedure not dated, read in part, It recognizes resident rights to be free from physical, or mental abuse, corporal punishment, involuntary seclusion, and any chemical and physical restraints as defined by federal regulations. The policy also read, Immediate reporting. Facility employee or immediate supervisor, who will report incidents immediately to local police and report to the Oklahoma State Department of Health as required by State law or regulation. The policy also read, Identification and Investigation. The investigation should determine whether an incident has occurred, to what extent the resident was mistreated, by whom, and the measures needed to protect occupants from further incidents. The policy also read, Interviews. The investigator should consider interviewing persons listed below: facility employees, contractors, volunteers; victim; . other occupants; .other persons who may have knowledge of the incident. The policy also read, Nursing Assessment. The Director of Nursing or designee is responsible for assessing the victim and shall document findings, including the lack of abnormal findings, if helpful, in the medical record. If a person alleges abuse, they should be assessed for mood and behavior changes that may indicate abuse, such as fear, isolation, depression, withdrawal, or other new signs. Findings will be documented in the medical record. The Medical Record and Care Plan will be reviewed. The policy also read, if physical abuse is alleged or suspected, vital signs may be taken and a skin audit completed by a licensed nurse following the incident and documented in the Medical Record. Resident #4 had diagnosis which included Schizophrenia, COPD, essential hypertension, and recurrent depressive disorders. An Incident Report Form Combined Initial and Final, Incident Date: 07/29/24, documented, Incident Type: Allegations of Abuse/Mistreatment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Description of Incident: While delivering a letter for [sic] OKDHS to [Res #4], [staff member #1] asked [Res #4] if they could read the letter with him so that the facility would be apprised of anything that needed to be done to keep Res #4 in DHS compliance and his title 19 Medicaid intact. Reportedly [Res #4] yanked the letter away and then struck [staff member #1] in the chest. [Res #4] came into the building claiming that [staff member #1] had pushed [Res #4] first that is when [Res #4] hit [staff member #1]. To protect this and all residents [staff member #1] was suspended pending the outcome of the investigation. While interviewing staff at the nurse's station who were in direct sight of the front porch, a resident, [Name removed-Res #9] approached the Administrator [Name removed]. [Res #9] had been on the porch during the incident and stated that [staff member #1] did not push him [Res #4]. The administrator asked [Res #9] if they had seen the incident. [Res #9] stated they had and then reiterated that [staff member #1] did not push [Res #4]. [Res #9] is AAO x4. [Staff member #1] will be allowed to return to work on 07-30-24. On 08/01/24 at 1:57 p.m., the DON reported they had left notes with the Administrator before related to staff member #1's approach and their tone. They reported they heard about the incident on 07/29/24 from Res #4 at 4:00 a.m., this morning. The resident asked the DON to fax a report to the police department, because the resident said they was turning staff member #1 in, because they put their hands on them. They reported staff member #1 and Res #4 had an ongoing personality conflict. The DON reported they made no assessment or updates to Res #4's clinical record or the plan of care related to the incident. On 08/01/24 at 2:30 p.m., the administrator was asked to submit statements from the nursing staff. The administrator stated, I didn't get statements, because I had a witness. The administrator was asked if they obtained a list of staff present. The administrator stated, As far as I know there was only one other person besides Res #4 and staff member #1. The administrator was asked how long staff member #1 was suspended. The administrator reported, The day it happened. They were asked if they notified the DON of the abuse allegation. They reported, No, I didn't they had been working nights. They were asked about reporting the incident to the local police department. They reported they did not, because they had a witness, and it was an allegation of abuse. They were asked if all witnesses were interviewed. They reported there was only one, it happened on the front porch. On 08/01/24 at 3:12 p.m., the ADON reported they were not aware of the allegation of abuse until July 31, 2024 and they were one of the charge nurses on duty on the day the allegation was made on 07/29/24.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873 Based on record review and interview, the facility failed to ensure notification of the bed hold policy was provided upon transfer/discharge for one (#1) of one resident reviewed for discharge. The Administrator reported 68 residents resided in the facility. Findings: A Readmission to the Facility policy, dated 03/01/2022, read in part A Medicaid resident whose hospitalization or therapeutic leave exceeds the bed hold period allowed by the state will be readmitted to the facility upon the first availability of a bed in a semi-private room if the resident meets the admission criteria . Bed hold terminates after a resident is discharged for 30 days and would be considered a new admission . Any resident who is admitted to another long term care facility from an acute care hospital stay will be discharged from this facility . Resident #1 had diagnoses which included hypertension and diabetes mellitus. A nurse's note, dated 06/21/24, documented resident #1 requested to go to [name removed] hospital for complaints of a swollen penis and difficulty breathing. A discharge summary, signed 06/29/24, documented a discharge date of [DATE]. The discharge summary documented, on 06/21/24, Resident #1 was transferred to [name removed] hospital for further evaluation of urinary retention and complaints of trouble breathing. The discharge summary documented Resident #1 was admitted to hospital for further work up. Resident #1's face sheet, read in part discharged - 06/21/24 .Discharge status - return anticipated . The clinical record did not contain documentation that the resident or representative had been provided written documentation of the bed hold policy at the time of discharge. On 08/07/24 at 10:50 a.m., the BOM reported not being aware of a bed hold policy for the facility. The BOM reported bed hold information is discussed in the admission packet. On 08/07/24 at 2:38 p.m., the ADON reported no information about bed hold was given to residents when they were transferred/discharged to a hospital. The ADON reported Resident #1 was not allowed to return as a resident since Resident #1 had been admitted to another long- term care facility after being discharged from the hospital on 06/27/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 4:37 p.m., the Administrator reported resident #1 was not allowed to readmit to the facility because the resident had been admitted to another long-term care facility after discharge from the hospital on 06/27/24. The Administrator reported bed hold had not been an issue when residents were transferred/discharged to the hospital since they were anticipated to return. The Administrator reported to meet the regulation requirements for bed hold they should have given resident #1 written notification related to the facility's bed hold policy upon transfer/discharge to the hospital.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41873 Based on observation, record review, and interview, the facility failed to ensure a resident at risk for elopement did not elope from the facility for one (#1) of one sampled resident reviewed for elopement. The Administrator reported 68 residents resided in the facility. Findings: An Elopements policy, dated 12/01/2007, read in part Staff shall investigate and report all cases of missing residents .The facility will encourage each resident to sign themselves out of the facility so that the facility will remain informed .When the resident returns to the facility, the DON or Charge Nurse should complete and file an incident report . A form, dated 10/03/19, presented by the Administrator for the illicit drug policy and procedure, read in part It is the policy of the [facility name removed] to prohibit the use of alcoholic beverages or illicit drugs on facility property unless prescribed by a physician .There is a concern with interaction of prescribed medications and the use of alcoholic beverages and/or illicit drugs .Residents who have been found to be in violation of facility policy will be reviewed by the administrative staff, care plan team, and physician or facility medical director to determine if the facility is able to meet the continued needs of the resident .If the resident is a danger to himself/herself or other residents as documented by the medical record and the facility is not capable of managing the resident then the facility will proceed with an involuntary transfer or discharge . 1. Res #3 had diagnoses which included traumatic brain injury, depression, schizoaffective disorder, and dementia disorder. The clinical record documented a court appointed co-guardianship, dated 09/25/18, for the person and estate of resident #3, an adult incompetent. A nurse note, dated 12/15/23 at 4:45 a.m., documented resident #3 was found in a peer's room smoking marijuana. A nurse note, dated 01/30/24 at 10:00 p.m., documented a staff member found resident #3 vape outside passed out on the ground by the dumpster. The nurse note documented the resident's room was searched for marijuana and five gummies and two vapes were found and confiscated. A nurse note dated 03/04/24 at 6:10 p.m., resident #3 was found rolling down the main highway in wheelchair heading towards the facility. The nurse's note documented that the resident left the facility without signing out or informing staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse note, dated 04/05/24 at 3:45 p.m., documented resident #3 left the facility without signing out via wheelchair. At 4:25 p.m. resident returned to the facility. At 8:00 p.m. the resident left the facility without notifying staff via wheelchair and refused to return. The note documented after two attempts the resident returned to the facility with staff. A nurse note, dated 04/07/24 at 9:00 a.m., resident #3 refused medication. A nurse's note, dated 04/09/24 at 8:00 p.m., documented a call was received reporting resident #3 was seen in wheelchair going down the main highway toward store. The note documented the resident sign out book was checked, and the resident had not signed out, and the staff could not see the resident. A nurse note, dated 04/09/24 at 8:30 p.m., documented the facility received a call from officer [name removed] who found resident #3 in someone's yard passed out. The note documented the officer had to repeatedly shake resident to wake resident up and the resident arrived back to the facility 8:40 p.m. The note documented resident's guardian was upset and wants him placed in a locked down facility. A nurse note, dated 04/10/24, documented resident #3 continued with one-on-one supervision, resident not concerned about doing things right because they will be leaving in 3 days. A nurse note, dated 04/12/24, documented resident #3 stated I don't want to be here I want to be closer to my daughter. A nurse note, dated 04/14/24 at 3:50 p.m., documented resident's guardian wants the resident in a locked facility so resident would not be allowed to leave because he is incompetent and makes terrible decisions. A nurse note, dated 04/19/24 at 3:45 p.m., resident #3 no signs of elopement noted. A comprehensive assessment, dated 05/16/24, documented resident cognition was intact and exhibited no behaviors. The assessment documented independent with wheelchair use. An elopement risk assessment, dated 05/25/24, documented the resident remained not a risk for elopement. The assessment instructions read in part One YES answer places the resident as a risk .Proceed to interventions. The assessment documented a YES answer for 4 of the resident evaluation factors. The assessment documented an intervention was: secured unit - all exit doors are key padded, date initiated was documented as continuous. A nurse note, dated 05/29/24 at 2:35 a.m., a staff member seen resident #3 propelling self in wheelchair down the street, charge nurse sent another staff member to pick up the resident, the resident refused to get in with staff member, and returned self to the facility. The note documented resident was placed on one-on-one supervision at this time. The note documented the resident stated who cares I will be on supervision for a little bit and when I come off, I will just do it again, unable to redirect. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse note, dated 06/08/24 at 12:10 a.m., documented a resident approached this nurse reporting that resident #3 had rolled off again. The note documented the facility and perimeter was searched and resident was not found, staff member sent to find the resident. The note documented the staff member found the resident on [name removed] street and refused to return to facility. The note documented the police department was contacted. A nurse note, dated 06/08/24 at 1:25 a.m., documented resident #3 arrived back to facility via police department escort. A nurse note, dated 06/19/24 at 12:00 a.m., documented a call was received that resident #3 had gone from the facility and in the road. The note documented a staff member was sent to pick up resident, the resident refused to get in with staff member and was ramming the staff member with the wheelchair and trying to through self out of wheelchair into the road. The note documented it took over an hour to get the resident back to the facility and resident was ramming into furniture with the wheelchair. The note documented the resident trying to get out of every exit door. The note documented the resident's guardian requested resident's wheelchair be taken away and for resident to use the walker only to ambulate. A nurse note, dated 07/01/24 at 8:30 p.m., documented resident #3 asked the nurse to take him to town when the nurse declined, the resident asked if another resident's wheelchair could be used to go to the store. The note documented the nurse informed resident another resident's wheelchair could not be taken. A comprehensive care plan related to elopement and illicit drug use was not developed. State reportables provided by the facility for the past 6 months documented no incidents of elopement or drug use for resident #3. On 08/05/24, the Administrator reported the facility had no incidents reports for elopement in the past 3 months. The Administrator reported resident #3 was not an elopement risk and residents were allowed to sign themselves out of the facility at any time. The Administrator reported a resident leaving the facility is considered an elopement if the resident has dementia, leaves the facility unattended, and leaves the facility premises. On 08/06/24 at 1:48 p.m., LPN #5 reported resident #3 is considered an elopement risk because he has a guardian that does not want him to leave the facility unsupervised. The LPN reported not being aware until they were informed on 08/05/24 by the RN consultant that an incident report needed to be filled out when any resident eloped from the facility. The LPN not being sure what interventions are in place for resident #3 to prevent elopement but they watch the resident closely because of his multiple elopements. The LPN reported no residents are safe being off facility premises at night unsupervised. On 08/06/24 at 3:46 p.m., resident #3 was in their room, wheelchair beside the bed, and reported residents are supposed to sign out in a book up front before leaving the facility but I never go anywhere. The resident reported he would like to go to a better facility. The resident refused to answer any other questions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/06/24 at 4:01 p.m., the DON reported the incident on 04/09/24 when resident #3 was found by police passing out in someone's yard was considered an elopement. The DON reported anytime a resident is off facility premises out of staff sight, without signing out is an elopement event. The DON reported interventions have not been put into place officially on a care plan. The DON was not aware until 08/05/24 that incident reports were not being done for elopements or drug use.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 30875 Based on record review and interview, the facility failed to ensure the DON did not work as a charge nurse when the facility census was more than 60 residents. Findings: The Administrator reported 68 residents resided in the facility. A facility policy titled Staffing not dated, documented, RN must be on duty 8 hours a day 7 days a week. DON will not work as a charge nurse when census rises above 60 per regulations. A document titled, Quality of Care Monthly Report date period, June 2024, documented, a census greater than 60 residents on June 24th, 26th, 27th, 28th, 29th, 30th. The census ranged from 61 to 62 residents on these days. A document titled, Daily Census dated, July, 2024, documented a census over 60 on July 17, 2024 through July 31, 2024. The census ranged from 61 residents to 68 residents on these days. On 08/07/24 at 11:55 p.m., the DON reported they worked as the charge nurse on July 25th and July 31st. The DON reported they worked as the charge nurse on June 24th. On 08/07/24 at 12:15 p.m., the corporate consultant was asked if the facility had the DON working as charge nurse with a resident's census over 60. They stated, Yes, but I do not know which days. On 08/07/24 at 1:24 p.m., LPN #2 reviewed staffing sheets. They reported the DON worked as the charge nurse on July 25, 2024 and July 31, 2024. They reported the DON was documented as the charge nurse on August 1st, 5th, and 6th, 2024, with a census range from 69-72 residents. The DON was available only upon request during the survey, because they were covering night shifts.