STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375222	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24th Place	600 24th Avenue Southwest Norman, OK 73069

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on observation, record review, and interview, the facility failed to ensure a resident's property was not misappropriated for one (#4) of four sampled residents reviewed for misappropriation. The administrator identified 76 residents resided in the facility. Findings: The facility Abuse and Neglect policy, revised 08/12/22, documented the facility would investigate all allegations of abuse, neglect, or misappropriation and analyze all occurrences of abuse during the next scheduled QA committee meeting. Res #4 had diagnoses which included MS. A quarterly MDS, dated [DATE], documented Res #4 was cognitively intact. A facility incident report, dated 09/13/24, documented Res #4's purse containing their wallet had been stolen from their safe while they were in the shower. An In-Service Training Report, dated 09/16/24 at 2:00 p.m., documented the facility provided training to staff over the facility abuse, neglect, and misappropriation policy. A final incident report, dated 09/19/24, documented the facility's investigation was substantiated and the CNA was terminated. The report documented the local police were notified and a plan of action was initiated to prevent recurrence. The report documented the plan of action included placing the resident's key to their safe in the possession of administration during showers. The report documented the codes to the doors were changed to prevent the CNA from re-entering the facility. On 10/11/24 at 10:29 a.m., Res #4 stated they had a credit card stolen from the lock box in their closet. They stated they kept the key to the box on a necklace, but took it off to shower. They stated a CNA had come into their room while they were showering and taken the key since they knew where Res #4 placed the key during showers. They stated the facility fired the employee and called the police to press charges. They denied any current concerns. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/24 at 3:00 p.m., the administrator stated they were alerted to the missing property on 09/13/24 when the activities staff was instructed to get the purse from the lock box in the closet for Res #4 and it was not there. They stated they immediately notified the police and the resident was able to determine a charge to their account was made at a gas station down the road. The administrator stated the facility contacted the gas station and was able to get a photo of the person who used the card. They stated the police confirmed it was the CNA who was accused of taking the purse. The administrator stated the CNA was terminated immediately. They stated they implemented the plan documented in the incident report and inserviced all staff on misappropriation and the abuse policy. The administrator stated they have followed up with the resident periodically to ensure they felt safe in the facility. A QA summary form, dated 10/14/24, documented the facility reviewed the incident regarding Res #4's misappropriated property. The form documented the plan to prevent recurrence and the facilities immediate actions following the allegation.