

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Ranchwood Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 824 South Yukon Parkway Yukon, OK 73099	

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 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>21731</p> <p>Based on record review and interview, the facility failed to ensure allegations of abuse were reported to OSDH for seven (#1, #3, #4, #7, #9, #10, and #11) of 11 residents reviewed for allegations of abuse reported to the OSDH.</p> <p>The facility census was 115.</p> <p>Findings:</p> <p>An Abuse, Neglect and Exploitation and Misappropriation of Resident Property policy, dated 06/23/17, read in parts, .comply with federal and state regulations .timely investigation of and reporting to state and local agencies .Upon receiving an allegation .report such allegation to the State Regulatory Agency, Adult Protective Services .Local law enforcement .not later than 2 hours after the allegation is made, if the events .involve abuse .</p> <p>1. Resident #1 had diagnosis to include pleural effusion, ascities, and anxiety.</p> <p>A Progress Note, dated 12/26/23 at 6:43 a.m., read in part, .could hear resident shouting at a male and female CNA, 'Don't touch me! Go get the nurse, if you touch me I'm going to call 911' .</p> <p>An Incident Report was not completed or reported to OSDH or other required agencies.</p> <p>A Progress Note, dated 01/04/23 at 8:52 a.m., read in part, .phone call from .Police Department .[Resident #1] told staff .need to file a report as a staff member held her down against her will .last night .leaned on [resident] to hold [resident] down and put [their] gloved hand over [resident's] mouth .</p> <p>A Progress Note, dated 01/04/24 at 12:19 p.m., read in part, . Called nonemergency police dept. [sic] to come .resident wanting to make a report .states that during care CNA leaned on her holding her down and covered her mouth with gloved hand .Police state .will not come to take statement from resident .</p> <p>The Incident Report, dated 01/04/24 documented the final reports was submitted to OSDH on 01/15/24 at 12:11 p.m., not within the required 5 day period.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Progress Note, dated 01/14/24 at 7:39 a.m., read in part, .Resident is telling the morning nurse that night nurse busted her mouth .</p> <p>The initial Incident Report, dated 01/14/24, was sent to OSDH on 01/15/24 at 10:36 a.m., not within the two hours required for allegations of abuse.</p> <p>A Discharge Assessment-Return Anticipated assessment, dated 01/16/24, documented Resident #1 had modified cognition for new situations.</p> <p>2. Resident #10 had diagnoses to include acute kidney failure, and Diabetes Mellitus-Type 2.</p> <p>A Incident Report, dated 01/04/24, included investigative notes that documented Resident #10 was asked if there were any concerns or complaints. The resident responded Therapy [staff, name omitted] not being nice mean .</p> <p>The allegations of abuse from Residents #10 was not reported to OSDH or other governing agencies.</p> <p>3. Resident #11 had diagnoses to include sepsis, chronic kidney disease, and spinal stenosis.</p> <p>An Incident Report, dated 01/04/24, included investigative notes that documented Resident #11 was asked, Do you feel that the staff treats you with respect? Resident #11 responded, Sometimes .takes them a long time to answer [call light] in the evening/night worst .</p> <p>The allegations of abuse from Resident #11 was not reported to OSDH or other governing agencies.</p> <p>On 04/02/24 at 3:30 p.m., the DON and Corporate RN were asked if the progress note dated 12/26/24 had been reported to OSDH as a potential abuse allegation. The Corporate RN stated, Resident #1 often states this. They were asked if the allegation on 01/04/24 had been reported within required time frames. They stated the initial was reported within the two hours. No comment was provided regarding the final report. The Corporate RN stated, It looks like only the initial was investigated [on 01/04/24 and 01/14/24] but there was no follow up on the findings. They were asked if the allegation of Resident #1 screaming and disturbing other residents was investigated and reported for the effect to other residents. The Corporate RN stated the allegation should have been investigated and reported.</p> <p>4. Resident #4 had diagnosis to include bipolar and a malignant neoplasm.</p> <p>An initial Incident Report, dated 01/29/24, documented Resident #4 had made threats to another resident and an investigation was underway.</p> <p>There were no documents a final report had been submitted to OSDH as required.</p> <p>A quarterly assessment, dated 02/12/24, documented Resident #4 had moderate cognitive impairment.</p> <p>A Progress Note, dated 02/25/24 at 9:50 p.m., read in part, .[Resident #4] left facility without letting anyone know or signing out .resident called .stuck at Walmart and did not have a way to get back to facility and was with a police officer .</p> <p>The event of a missing person had not been reported to OSDH.</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 03/10/24 at 5:11 p.m., read in part, .in dining room, began yelling at another resident . decided to unlock wheelchair, kick it back, and lay on floor .laid in floor, with legs spread showing naked peri area to all staff and residents in dining area .</p> <p>A Progress Note, dated 03/14/24 at 5:32 p.m., read in part, .CNA reported to this nurse that resident was being very rude to male resident while in dining room .</p> <p>The events on 03/10/24 or 03/14/24, had not been reported as resident to resident altercations.</p> <p>5. Resident #7 had diagnosis to include malignant neoplasm of the endometrium, and repeated falls.</p> <p>An Incident Report, dated 01/26/24, included investigative notes that documented Resident #7 was asked, Do you feel that the staff treats you with respect . Resident #7 stated, .Once in a while .</p> <p>The investigative notes did not include documentation the statements from Residents #7 had been reported to OSDH.</p> <p>6. Resident #3 had diagnosis to include Major depressive disorder and chronic respiratory failure.</p> <p>An Incident Report, dated 02/06/24, included investigative notes, that documented Resident #3 was asked . Are you afraid of any resident or relative? . Resident #3 responded, .[name omitted] makes comments about me .</p> <p>There was no documentation the allegations made by Resident #3 had been reported to OSDH.</p> <p>7. Resident #9 had diagnosis to include Alzheimer's disease and repeated falls.</p> <p>An Incident Report, dated 02/06/24, included investigative notes, that documented Resident #9 was asked, . Do you feel that the staff treats you with respect? . Resident #9 responded, .Most of the time .</p> <p>There was no documentation the allegations made by Resident #3 had been reported to OSDH.</p> <p>On 04/02/24 at 3:00 p.m., the DON and Corporate RN were asked if the allegations on 01/26/24 and 02/26/24, of residents allegations of abuse had been reported. The Corporate RN stated, they should have been, but were not. The DON and Corporate RN were asked if a final report had been submitted within 5 days, or the investigative findings of resident allegations, on 01/26/24, had been reported to OSDH. The Corporate RN stated the investigation had been a group effort but the facility should have looked into the allegations discovered during the resident interviews. The DON and Corporate RN stated they did not know Resident #4 had left the building prior to the resident leaving and the incident had not been reported. The DON stated the resident to resident altercations on 03/10/24 and 03/14/24 had not been reported.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21731</p> <p>Based on record review and interviews, the facility failed to fully investigate allegations of abuse for nine (#1, #2, #3, #4, #7, #9, #10, and #11) of eleven sampled residents reviewed for abuse.</p> <p>The facility census was 115.</p> <p>Findings:</p> <p>An Abuse, Neglect and Exploitation and Misappropriation of Resident Property policy, dated 06/23/17, read in parts, .comply with federal and state regulations .timely investigation .Upon receiving an allegation . immediately begin an investigation .</p> <p>1. Resident #1 had diagnosis to include pleural effusion, ascities, and anxiety.</p> <p>A Progress Note, dated 12/26/23 at 6:43 a.m., read in part, .could hear resident shouting at a male and female CNA, 'Don't touch me! Go get the nurse, if you touch me I'm going to call 911' .</p> <p>The records contained no documentation an investigation was not initiated.</p> <p>A Progress Note, dated 01/04/24 at 12:19 p.m., read in part, . Called nonemergency police dept. [sic] to come .resident wanting to make a report .states that during care CNA leaned on her holding her down and covered her mouth with gloved hand .Police state .will not come to take statement from resident .</p> <p>The records did not contain documentation an investigation was initiated for the complaints voiced by Residents #10 or #11.</p> <p>A Progress Note, dated 01/10/24 at 3:57 a.m., read in part, .Resident is trying to call 911 now. [Resident] screaming loudly and disturbing other residents .</p> <p>There was no documentation Resident #1's disturbing other residents had been investigated to ensure other residents were not fearful.</p> <p>2. Resident #10 had diagnoses to include acute kidney failure, and Diabetes Mellitus-Type 2.</p> <p>A Incident Report, dated 01/04/24, included investigative notes that documented Resident #10 was asked if there were any concerns or complaints. The resident responded Therapy [staff, name omitted] not being nice mean .</p> <p>The records did not contain documentation the allegations of abuse or neglect reported by Resident #10 had been investigated.</p> <p>3. Resident #11 had diagnoses to include sepsis, chronic kidney disease, and spinal stenosis.</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>An Incident Report, dated 01/04/24, included investigative notes that documented Resident #11 was asked, Do you feel that the staff treats you with respect? Resident #11 responded, Sometimes .takes them a long time to answer [call light] in the evening/night worst .</p> <p>The records did not contain documentation the allegations of abuse or neglect reported by Resident #11 had been investigated.</p> <p>On 04/02/24 at 3:30 p.m., the DON and Corporate RN were asked if the progress note dated 12/26/24 had been investigated as a potential abuse allegation. The Corporate RN stated, Resident #1 often states this. They were asked how the facility determined the allegations on 01/04/24 and 01/14/24 had been fully investigated when other residents had reported concerns of treatment from staff. The Corporate RN stated, It looks like only the initial was investigated but there was no follow up on the findings. They were asked if the allegation of Resident #1 screaming and disturbing other residents was investigated and reported for the effect to other residents. The Corporate RN stated the allegation should have been investigated.</p> <p>4. Resident #2 had diagnoses to include major depression, chronic respiratory failure, anxiety, and chronic kidney disease.</p> <p>A Five-day assessment dated [DATE], documented Resident #2 had severe cognitive impairment.</p> <p>An Incident Report, dated 03/15/24, documented the administration was notified by a hospital liaison that Resident #2 did not want to return to the facility due to a nurse had slapped the resident twice.</p> <p>The investigative notes, only contained documentation the facility had attempted and/or spoken with the resident's family. An investigation had not been initiated to include interviews with other residents or facility staff.</p> <p>On 04/02/24 at 3:50 p.m., the DON stated they had only interviewed the resident's family regarding the allegation.</p> <p>5. Resident #4 had diagnosis to include bipolar and a malignant neoplasm.</p> <p>An initial Incident Report, dated 01/29/24, documented Resident #4 had made threats to another resident and an investigation was underway.</p> <p>There were no documents the allegation had been investigated.</p> <p>A quarterly assessment, dated 02/12/24, documented Resident #4 had moderate cognitive impairment.</p> <p>A Progress Note, dated 02/25/24 at 9:50 p.m., read in part, .[Resident #4] left facility without letting anyone know or signing out .resident called .stuck at Walmart and did not have a way to get back to facility and was with a police officer .</p> <p>The records did not contain an investigation was initiated for a missing resident.</p> <p>(continued on next page)</p>		

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