

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Four Seasons Rehabilitation & Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1212 Four Seasons Drive Durant, OK 74701	

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 - Few</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 for one (#1) of four residents reviewed for allegations of abuse.</p> <p>The administrator identified four allegations of abuse in the last six months.</p> <p>Findings:</p> <p>The facility policy titled Abuse Investigation and Reporting documented in parts .The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation .</p> <p>Resident #1 had diagnoses which included muscle weakness, altered mental status, and anxiety.</p> <p>An incident report, dated 08/06/24, documented an allegation of abuse. The report documented an employee inappropriately touched themselves in the resident's room. The report documented the employee was immediately suspended pending the investigation.</p> <p>An employee timecard, dated 08/06/24, documented CNA #1 clocked in at 2:49 p.m., clocked out at 4:49 p.m. , clocked back in at 5:22 p.m., and clocked out again at 11:10 p.m.</p> <p>On 09/19/24 at 11:19 a.m., the administrator reviewed CNA #1's timecard. The administrator stated the timecard had been altered to reflect time paid during the suspended time pending the investigation. The administrator could not provide documentation the staff was not working during the time of the investigation. The administrator stated they were unsure what time the staff member was allowed to return to work.</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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