

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/14/2024
NAME OF PROVIDER OR SUPPLIER  Clinton Therapy & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2316 Modelle Clinton, OK 73601	

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 0575</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>21731</p> <p>Based on observation and interview, the facility failed to ensure resident rights were posted. This had the potential to affect 35 residents in the facility.</p> <p>LPN #1 identified the census was 35.</p> <p>Findings:</p> <p>On 03/11/24 at 6:05 p.m., and on 03/12/24 at 10:40 a.m., tours of the common areas that were accessible to residents was completed. The resident rights were not located.</p> <p>On 03/14/24 at 11:30 a.m., the Administrator was asked if the resident rights were posted in any of the common areas that were accessible to all residents. A tour of the halls and common areas were conducted with the Administrator. They stated, I guess they aren't posted.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>21731</p> <p>Based on observation, record review, and interview, the facility failed to:</p> <p>a. assess a resident's physical limitations to prevent psychological abuse, and</p> <p>b. follow their abuse policy to fully investigate and report allegations of neglect for one (#5) of three residents reviewed for abuse.</p> <p>LPN #1 identified the facility census was 35.</p> <p>Findings:</p> <p>An undated, Abuse Neglect Exploitation Mistreatment and Misappropriation of Property Prevention policy, read in parts, .Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness .occurs when .staff fails .delivery of patient/resident care and service to assure care is provided as required .Mental abuse includes .humiliation, harassment, treats of punishment or deprivation .Residents .shall be protected .staff assigned have knowledge of the individual residents' care needs .identify .patterns, and trends .Investigate different types of incidents .Report all alleged violations . immediately .have evidence that all alleged violations are thoroughly investigated .</p> <p>Resident #5 had diagnoses to include bipolar disorder, chronic pain, congestive heart failure, and morbid obesity.</p> <p>A Care Plan, dated 03/16/23, documented Resident #5 was dependent on staff to meet emotional, intellectual, physical, and social needs.</p> <p>A Care Plan, updated on 08/05/23, documented Resident #5 had limited physical mobility related to obesity and shortness of breath, and chronic pain. An identified goal stated Resident #5 was to be evaluated for the effectiveness of pain interventions, reviewed for compliance, alleviating symptoms, dosing schedules and resident satisfaction with the results, and the impact on the functional ability and impact on cognition.</p> <p>A Care Plan, updated on 11/17/23 documented Resident #5 had terminal prognosis related to congestive heart failure. A documented goal included for Resident #5 to be provided dignity and autonomy at the highest practical level, continue hospice services, and encourage the resident to express feelings, listen with non-judgmental acceptance and compassion.</p> <p>A Quarterly Assessment, dated 01/03/24, documented Resident #5 required supervision and touching to dress, putting on and taking off footwear, and weighed 406 pounds.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/12/24 at 9:20 a.m., Resident #5 stated staff refused to assist the resident to put on their shoes yesterday. Resident #5 stated three staff came into their room, one was the Ring Leader that told the resident to put on their own shoes. Resident #5 stated, I have had two separate back surgeries with fusions in to separate areas of the spine, and I'm too large to bend over. I am on hospice, so I don't have staff bath me, I toilet myself, I told [name omitted/ ADON]. Resident repeated, I can't reach my feet, I cant bend over this, pointed to their large abdomen, and began to cry and sob. Resident #5 stated, They do this to me all of the time, staff can assist everyone except for me, and I don't understand why they are so mean.</p> <p>On 03/12/24 at 2:16 p.m., CNA #2 stated a couple of residents get upset when staff try to encourage them to do as much as they can for themselves, the residents ask why they cant get the staff to help them. CNA #2 stated they did not report an event that occurred on 03/11/24 with Resident #5 getting upset when told to put his shoes on and the information should have been reported to the charge nurse.</p> <p>On 03/12/24 at 2:35 p.m., LPN #2 stated Resident #5 does report that if their medications are not administered on time and feels it is abuse. We always let the administrator know. Today, the Administrator was informed at 12:30 p.m., of the complaint made by the resident today. LPN #2 stated they reported that Resident #5 alleged the aides are not wanting to help the resident put on their shoes, but the resident, Likes to be pampered.</p> <p>On 03/12/24 at 2:52 p.m., the Administrator stated they had been informed yesterday by CNA #3, that Resident #5 was upset and alleged staff refused to provide assistance to put on their shoes. The Administrator stated the ADON had been informed by the Resident and a grievance had been initiated. The Administrator was asked if neglect investigation had been considered per the facility abuse policy. They stated, Would have to look.</p> <p>On 03/12/24 at 3:20 p.m., the Administrator was asked how the facility followed their abuse policy to ensure Resident #5's physical limitation have been assessed, and an allegation for neglect and psychological abuse been initiated due to their limitations after repeated requests of staff to assist with putting on shoes. They stated, I didn't think about that, probably should have been.</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>21731</p> <p>Based on record review and interview, the facility failed to coordinate care and services with mental health providers for one (#1) of three residents reviewed for mental health services.</p> <p>The facility census was 35.</p> <p>Findings:</p> <p>Resident #1 had diagnoses to include depression.</p> <p>A Physician Order, dated 05/26/23, documented staff were to complete behavior monitoring every shift for scratching, itching, biting, sexual inappropriate behavior, hitting, attention seeking, hand wrenching, cussing, elopement attempts, refusal of care or hallucinations. The behaviors were to be documented in the clinical record.</p> <p>A Care Plan, dated 06/26/23, documented Resident #1 had behavioral problems to make frequent, and false statements and allegations against others and threatens to call the state complaint department.</p> <p>A Physician Order, dated 07/23/23, documented mental health services were to be evaluated and treat Resident #1 as indicated.</p> <p>A Progress Note, dated 07/23/23, documented Resident #1 was seen by mental health staff , on 07/21/23, and no changes in order or care plan were made at the time of the visit.</p> <p>A Care Plan, updated on 12/12/23, documented Psychiatric and/or Psychogeriatric consult was to be initiated for mental health specialists to provide an evaluation and treatment.</p> <p>A Care Plan, update on 02/21/24, documented mental health was to be complete and evaluation and treat Resident #1 as indicated.</p> <p>An Admission Assessment, dated 02/15/24, documented Resident #1:</p> <ul style="list-style-type: none"> <li>a. was cognitively intact,</li> <li>b. displayed verbal behavioral symptoms directed toward other, such as threatening others, screaming at others, or cursing at others, one to three days of the assessment process, that created a significantly interference with the resident's care,</li> <li>c. rejected care one to three days of the assessment process, and</li> <li>d. the residents behaviors remained the same as the prior assessment.</li> </ul> <p>The clinical record contained no documentation Resident #1 had been provided mental health services after 07/23/23.</p> <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/14/24 at 10:45 a.m., the DON was asked if Resident #1, currently received mental health services. The DON stated the clinical record only contained documentation Resident #1 had been seen on 07/23/23. The DON stated, We don't always know who [mental health] is visiting when they come and we usually do not receive progress notes, only orders if an order has been added or changed. The DON was asked how the facility ensured coordination of care with mental health services. No answer was provided.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>21731</p> <p>The facility failed have a system in place to ensure medications were available for one (#1) of three sampled residents reviewed for medication availability.</p> <p>LPN #1 stated the facility census was 35.</p> <p>Findings:</p> <p>Resident #1 had diagnoses to include ankylosing spondylitis, depressive episodes, and anxiety.</p> <p>Physician Orders, dated 05/26/23, documented Resident #1 was to be administered:</p> <ul style="list-style-type: none"> <li>a. Elderberry Immune Complex, two gummies one time a day,</li> <li>b. Turmeric 500 mg, two capsules one time a day, and</li> <li>c. Vitamin E, 1200 units one time a day.</li> </ul> <p>Physician Orders, dated 05/27/23 documented Resident #1 was to be administered:</p> <ul style="list-style-type: none"> <li>a. Vitamin C gummies 500 mg one time a day, and</li> <li>b. Vitamin D-3 extra strength, gummies 150 mcg one time a day;</li> </ul> <p>The MAR, dated 12/2023, documented the following medications were held and not administered:</p> <ul style="list-style-type: none"> <li>a. Elderberry Immune Complex from 12/29/23 to 01/01/24,</li> <li>b. Turmeric from 12/12/23 to 12/19/23, and</li> <li>c. Vitamin E from 12/12/23 to 12/19/23 and, from 12/29/23 to 01/01/24.</li> </ul> <p>The clinical record did not contain signed physician orders to hold the medication or an entry the physician had been notified with the rational the medications were not administered.</p> <p>The MAR, dated 01/2024, documented the following medications were held and not administered:</p> <ul style="list-style-type: none"> <li>a. Elderberry Immune Complex from 01/01/24 to 01/08/24, from 01/12/24 to 01/22/24, and</li> <li>b. Vitamin E from 01/01/24 to 01/08/24, 01/12/24 to 01/22/24, and from 01/27/24 to 02/01/24.</li> </ul> <p>The clinical record did not contain signed physician orders to hold the medication or an entry the physician had been notified with the rational the medications were not administered.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The MAR, dated 02/2024, documented the following medications were held and not administered:</p> <ul style="list-style-type: none"> <li>a. Elderberry Immune Complex from 02/12/24 to 03/01/24,</li> <li>b. Turmeric from 02/12/24 to 03/01/24, and</li> <li>c. Vitamin E from 02/01/24 to 02/05/24, and from 02/12/24 to 03/01/24.</li> </ul> <p>The clinical record did not contain signed physician orders to hold the medication or an entry the physician had been notified with the rationale the medications were not administered.</p> <p>The MAR, dated 03/2024, documented the following medications were held and not administered:</p> <ul style="list-style-type: none"> <li>a. Elderberry Immune Complex from 03/01/24 to 03/13/24,</li> <li>b. Turmeric from 03/01/24 to 03/13/24, and</li> <li>c. Vitamin E from 03/01/24 to 03/13/24</li> </ul> <p>The clinical record did not contain signed physician orders to hold the medication or an entry the physician had been notified with the rationale the medications were not administered.</p> <p>On 03/13/24 at 1:30 p.m., LPN #1 was asked to review the MAR documentation with multiple medications being held and not given without documentation of the rationale. LPN #1 stated, they were unaware of any of the medications being on hold but the resident does like to order their own medications.</p> <p>On 03/14/24 at 12:30 p.m., the DON stated a medication nurse was aware Resident #1 did not have the medications available, they documented the wrong thing in the computer and created a hold order. They stated there was not a physician hold order, the medications had not been available to administer to the resident.</p>