

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  06/12/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>41872</p> <p>Based on record review and interview the facility failed to ensure staff followed their policy to report an allegation of abuse to the Administrator for one (#10) of four sampled residents reviewed for abuse.</p> <p>The Administrator identified 31 residents resided in the facility.</p> <p>Findings:</p> <p>An Abuse Policy and Procedure policy, read in part .Immediate reporting. ALL allegations of maltreatment, including .verbal abuse .must be reported immediately to the Administrator by a Facility employee or immediate supervisor .</p> <p>Resident #10 had diagnoses which included acute respiratory failure and depressive disorder.</p> <p>On 06/12/24 at 8:40 a.m., CNA #2 was asked if they had ever heard staff curse or talk in a demeaning was to residents. They stated Yes. They were asked who and when. CNA #2 stated, This weekend by the nurses station there was a verbal altercation with [LPN #1] and [Resident #10]. I was coming down the hall heard [Resident #10] called [LPN #1] a bitch. then [LPN #1] stated 'Don't ever call me a bitch you look like a pig, you smell like a pig, and you breathe like a pig'. I looked at LPN #2 hoping [they] would say something. [LPN #2] just laughed. CNA #2 was asked if they had reported the altercation. They stated, No.</p> <p>On 06/12/24 at 9:24 a.m., the Administrator was asked if any staff had reported the incident with LPN #1. They stated No.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41872</p> <p>Based on observation, record review, and interview, the facility failed to ensure supervision to prevent an elopement for one (#3) of three sampled residents reviewed for elopement.</p> <p>The Administrator identified 31 residents resided in the facility. The MDS coordinator identified three residents who were at risk for elopement.</p> <p>Findings:</p> <p>An Elopement policy, revised 2007, read in part .Staff shall investigate and report all cases of missing residents .</p> <p>Resident #3 had diagnoses which included Alzheimer's, dementia and delusional disorder.</p> <p>A Wandering Risk Scale, dated 04/29/24 documented Resident #3 was a low risk to wander.</p> <p>A Behavior Note, dated 04/30/24 at 3:01 p.m., .Resident went outside to smoke and [the resident] started to walk off stating [they] was going home. Staff informed this nurse and was able to get [the resident] to come back inside .</p> <p>A Health Status Note, dated 04/30/24 at 9:51 p.m., read in part .does exit seek .</p> <p>A Release of Responsibility for Outside Activity, dated 05/01/24 at 2:30 P.M., had Resident #3's signature on it with a return time of 3:30 p.m.</p> <p>The staff schedule for 05/01/24 through 05/31/24, documented the DON worked on 05/01/24 and RN #1 worked on 05/26/24.</p> <p>A police Radio Log Public report, dated 05/01/24 at 3:02 p.m., read in part .Missing patient .[name of facility withheld] .walked past office approx 30 minutes ago [Resident #3] .wearing jeans, white shirt, and a pillow case .@ [3:10 p.m. name of facility withheld] adv subject is at [daughters address withheld] .subject returned to nursing home .manager adv will place subject on 24/7 supervision .</p> <p>The clinical health record did not contain documentation the resident had left the facility on [DATE].</p> <p>A 1:1 Monitoring for Resident Safety form documented Resident #3 was started on 1:1 supervision on 05/01/24.</p> <p>On 06/11/24 at 1:50 p.m., Resident #3's 1:1 Monitoring for Resident Safety forms, dated 05/01/24 through 05/28/24 were reviewed with the Administrator, and had missing documentation [times or initials] for the following dates:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/08/24 from 7:00 a.m. to 2:30 p.m.,</p> <p>On 05/10/24 from 5:30 p.m. to 7:30 p.m.,</p> <p>On 05/15/24 from 6:30 p.m. to 05/16/24 at 7:30 a.m.,</p> <p>On 05/17/24 from 5:30 a.m. to 7:00 a.m., and 5:30 p.m., to 7:00 p.m.,</p> <p>On 05/18/24 from 10:30 a.m. to 3:00 p.m. and 7:00 p.m., to 9:30 p.m.,</p> <p>On 05/19/24 from 5:00 a.m., to 7:00 a.m.,</p> <p>On 05/20/24 from 4:00 p.m. to 8:00 p.m.,</p> <p>On 05/21/24 from 11:30 p.m. to 2:00 a.m.,</p> <p>On 05/22/24 from 3:15 p.m. to 3:45 p.m., and</p> <p>On 05/26/24 from 1:30 p.m. to 3:00 p.m.</p> <p>The Administrator verified the resident was in the facility at these times and the 1:1 documentation had not been completed.</p> <p>A Behavior Note, dated 05/03/24 read in part .Resident noted trying to open windows in room. Reports [the resident] was going to try and leave facility to go get a phone .[family member] notified and stated Yall better watch [the resident] [the resident] likes to run away and stays moving Staff 1:1 with resident .</p> <p>A Behavior Note dated 05/09/24 at 5:30 a.m., read in part While this nurse was in another resident's room heard CNA yell for assistance. This resident had gone out the activities door .Resident had gone through gate and around parking lot. Resident did not leave .property .Resident returned to room and 1:1 resumed now that resident is awake .</p> <p>A Health Status Note, dated 05/15/24 at 8:01 p.m., read in part .resident up at will, about center, resident remain 1:1 .</p> <p>The 1:1 supervision did not contain documentation the resident was on 1:1.</p> <p>A Behavior Note, dated 05/20/24 at 5:00 p.m., read in part .Staff remained 1:1 with resident when resident attempted to go through back door heading toward the staff break room .</p> <p>A Behavior Note, dated 05/24/24 at 3:00 p.m., read in part .Resident was ambulating in front of facility and attempted to exit the ambulance entrance and was stopped by the CNA .</p> <p>A Health Status Note, dated 05/25/24 at 7:57 p.m., read in part .resident remain on 1:1 due to flight risk .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An Incident Note, dated 05/26/24 at 10:47 a.m., read in part .Late Entry .Staff called this nurse to report resident got out of this facility while being 1:1. [CNA #3] that was 1:1 with resident had to use the bathroom and left resident unattended without communicating to staff so other staff member could remain with resident. Resident found by this nurse blocks away from building. Resident was trying to get a ride from a silver car .Resident got into vehicle and was taken back to facility. Unable to reach on call or POA. Notified RN on duty [RN #1] that remained with residents and building while this nurse looked for the resident, then notified DON .and Administrator .</p> <p>An incident report, dated 05/26/24 at 10:47 a.m., read in part .Staff called this nurse to report resident got out of facility while being one on one .Resident Description: I got out to go to my nephews house .Resident found by this nurse blocks away from the building. Resident was trying to get a ride from a silver car. This nurse asked resident if [they] would get into vehicle. Resident got into vehicle and was taken back to facility. Unable to reach on call, or POA. Notified RN on duty [RN #1] that remained with residents and building while this nurse looked for the resident, then notified DON .and Administrator .oriented to person .had impaired memory .wandered .</p> <p>A faxed communication result report, dated 06/05/24, Incident Report Form, documented the form was a combined initial and final report regarding Resident #3's elopement from the facility on 05/26/24. The incident report read in part, .During an audit of documentation it was discovered that [the resident] had left the building on 05-26-24, around 10:47 a.m. Resident was located around the intersection of [name of street withheld] and [name of street withheld] approx. 3 blocks away. [The resident] has been on 1:1 since 5/1/24 . [LPN #3] reported to the administrator on 05/26/24 that [the resident] had gotten out of the facility but never left the grounds or out of sight of the staff .</p> <p>On 06/11/24 at 9:39 a.m., RN #1 was asked what happened when Resident #3 left the facility on [DATE] and were they notified. They stated they had been notified, so they went to the front desk and asked what happened. Staff at desk stated the resident left out the back door. They were asked when the resident returned what did they do. They stated they called the Administrator. They were asked if the facility was aware the resident left why wasn't a state report done at the time of the incident. They stated they did not know why it was not done. RN #1 was shown the state incident report, dated 06/05/24, and asked if it was accurate. RN #1 stated, I called the Administrator and told them staff were out looking for the resident. They were asked if the Administrator was aware Resident #3 had left. They stated Yes.</p> <p>On 06/11/24 at 12:39 p.m., the DON was asked what the care plan documented for elopement. They stated it did not have anything on the care plan. The DON was asked where Resident #3 went when they signed themselves out on 05/01/24. They stated, they did not see any documentation in the record where the resident left the facility. They were asked about the police call log that documented the resident was missing. They stated they did not know about that. The DON was asked if they had been notified Resident #3 was missing on 05/26/24. They stated they did not remember.</p> <p>On 06/11/24 at 1:01 p.m., Resident #3's family member was asked what had the facility informed them about Resident #3 eloping. They stated the resident had gotten out two times, the first time the resident came to their house and the second time the resident was near the bowling alley. They stated they live about a mile and a half from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/11/24 at 1:33 p.m., the Administrator was asked about Resident #3 leaving the facility unattended on 05/01/24 and the police report that was filed as a missing resident. They stated staff thought resident was missing before they checked the sign out sheet. They were asked if that should have been charted in the resident's chart. They stated, I would think so. They were asked how did the resident get to the family members house on that day. They stated the resident may have walked there. They were asked why the resident was put on 1:1 they stated because the resident did not tell anyone they were leaving, just signed out and left. They stated the DON reported the information to them. The Administrator stated, I remember getting a phone call stating [the resident] was gone. They stated the DON reported the resident as missing. The Administrator was asked where the documentation was for the incident on 05/01/24. They stated there was none. They were asked what did the policy state. To investigate and report all cases of missing residents. The Administrator was asked if the care plan should be updated for elopement. They stated, I would think so.</p> <p>On 06/11/24 at 1:30 p.m., the Administrator reviewed the late entry progress note dated 05/26/24 and was asked if that had been reported to them. They stated they did not know until 06/05/24. They were asked if staff informed them. They stated, No.</p> <p>On 06/12/24 at 8:15 a.m., CNA #1 was asked if Resident #3 had eloped. They stated when the resident first got here and recently. They were asked about the incident on 05/01/24. They stated the resident was found at a family members house, someone had called the family member.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41872</b></p> <p>Based on observation, record review, and interview, the facility failed to maintain an effective pest control for four (#1, #4, #6 and #7) of four sampled residents reviewed for pest control.</p> <p>The Administrator identified 31 residents resided in the facility.</p> <p>Findings:</p> <p>A Pest Control policy, undated, read in part .Our facility shall maintain an effective pest control program .This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents .</p> <p>A Bed Bugs, Preventing and Managing Infestations of policy, revised August 2011, read in part .Staff will employ infection control strategies to prevent and manage infestation of bed bugs .Identification .check resident rooms at night when bed bugs are active .Remove and/or treat all infested materials using non-chemical methods, including: .Washing and drying bedding, linens, and clothing at a high temperature; vacuuming or steam cleaning floors, mattresses, and any porous surfaces that cannot be machine-washed: Steaming or heat-treating infested rooms and areas .The following should be documented at the facility level . Identified instances of infestation .Response to the report .Actions taken, including all interventions .The following should be documented at the resident-level for those directly affected by the infestation .Resident response to the infestation .Interventions and treatment .Notification of family/responsible party .</p> <p>A pest control invoice, dated 05/14/24, read in part .Bed Bugs-Blood Spots, Body Parts, Shed Skins in room [ROOM NUMBER] .</p> <p>A Maintenance Work Order, dated 06/06/24, documented roaches in Resident #6's room.</p> <p>On 06/10/24 at 1:39 p.m., Resident #6 was asked if there were any concerns with pests. They stated with cockroaches around the sink area. Resident #6 stated there was a couple of roaches on the nightstand within the last 2-3 weeks. A small live roach was observed by this surveyor and Resident #6 on the floor near the sink.</p> <p>On 06/10/24 at 2:25 p.m., LPN #1 was asked why there was a blue gown hanging on Resident #4's and Resident #7's door. They stated the residents were moved to another room last week. They stated they did not know why.</p> <p>On 06/10/24 at 2:27 p.m., RN #1 was asked why Resident #4 and Resident #7 had been moved to another room. They stated there were bed bugs in their room on 06/06/24.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/10/24 at 2:46 p.m., Resident #4 was asked why they moved rooms. They stated there was an outbreak of bed bugs. They stated their room was sprayed once and waited until chemicals were gone then they returned to their room. They stated they felt itching on their arm and there was still bed bugs in the room so they were moved to this room. They were asked how the facility responded. Resident #4 stated the facility had them shower and took all their clothes in plastic bags. There was no documentation in the clinical health record of room change, resident response or interventions implemented.</p> <p>On 06/11/24 at 8:32 a.m., the activities director was asked if they had any concerns with bed bugs, mice or roaches. They stated they observed roaches in their room sometime last week.</p> <p>On 06/11/24 at 3:02 a.m., Resident #1 was asked if they had any concerns with roaches, bed bugs or mice. They stated they had seen a roach yesterday (06/10/24) by their television.</p> <p>A bed bug service agreement, dated 06/11/24, documented a bed bug treatment had been completed but did not document what areas had been treated.</p> <p>On 06/12/24 at 11:13 a.m., Resident #7 was asked about bed bugs. They stated they were moved last week from their other room. About three weeks ago bed bugs were identified and the room was treated. The clinical health record did not contain documentation of room change, resident response or interventions implemented.</p> <p>On 06/12/24 at 11:08 a.m., the Administrator was asked what rooms had been treated on 06/11/24 and was there evidence of pests (bed bugs). They stated two rooms (37 and 38) had been treated and there was evidence of pests.</p>