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 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Therapy & Living Center	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on record review and interview, the facility failed to ensure a resident and/or their legal representative was informed in writing of treatments and side effects of the use of psychotropic medications for one (#24) of five sampled residents who were reviewed for education, alternative treatments, and consents for psychotropic medication treatments. The DON identified 11 residents who had diagnosis of dementia and 18 residents who received psychotropic medications. Findings: Resident #24 was admitted to the facility on [DATE] with diagnoses which included dementia, schizoaffective-bipolar type, delusional disorder, depression, and obsessive compulsive behavior. Resident #24's admission assessment, dated 04/25/24, documented they were taking antipsychotic, antianxiety, and antidepressants on a routine basis. The assessment documented the resident's cognition was severely impaired. Resident #24's physician orders, dated 11/05/24, documented the resident was prescribed the following psychotropic medications: a. Vistaril Oral Capsule 25 MG (hydroxyzine pamoate) 1 capsule by mouth one time only related to schizoaffective disorder/bipolar type on 11/05/24 , b. Seroquel oral tablet 50 MG (quetiapine fumarate) 1 tablet by mouth one time a day related to other specified mood disorder on 07/13/24, c. lorazepam oral tablet .5 MG by mouth every 6 hours as needed for increased anxiety related to other specified mood disorder on 11/01/24, and d. Depakote oral tablet delayed Release 500 MG Give 1 tablet by mouth two times a day related to unspecified dementia, unspecified severity, with other behavior disturbance on 08/07/24. Resident #24's EHR was reviewed. The EHR did not contain documentation of consents, education, and alternative treatments for psychotropic medications. (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: 375253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Therapy & Living Center	2316 Modelle Clinton, OK 73601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/24 at 9:20 a.m., the DON stated they did not complete consents, education, and alternative treatments for psychotropic medications, and they knew they should of been completed.

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 11/07/2024
NAME OF PROVIDER OR SUPPLIER Clinton Therapy & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2316 Modelle Clinton, OK 73601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to ensure a clean, safe, and comfortable home like environment for residents. The administrator identified 31 residents resided in the facility. Findings: An undated facility Safe Environment policy, read in part, The facility will maintain comfortable and safe temperature levels between 71 and 81 degrees F(Fahrenheit). The policy also read, The facility will be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. On 11/05/24 at 7:30 a.m., residents were observed in the common area and dining room wearing coats and covered in blankets. The temperature in the dining room was 68.3 degrees F. On 11/05/24 at 7:35 a.m., the corner wall leading into the dining room from the common area was observed. The sheetrock was missing and a metal strip was protruding from the wall. The metal strip was sharp to the touch. This was the main thoroughfare where all residents accessed the dining room. On 11/05/24 at 8:48 a.m., the maintenance supervisor went to room [ROOM NUMBER]. The temperature was 68.3 degrees F. They were asked what the temperature in the building should be. They stated between 71-81 degrees F. They stated the heat had to be turned on and they did not have access to the thermostat program. On 11/05/24 at 8:52 a.m., room [ROOM NUMBER]'s temperature was measured and recorded at 69 degrees F. Resident #3 was observed covered with several blankets in their bed. They stated it was very cold. On 11/05/24 at 8:53 a.m., room [ROOM NUMBER]'s temperature was measured and recorded at 68.3 degrees F. Resident #27 was observed wearing a coat. They stated it was very cold and the heat was not working. On 11/05/24 at 8:55 a.m., room [ROOM NUMBER]'s temperature was measured and recorded at 69.3 degrees F. Resident #23 was wearing a coat. They stated it was cold in their room. On 11/05/24 at 9:00 a.m., the maintenance supervisor went down stairs and checked the heater control. They stated the heat was not turned on. They were asked about the damaged wall. They stated the residents hit the wall with their wheelchairs and damaged the wall. They stated they had not had a chance to repair the wall. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Clinton Therapy & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2316 Modelle Clinton, OK 73601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/05/24 at 9:25 a.m., CNA #2 was shown the damaged wall. They stated they noticed the wall the day prior. They were asked if the damaged wall was a concern. CNA #2 stated if a resident hit it they could cut themselves. They were asked if they thought the wall looked like a safe, comfortable, and homelike environment. They stated, No, and it's a safety risk. On 11/05/24 at 9:43 a.m., the DON stated the damaged wall could cause skin tears and it did not look homelike. The DON stated they were unsure what the policy was for maintaining temperatures in the facility.

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 11/07/2024
NAME OF PROVIDER OR SUPPLIER: Clinton Therapy & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2316 Modelle, Clinton, OK 73601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to prevent sexual abuse for one (#13) of three sampled residents who were reviewed for abuse. The administrator identified 31 residents resided in the facility. Findings: An undated facility policy titled Abuse Policy and Procedure, read in part, Isolating If the accused person is agitated, [they] will be removed from the area and temporarily separated as a therapeutic intervention until [their] agitation is lowered. {name of facility with held} will implement steps aimed at preventing the accused person from visiting other peoples rooms unattended, until [their] behavior is stabilized. The policy also read, Nursing staff shall document the incident and interventions in the Medical Record. 1. Resident #13 had diagnoses which included cerebral aneurysm and muscle wasting with atrophy. Resident #13's quarterly assessment, dated 07/24/24, documented their cognition was intact. On 11/04/24 at 1:22 p.m., Resident #24 was observed to exit their room and go into Resident #13's room. Resident #24 was naked. Resident #13 was observed to yell in a loud tone help repeatedly. Staff rushed to Residents #13's room and redirected Resident #24 back to their room while attempting to cover Resident #24 with a gown. On 11/04/24 at 2:53 p.m., Resident #13 stated Resident #24 had gone to their room naked. They stated they had to yell for help. They stated Resident #24 tried to take their candy and sodas. Resident #13 stated Resident #24 stood over them naked and they screamed for help until staff arrived. Resident #13 stated this type of action happened 10 times a day daily since Resident #24 was admitted . Resident #13 stated the facility was aware and came and got the resident right away. Resident #13 stated they were annoyed and would like it to stop. 2. Resident #24 was admitted to the facility on [DATE] with diagnoses which included dementia, schizoaffective/bipolar type, and delusional disorder. Resident #24's quarterly assessment, dated 07/24/24, documented their cognition was significantly impaired. Resident #24's progress notes documented they had entered into other residents' rooms on the following dates: a. On 10/25/24 at 7:45 a.m., 8:06 a.m., and 8:40 a.m., pt is not wearing any clothes, entering other pt room, staff was eventually able to redirect back into [their] room, (continued on next page)

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 11/07/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. on 10/26/24 at 12:56 p.m., pt entering other resident room, taking their belongings, pt refuses to put on a gown or clothing., c. on 10/26/24 at 1:41 p.m., this nurse asked CMA if [they] received [their] PRN for Behaviors, CMA indicated [they] received it. pt continues to come out of [their] room naked. pt continues to refuse to put on gown or clothing. pt was redirected back to [their] room, d. on 10/27/24 at 8:07 a.m., pt is wearing a gown, however pt continues to attempt to go into other residents' rooms and take items/things from their room to [theirs], e. on 10/27/24 at 2:50 p.m., pt continues to go into other pt rooms, pt has removed [their] gown and refuses to put it back on, pt hides from the gown under [their] blanket, f. on 10/30/24 at 6:24 p.m., Resident has come out of [their] room completely naked multiple times this shift. Goes into other residents' rooms and attempt to take their belongings. Resident laughs but does not say anything though [they] is able to speak. Staff redirects resident back to [their] room and ensures bed is clean and dry, provides snacks and fluids in case of hunger or thirst. PRN lorazepam given, g. on 11/01/24 at 8:58 a.m., pt has been out of [their] room [ROOM NUMBER] times this morning, pt has refused to put on a gown the previous 3 times, this last time [they] finally put on a gown. pt has been redirected to [their] room at this time, h. on 11/01/24 at 9:44 p.m., resident continue to go into other rooms in the nude, and out in the hall. resident redirected back into [their] room, i. on 11/02/24 at 7:57 a.m., pt continues to come out of [their] room without a gown, pt continues to refuse to put on a gown, pt continues to enter female rooms naked, pt continues to encroach on other residents' personal space it is getting progressively more difficult to redirect pt out of female residents' rooms. pt is beginning to actively resist leaving female residents' rooms, and j. on 11/04/24 at 3:59 p.m., Resident continues to wander into other residents rooms and requires staff to redirect resident to [their] own room. On 11/07/24 at 8:53 a.m., CNA #1 was asked to discuss Resident #24's behaviors. They stated the resident did not like to wear clothes and went into the female resident room across the hall. They stated Resident #24 was always naked and took their candy and sodas. They were asked how Resident #13 responded when this happened. CNA #1 stated Resident #13 yelled for help and Resident #24 was naked when it happened. They stated Resident #13 was tired of seeing a naked individual and this occurred at least five times a day since Resident #24 was admitted . CNA #1 stated that the administrator and nurses acted like it was normal for a naked individual to stand over a resident and laugh. They stated Resident #13 did not like it and wanted it to stop. On 11/07/24 at 9:22 a.m., LPN #1 was asked about Resident #24's behaviors. They stated Resident #24 went into Resident #13's room naked and they screamed for help. They stated this occurred two to three times daily since Resident #24 was admitted . They stated they reported the behaviors to the administrator. LPN #1 stated there had to be a better system to protect Resident #13 from these types of behaviors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375253	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Therapy & Living Center	2316 Modelle Clinton, OK 73601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 1:19 p.m., the administrator was asked about the incident involving Resident #24 and Resident #13. The administrator stated Resident #24 had gone into Resident #13's room since admit several times a day, naked, and tried to take candy. The administrator stated if someone was going into another residents room naked it would be considered sexual abuse. The administrator stated they only reported misappropriation on 11/06/24 and did not report sexual abuse until prompted by the SA. An OSDH 283 form, dated 11/06/24, documented misappropriation and abuse were sent to OSDH by fax at on 11/06/24 at 1:22 p.m.

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NAME OF PROVIDER OR SUPPLIER Clinton Therapy & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2316 Modelle Clinton, OK 73601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to implement their abuse policy by: a. not reporting abuse to the administrator and investigating immediately; and b. not taking steps to prevent further abuse for two (#13 and #82) of three sampled residents who were reviewed for abuse. The administrator identified 31 residents resided in the facility. Findings: An undated facility policy titled Abuse Policy and Procedure, documented residents had the right to be free from physical abuse, all incidents would be reported to the administrator and investigated immediately, and steps should be immediately implemented to prevent future abuse. 1. Resident #13 had diagnoses which include cerebral aneurysm and muscle wasting with atrophy. Resident #13's quarterly assessment, dated 07/24/24, documented their cognition was intact. On 11/04/24 at 1:22 p.m., Resident #24 was observed to exit their room and go into Resident #13's room. Resident #24 was naked. Resident #13 was observed to yell in a loud tone help repeatedly. Staff rushed to Residents #13's room and redirected Resident #24 back to their room while attempting to cover Resident #24 with a gown. On 11/04/24 at 2:53 p.m., Resident #13 stated Resident #24 had gone to their room naked. They stated they had to yell for help. They stated Resident #24 tried to take their candy and sodas. Resident #13 stated Resident #24 stood over them naked and they screamed for help until staff arrived. Resident #13 stated this type of action happened 10 times a day daily since Resident #24 was admitted . Resident #13 stated the facility was aware and came and got the resident right away. Resident #13 stated they were annoyed and would like it to stop. 2. Resident #24 was admitted to the facility on [DATE] with diagnoses which included dementia, schizoaffective/bipolar type, and delusional disorder. Resident #24's quarterly assessment, dated 07/24/24, documented their cognition was significantly impaired. Resident #24's progress notes documented they had entered into other residents' rooms on the following dates: a. On 10/25/24 at 7:45 a.m., 8:06 a.m., and 8:40 a.m., pt is not wearing any clothes, entering other pt room, staff was eventually able to redirect back into {their} room, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. on 10/26/24 at 12:56 p.m., pt entering other resident room, taking their belongings, pt refuses to put on a gown or clothing., c. on 10/26/24 at 1:41 p.m., this nurse asked CMA if [they] received [their] PRN for Behaviors, CMA indicated [they] received it. pt continues to come out of [their] room naked. pt continues to refuse to put on gown or clothing. pt was redirected back to [their] room, d. on 10/27/24 at 8:07 a.m., pt is wearing a gown, however pt continues to attempt to go into other residents' rooms and take items/things from their room to [theirs], e. on 10/27/24 at 2:50 p.m., pt continues to go into other pt rooms, pt has removed [their] gown and refuses to put it back on, pt hides from the gown under [their] blanket, f. on 10/30/24 at 6:24 p.m., Resident has come out of [their] room completely naked multiple times this shift. Goes into other residents' rooms and attempt to take their belongings. Resident laughs but does not say anything though [they] is able to speak. Staff redirects resident back to [their] room and ensures bed is clean and dry, provides snacks and fluids in case of hunger or thirst. PRN lorazepam given, g. on 11/01/24 at 8:58 a.m., pt has been out of [their] room [ROOM NUMBER] times this morning, pt has refused to put on a gown the previous 3 times, this last time [they] finally put on a gown. pt has been redirected to [their] room at this time, h. on 11/01/24 at 9:44 p.m., resident continue to go into other rooms in the nude, and out in the hall. resident redirected back into [their] room, i. on 11/02/24 at 7:57 a.m., pt continues to come out of [their] room without a gown, pt continues to refuse to put on a gown, pt continues to enter female rooms naked, pt continues to encroach on other residents' personal space it is getting progressively more difficult to redirect pt out of female residents' rooms. pt is beginning to actively resist leaving female residents' rooms, and j. on 11/04/24 at 3:59 p.m., Resident continues to wander into other residents rooms and requires staff to redirect resident to [their] own room. On 11/07/24 at 8:53 a.m., CNA #1 was asked to discuss Resident #24's behaviors. They stated the resident did not like to wear clothes and went into the female resident room across the hall. They stated Resident #24 was always naked and took their candy and sodas. They were asked how Resident #13 responded when this happened. CNA #1 stated Resident #13 yelled for help and Resident #24 was naked when it happened. They stated Resident #13 was tired of seeing a naked individual and this occurred at least five times a day since Resident #24 was admitted . CNA #1 stated that the administrator and nurses acted like it was normal for a naked individual to stand over a resident and laugh. They stated Resident #13 did not like it and wanted it to stop. On 11/07/24 at 9:22 a.m., LPN #1 was asked about Resident #24's behaviors. They stated Resident #24 went into Resident #13's room naked and they screamed for help. They stated this occurred two to three times daily since Resident #24 was admitted . They stated they reported the behaviors to the administrator. LPN #1 stated there had to be a better system to protect Resident #13 from these types of behaviors. (continued on next page)

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 11/07/2024
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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 1:19 p.m., the administrator was asked about the incident involving Resident #24 and Resident #13. The administrator stated Resident #24 had gone into Resident #13's room since admit several times a day, naked, and tried to take candy. The administrator stated if someone was going into another residents' room naked it would be considered sexual abuse. The administrator stated they only reported misappropriation on 11/06/24 and did not report sexual abuse until prompted by the SA. A OSDH 283 form, dated 11/06/24, documented Resident #24 had gone into Resident #13's room with no clothes and attempted to take personal items from Resident #13. A facsimile confirmation documented misappropriation and abuse were sent to OSDH by fax on 11/06/24 at 1:22 p.m. No other incident reports were documented regarding previous incidents documented in Resident #24's EHR. 3. Resident #82 was admitted to the facility on [DATE] with diagnoses which included Alzheimer disease early onset, schizoaffective bipolar type, and type 2 diabetes. Resident #82's comprehensive assessment, dated 03/18/24, documented their cognition was moderately impaired. The facility's Incident Report Form, dated 11/02/24, documented Resident #82 called the police at 12:48 p.m. alleging they were thrown against the wall by CMA #2 and LPN #3. Facsimile confirmation documented the initial incident report was faxed to OSDH on 11/02/24 at 7:35 p.m. CMA #2's Employee Timecard Report, dated 11/02/24, documented they worked on 11/02/24 from 7:12 a.m. until 7:08 p.m. LPN #3's Employee Timecard Report, dated 11/02/24, documented they worked on 11/02/24 from 6:50 a.m. until 7:09 p.m. On 11/05/24 at 1:34 p.m., the administrator stated they were made aware by LPN #3 on 11/02/24 at 4:49 p. m. Resident #82 was ready to be discharged from the hospital and was refusing to return to the facility. The administrator stated they drove to the hospital on 11/02/24 at 5:50 p.m. and was made aware of the alleged abuse allegation. The administrator stated the accused employees were suspended on 11/02/24 around 7:00 p.m. pending an investigation. On 11/05/24 at 3:33 p.m., CMA #2 stated Resident #82 came to the nurses station and wanted to call the police to report an issue. They stated they gave them the phone and Resident #82 told the 911 operator they were alleging abused on 11/02/24 around 1:30 pm. CMA #3 stated LPN #3 was present and they reported the resident was calling the police. CMA #2 stated the police came to the facility and made staff aware Resident #82 was alleging abuse. CMA #2 stated RN #1 and LPN # 3 were aware of the abuse allegation when the police arrived at the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/05/24 at 3:51 p.m., RN #1 stated they became aware of the abuse allegation on 11/02/24 between 1:30 p.m. and 2:00 p.m. when the police came to the facility. RN #1 stated they notified the DON of the abuse allegation on 11/02/24 at 2:15 p.m. RN #1 stated the abuse policy was not followed because the incident was not reported to the administrator within 2 hours and the accused staff members were not suspended after the police arrived until after their shift due to not having staff to cover the shift. On 11/05/24 at 4:06 p.m., the DON stated they were made aware of the abuse allegation on 11/02/24 at 5:30 p.m. The DON stated LPN #3 sent a text to them about 1:30 p.m. to 2:00 p.m. on 11/02/24 involving an incident. The DON stated the accused staff were suspended on 11/02/24 around 7:00 p.m. and the administrator/abuse coordinator should of been notified when the police arrived at the facility. On 11/06/24 at 8:40 a.m., the administrator stated when they were completing the incident report for the abuse, they realized they needed to suspend the two employees. The administrator stated they were not notified of the abuse allegation until 5:33 p.m. on 11/02/24 when they visited Resident #82 in the hospital. The administrator stated they suspended the two employees around 7:00 p.m. on 11/02/24 after completing the incident report.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review and interview, the facility failed to ensure allegations of abuse were reported to OSDH within two hours of the allegation for three (#13, 24 and #82) of three sampled residents who were reviewed for reporting timely abuse allegations. The administrator identified 31 residents resided in the facility. Findings: An undated facility policy titled Abuse Policy and Procedure, read in part, All allegations of maltreatment, including neglect, physical abuse,mental abuse,sexual abuse, involuntary seclusion, verbal abuse, injuries of unknown origin, and/or/or misappropriation of resident property, must be reported to the Administrator and Investigated by facility management. The Administrator will immediately report the allegation to the Oklahoma State Department of Health and the local police. 1. Resident #13 had diagnoses which included cerebral aneurysm and muscle wasting with atrophy. Resident #13's quarterly assessment, dated 07/24/24, documented their cognition was intact. On 11/04/24 at 1:22 p.m., Resident #24 was observed to exit their room and go into Resident #13's room. Resident #24 was naked. Resident #13 was observed to yell in a loud tone help repeatedly. Staff rushed to Residents #13's room and redirected Resident #24 back to their room while attempting to cover Resident #24 with a gown. On 11/04/24 at 2:53 p.m., Resident #13 stated Resident #24 had gone to their room naked. They stated they had to yell for help. They stated Resident #24 tried to take their candy and sodas. Resident #13 stated Resident #24 stood over them naked and they screamed for help until staff arrived. Resident #13 stated this type of action happened 10 times a day daily since Resident #24 was admitted . Resident #13 stated the facility was aware and came and got the resident right away. Resident #13 stated they were annoyed and would like it to stop. 2. Resident #24 was admitted to the facility on [DATE] with diagnoses which included dementia, schizoaffective/bipolar type, and delusional disorder. Resident #24's quarterly assessment, dated 07/24/24, documented their cognition was significantly impaired. Resident #24's progress notes documented they had entered into other residents' rooms on the following dates: a. on 10/25/24 at 7:45 a.m., 8:06 a.m., and 8:40 a.m., pt is not wearing any clothes, entering other pt room, staff was eventually able to redirect back into (their] room, (continued on next page)

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 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Therapy & Living Center	2316 Modelle Clinton, OK 73601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

b. on 10/26/24 at 12:56 p.m., pt entering other resident room, taking their belongings, pt refuses to put on a gown or clothing.,

c. on 10/26/24 at 1:41 p.m., this nurse asked CMA if [they] received [their] PRN for Behaviors, CMA indicated [they] received it. pt continues to come out of [their] room naked. pt continues to refuse to put on gown or clothing. pt was redirected back to [their] room,

d. on 10/27/24 at 8:07 a.m., pt is wearing a gown, however pt continues to attempt to go into other residents' rooms and take items/things from their room to [theirs],

e. on 10/27/24 at 2:50 p.m., pt continues to go into other pt rooms, pt has removed his gown and refuses to put it back on, pt hides from the gown under [their] blanket,

f. on 10/30/24 at 6:24 p.m., Resident has come out of [their] room completely naked multiple times this shift. Goes into other residents' rooms and attempt to take their belongings. Resident laughs but does not say anything though [they] is able to speak. Staff redirects resident back to [their] room and ensures bed is clean and dry, provides snacks and fluids in case of hunger or thirst. PRN lorazepam given,

g. on 11/01/24 at 8:58 a.m., pt has been out of [their] room [ROOM NUMBER] times this morning, pt has refused to put on a gown the previous 3 times, this last time [they] finally put on a gown. pt has been redirected to [their] room at this time,

h. on 11/01/24 at 9:44 p.m., resident continue to go into other rooms in the nude, and out in the hall. resident redirected back into [their] room,

i. on 11/02/24 at 7:57 a.m., pt continues to come out of [their] room without a gown, pt continues to refuse to put on a gown, pt continues to enter female rooms naked, pt continues to encroach on other residents' personal space it is getting progressively more difficult to redirect pt out of female residents' rooms. pt is beginning to actively resist leaving female residents' rooms, and

j. on 11/04/24 at 3:59 p.m., Resident continues to wander into other residents rooms and requires staff to redirect resident to [their] own room.

On 11/07/24 at 8:53 a.m., CNA #1 was asked to discuss Resident #24's behaviors. They stated the resident did not like to wear clothes and went into the female resident room across the hall. They stated Resident #24 was always naked and took their candy and sodas. They were asked how Resident #13 responded when this happened. CNA #1 stated Resident #13 yelled for help and Resident #24 was naked when it happened. They stated Resident #13 was tired of seeing a naked individual and this occurred at least five times a day since Resident #24 was admitted . CNA #1 stated that the administrator and nurses acted like it was normal for a naked individual to stand over a resident and laugh. They stated Resident #13 did not like it and wanted it to stop.

On 11/07/24 at 9:22 a.m., LPN #1 was asked about Resident #24's behaviors. They stated Resident #24 went into Resident #13's room naked and they screamed for help. They stated this occurred two to three times daily since Resident #24 was admitted . They stated they report the behaviors to the administrator. LPN #1 stated there had to be a better system to protect Resident #13 from these types of behaviors.

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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 11/07/2024
NAME OF PROVIDER OR SUPPLIER: Clinton Therapy & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2316 Modelle Clinton, OK 73601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/24 at 1:19 p.m., the administrator was asked about the incident involving Resident #24 and Resident #13. The administrator stated Resident #24 had gone into Resident #13's room since admit several times a day, naked, and tried to take candy. The administrator stated if someone was going into another residents room naked it would be considered sexual abuse. The administrator stated they only reported misappropriation on 11/06/24 and did not report sexual abuse until prompted by the SA. A OSDH 283 form, dated 11/06/24, documented Resident #24 had gone into Resident #13's room with no clothes and attempted to take personal items from Resident #13. A facsimile confirmation documented misappropriation and abuse were sent to OSDH by fax on 11/06/24 at 1:22 p.m. No other incident reports were documented regarding previous incidents documented in Resident #24's EHR. 3. Resident #82 was admitted to the facility on [DATE] with diagnoses which included Alzheimer disease early onset, schizoaffective bipolar type, and type 2 diabetes. Resident #82's comprehensive assessment, dated 03/18/24, documented their cognition was moderately impaired. The facility's Incident Report Form, dated 11/02/24, documented Resident #82 called the police at 12:48 p.m. alleging they were thrown against the wall by CMA #2 and LPN #3. Facsimile confirmation documented the initial incident report was faxed to OSDH on 11/02/24 at 7:35 p.m. CMA #2's Employee Timecard Report, dated 11/02/24, documented they worked on 11/02/24 from 7:12 a.m. until 7:08 p.m. LPN #3's Employee Timecard Report, dated 11/02/24, documented they worked on 11/02/24 from 6:50 a.m. until 7:09 p.m. On 11/05/24 at 1:34 p.m., the administrator stated they were made aware by LPN #3 on 11/02/24 at 4:49 p. m. Resident #82 was ready to be discharged from the hospital and was refusing to return to the facility. The administrator stated they drove to the hospital on 11/02/24 at 5:50 p.m. and was made aware of the alleged abuse allegation. The administrator stated the accused employees were suspended on 11/02/24 around 7:00 p.m. pending an investigation. On 11/05/24 at 3:33 p.m., CMA #2 stated Resident #82 came to the nurses station and wanted to call the police to report an issue. They stated they gave them the phone and Resident #82 told the 911 operator they were abused on 11/02/24 around 1:30 pm. CMA #3 stated LPN #3 was present and they reported the resident was calling the police. CMA #2 stated the police came to the facility and made staff aware Resident #82 was alleging abuse. CMA #2 stated RN #1 and LPN # 3 were aware of the abuse allegation when the police arrived at the facility. On 11/05/24 at 3:51 p.m., RN #1 stated they became aware of the abuse allegation on 11/02/24 between 1:30 p.m. and 2:00 p.m. when the police came to the facility. RN #1 stated they notified the DON of the abuse allegation on 11/02/24 at 2:15 p.m. RN #1 stated the abuse policy was not followed because the incident was not reported to OSDH until 6:50 p.m. on 11/02/24, the administrator was not notified within 2 hours, and the accused staff members were not suspended after the police arrived until after their shift due to not having staff to cover the shift. (continued on next page)

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	375253	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Therapy & Living Center	2316 Modelle Clinton, OK 73601

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/05/24 at 4:06 p.m., the DON stated they were made aware of the abuse allegation on 11/02/24 at 5:30 p.m. The DON stated LPN #3 sent a text to them about 1:30 p.m. to 2:00 p.m. on 11/02/24 involving an incident. The DON stated the accused staff were suspended on 11/02/24 around 7:00 p.m. and the administrator/abuse coordinator should of been notified when the police arrived at the facility. On 11/06/24 at 8:40 a.m., the administrator stated when they were completing the incident report for the abuse, they realized they needed to suspend the two employees. The administrator stated they were not notified of the abuse allegation until 5:33 p.m. on 11/02/24 when they visited Resident #82 in the hospital. The administrator stated they suspended the two employees around 7:00 p.m. on 11/02/24 after completing the incident report.

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NAME OF PROVIDER OR SUPPLIER: Clinton Therapy & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2316 Modelle Clinton, OK 73601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to ensure an allegations of abuse were investigated for two (#13 and #24) of three sampled residents who were reviewed for investigating allegations of abuse. The administrator identified 31 residents resided in the facility. Findings: The facility's Abuse Policy and Procedure policy, undated, documented residents have the right to be free from physical abuse and all incidents will be reported to the administrator and investigated immediately. 1. Resident #13 had diagnoses which included cerebral aneurysm and muscle wasting with atrophy. Resident #13's quarterly assessment, dated 07/24/24, documented their cognition was intact. On 11/04/24 at 1:22 p.m., Resident #24 was observed to exit their room and go into Resident #13's room. Resident #24 was naked. Resident #13 was observed to yell in a loud tone help repeatedly. Staff rushed to Residents #13's room and redirected Resident #24 back to their room while attempting to cover Resident #24 with a gown. On 11/04/24 at 2:53 p.m., Resident #13 stated Resident #24 had gone to their room naked. They stated they had to yell for help. They stated Resident #24 tried to take their candy and sodas. Resident #13 stated Resident #24 stood over them naked and they screamed for help until staff arrived. Resident #13 stated this type of action happened 10 times a day daily since Resident #24 was admitted . Resident #13 stated the facility was aware and came and got resident right away. Resident #13 stated they were annoyed and would like it to stop. 2. Resident #24 was admitted to the facility on [DATE] with diagnoses which included dementia, schizoaffective/bipolar type, and delusional disorder. Resident #24's quarterly assessment, dated 07/24/24, documented their cognition was significantly impaired. Resident #24's progress notes documented they had entered into other residents' rooms on the following dates: a. On 10/25/24 at 7:45 a.m., pt is not wearing any clothes, entering other pt room, staff was eventually able to redirect back into {their} room, b. on 10/26/24 at 12:56 p.m., pt entering other resident room, taking their belongings, pt refuses to put on a gown or clothing., (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

c. on 10/26/24 at 1:41 p.m., this nurse asked CMA if [they] received [their] PRN for Behaviors, CMA indicated [they] received it. pt continues to come out of [their] room naked. pt continues to refuse to put on gown or clothing. pt was redirected back to [their] room,

d. On 10/27/24 at 8:07 a.m., pt is wearing a gown, however pt continues to attempt to go into other residents' rooms and take items/things from their room to [theirs],

e. on 10/27/24 at 2:50 p.m., pt continues to go into other pt rooms, pt has removed his gown and refuses to put it back on, pt hides from the gown under [their] blanket,

f. on 10/30/24 at 6:24 p.m., Resident has come out of [their] room completely naked multiple times this shift. Goes into other residents' rooms and attempt to take their belongings. Resident laughs but does not say anything though [they] is able to speak. Staff redirects resident back to [their] room and ensures bed is clean and dry, provides snacks and fluids in case of hunger or thirst. PRN lorazepam given,

g. on 11/01/24 at 8:58 a.m., pt has been out of [their] room [ROOM NUMBER] times this morning, pt has refused to put on a gown the previous 3 times, this last time [they] finally put on a gown. pt has been redirected to [their] room at this time,

h. on 11/01/24 at 9:44 p.m., resident continue to go into other rooms in the nude, and out in the hall. resident redirected back into [their] room,

i. on 11/02/24 at 7:57 a.m., pt continues to come out of [their] room without a gown, pt continues to refuse to put on a gown, pt continues to enter female rooms naked, pt continues to encroach on other residents' personal space it is getting progressively more difficult to redirect pt out of female residents' rooms. pt is beginning to actively resist leaving female residents' rooms, and

j. on 11/04/24 at 3:59 p.m., Resident continues to wander into other residents rooms and requires staff to redirect resident to [their] own room.

On 11/07/24 at 8:53 a.m., CNA #1 was asked to discuss Resident #24's behaviors. They stated the resident did not like to wear clothes and went into the female resident room across the hall. They stated Resident #24 was always naked and took their candy and sodas. They were asked how Resident #13 responded when this happened. CNA #1 stated Resident #13 yelled for help and Resident #24 was naked when it happened. They stated Resident #13 was tired of seeing a naked individual and this occurred at least five times a day since Resident #24 was admitted . CNA #1 stated that the administrator and nurses acted like it was normal for a naked individual to stand over a resident and laugh. They stated Resident #13 did not like it and wanted it to stop.

On 11/07/24 at 9:22 a.m., LPN #1 was asked about Resident #24's behaviors. They stated Resident #24 went into Resident #13's room naked and they screamed for help. They stated this occurred two to three times daily since Resident #24 was admitted . They stated they report the behaviors to the administrator. LPN #1 stated there had to be a better system to protect Resident #13 from these types of behaviors.

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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 11/07/2024
NAME OF PROVIDER OR SUPPLIER Clinton Therapy & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2316 Modelle Clinton, OK 73601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/24 at 1:19 p.m., the administrator was asked about the incident involving Resident #24 and Resident #13. The administrator stated Resident #24 had gone into Resident #13's room since admit several times a day, naked, and tried to take candy. The administrator stated if someone was going into another residents room naked it would be considered sexual abuse. The administrator stated they only reported misappropriation on 11/06/24 and did not report sexual abuse until prompted by the SA.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 47453 Based on record review and interview, the facilty failed to transmit MDS assessment data to CMS in the required timeframe for two (#7 and #23) of 12 sampled residents reviewed for MDS assessments. The administrator identified 31 residents resided at the facility. Findings: A facility policy titled MDS Completion and Submission Timeframe's, revised July 2017, read in part, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframe's. 1. Resident #7's quarterly assessment, completion date 09/25/24, had a submitted date of 11/05/24. The accepted date was documented as 11/05/24. 2. Resident #23's quarterly assessment, completion date 09/25/24, had a submitted date of 11/05/24. The accepted date was documented as 11/05/24. On 11/07/24 at 10:42 a.m., MDS coordinator #1 was asked what was the policy to ensure MDS assessments were submitted in a timely manner. They stated they had 14 days from date of completion to be submitted. They were then asked to review Resident #7 and Resident #23's quarterly MDS assessments with the date of 09/25/24. After review they were asked if the assessments were submitted within the 14 day timeframe according to CMS guidelines. They stated, No.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47453 Based on record review, and interview, the facility failed to ensure hospice services was care planned for one (#31) of three sampled residents reviewed for closed record review. The administrator identified 31 residents resided at the facilty. Findings: An undated Comprehensive Resident Centered Care Plans policy, read in part , The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's needs and will be complete and current. Resident #31 had diagnoses which included senile degeneration of the brain and dementia. An Order Summary Report, dated 11/05/24, documented Resident #31 had a physician order for hospice. There was no documentation hospice services was care planned. On 11/05/24 at 1:27 p.m., MDS Coordinator #1 was asked the policy and procedure regarding hospice services and where hospice services was documented. They stated the care plan. They were then asked when was hospice services added to a care plan. They stated immediately. They were asked to review Resident #31's careplan and asked if hospice services had been added to the comprehensive care plan. They stated, No.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47453 Based on observation, record review, and interview, the facility failed to ensure medications were supplied as ordered for one (#5) of five sampled residents observed during medication administration pass. The administrator identified 31 residents resided in the facility. Findings: A Medication and Treatment Orders policy, revised July 2023, read in part, Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available. An undated Certified Med Aide job description, read in part, monitor medications to ensure adequate accountability measures were taken when medications are ordered. Resident #5 had diagnoses which included congestive heart failure, bipolar, depression, and hypertension. A Physician order, dated 06/17/24, documented Resident #5 received clonidine HCL (blood pressure medication) 0.2 mg by mouth three times a day. On 11/05/24 at 7:54 a.m., during an observation of a medication pass, CMA #1 stated Resident #5's clonidine was not in the medication cart or in the medication room. They were asked who was responsible for re-ordering medications. They stated the CMAs re-ordered medications from the pharmacy and called hospice if they needed to re-order a medication hospice provided. There was no documentation Resident #5's clonidine had been re-ordered from hospice or the pharmacy. On 11/05/24 at 9:12 a.m., CMA #1 was asked if the clonidine for Resident #5 was administered as ordered. They stated the medication was not re-ordered and the charge nurse was notified. On 11/05/24 at 9:51 a.m., the DON was asked the policy for re-ordering of medication. The DON stated the CMAs were responsible for re-ordering medications. They stated if the medication did not come in a timely manner they stepped in and investigated. They were asked if they were notified of Resident #5 being out of their clonidine. They stated, Not until the staff told me.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47453 Based on record review and interview, the facility failed to ensure a physician order was completed for one (#14) of five sampled residents reviewed for unnecessary medications. The DON identified 18 residents who received psychotropic medications. Findings: A Medication and Treatment Orders policy, revised July 2016, read in part, orders for medications and treatments will be consistent with principles of safe and effective order writing. A Medication Orders policy, revised January 2018, read in part, new handwritten orders by the prescriber while in the facility. The nurse on duty at the time the order is received enters it on the physician order sheet/telephone order sheet/electronic medical record. A Antipsychotic Medication Use policy, revised November 2023, read in part, The physician shall respond appropriately by changing or stopping problematic doses or medications. Resident #14 had diagnoses which included senile degeneration of brain, dementia with other behavioral disturbance, and bipolar type. A Note to Physician/Clinician pharmacy report, dated 09/27/24, documented a signed physician order to change the order for Risperdal (antipsychotic medication) to 0. 5 mg in the morning and 1 mg at bedtime, and discontinue Zyprexa (antipsychotic medication). The order was noted by the DON on 10/10/24. A Physicians Progress Note, dated 10/10/24, documented a written physician order to change Risperdal to 0. 5 mg in the morning and 1 mg at bedtime. It documented to discontinue Zyprexa. An Order Summary Report, dated 11/07/24, documented Resident #14 received Risperdal 0.5 mg twice a day and Zyprexa 2.5 mg at bedtime. An October 2024 MAR documented Resident #14 continued to receive Risperdal 0.5 mg twice a day and Zyprexa 2.5 mg daily at bedtime. A November 2024 MAR documented Resident #14 continued to receive Risperdal 0.5 mg twice a day and Zyprexa 2.5 mg daily at bedtime. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/24 at 8:05 a.m., the DON was asked what was the facility policy for physician orders being implemented and followed as ordered. They stated the nurse that took the order, noted the order, then inputted the new order in the computer. The DON then stated if the DON noted the order then the DON inputted the order into the computer. They were asked to review a note to physician/clinician document from pharmacy for Resident #14 dated 09/27/24. They were asked if the order for Risperdal had been changed and Zyprexa discontinued per physician order signed on 10/10/24. They stated, No it was not changed.

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 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Therapy & Living Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46702 Based on observation, record review, and interview, the facility failed to ensure the dish machine temperature and sanitizer concentration and refrigeration temperatures were monitored and logged daily to ensure safe operation and safe storage of potentially hazardous foods during two of two of two kitchen observations. The DON identified 29 residents received nutrition and hydration from the kitchen. Findings: The facility's Dishwashing Machine Use policy, revised 03/2010, documented the temperature and sanitizer concentrations should be monitored and recorded in the facility approved log. On 11/05/24 at 11:18 a.m., there were no logs observed where refrigeration equipment temperatures were to be monitored. On 11/05/24 at 11:26 a.m., [NAME] #2 was observed testing the dish machine temperature and PPM of the sanitizer. An October 2024 dish machine temperature document was observed on the wall and did not have any documentation it was being utilized. On 11/05/24 11:27 a.m., the dietary manager stated the dish machine should be tested and logged on the form before breakfast, lunch and dinner. They stated they should be logging temp and ppm daily before each shift and they have not been doing so. On 11/05/24 at 11:30 a.m., the dietary manger stated they have not been logging the temperatures on the refrigeration equipment and they should of been.