

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Community Health Care of Gore		STREET ADDRESS, CITY, STATE, ZIP CODE 503 South Main Street Gore, OK 74435	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to investigate an allegation of abuse for two (#1 and #3) of three residents reviewed for allegations of abuse.</p> <p>The DON identified nine residents with allegations of abuse in the past six months.</p> <p>Findings:</p> <p>A policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program read in parts .All allegations are thoroughly investigated .The individual conducting the investigation as a minimum: .f. interviews the resident (as medically appropriate) or the resident's representative; .i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to whom the accused employee provides care or services; .l. documents the investigation completely and thoroughly .</p> <p>1. Resident #1 had diagnoses which included dementia, anxiety, depression, and acute respiratory failure.</p> <p>A quarterly assessment, dated 04/23/24, documented the resident was severely impaired cognitively and was dependent for most ADLs.</p> <p>An incident report/state reportable, dated 06/10/24, documented an allegation of abuse for the resident. The report documented the family notified the DON and administrator the roommate told them an agency staff person was rough with their family member. The report documented the date, time, or name of the staff member was unknown.</p> <p>On 06/27/24 at 2:57 p.m., the DON was interviewed regarding the allegation of abuse for the resident. The DON reviewed the documentation for the investigation completed and stated only one resident statement/interview was completed for the investigation. The DON provided an unsigned and undated document. The DON reported the document was the only resident statement/interview for the investigation. The DON provided a document dated four days after the reported allegation with a first name only documented. The DON stated the document was a staff member's statement identifying a different agency staff member as the accused.</p> <p>On 06/27/24 at 3:22 p.m., the DON and the administrator stated a through investigation had not been completed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #3 had diagnoses which included cerebral infarction, major depressive disorder, and pain.</p> <p>A quarterly assessment, dated 04/16/24, documented the resident was cognitively intact and required partial/moderate assistance with most ADLs.</p> <p>An incident report/state reportable, dated 03/21/24, documented an allegation of abuse for the resident. The report documented the resident stated a staff member slapped the in the face a month ago.</p> <p>On 06/27/24 at 3:43 p.m., the DON reviewed the documentation provided for the investigation completed for the allegation of abuse. The DON stated there were no interviews completed from residents who had received care from the identified staff member.</p> <p>On 06/27/24 at 3:47 p.m., the DON and the administrator stated a through investigation had not been completed.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>33097</p> <p>Based on observation, record review, and interview, the facility failed to follow the menus for the residents.</p> <p>The administrator identified 50 residents who resided in the facility and ate meals prepared by the kitchen.</p> <p>Findings:</p> <p>A dietary menu documented for the residents' meal they were to have a Philly steak sandwich, potato wedges, coleslaw, and cheesecake for desert.</p> <p>On 06/26/24 a meal service was observed. At 1:00 p.m. the surveyor asked for a test tray. The DM stated they did not have any more coleslaw or coconut cake. The staff stated four residents had received a salad and ice cream in place of the coleslaw and coconut cake.</p> <p>On 06/26/24 at 1:35 p.m., the DM stated to their knowledge they had never served cheesecake. The DM stated the evening menu had been changed because the staff forgot the thaw the meat. The DM stated they had substituted menu items a lot recently.</p>