STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375295	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Health Care of Gore	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)
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. Based on observation, record review, and interview, the facility failed to implement their abuse policy. The facility failed to:a. thoroughly investigate and document an abuse investigation; and b. notify the ombudsman of an abuse investigation for 1 (#1) of 3 sampled residents reviewed for abuse. The administrator identified 38 residents resided in the facility. Findings: On 06/09/26 at 9:57 a.m., Resident #1 was observed lying in a bariatric bed with the head of bed elevated. Resident #1 was alert and oriented to person, place, and situation. A policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised 09/2022, read in part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft, or misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management are documented and reported.9. The investigator notifies the ombudsman that an abuse investigation is being conducted. A nurse's note for Resident #1, dated 01/29/26, showed CNAs were transferring Resident #1 from the bed to a wheelchair with a mechanical lift. The note showed when the CNA pulled the mechanical sling pad, the mechanical lift tipped and the resident came to rest in the wheelchair. The note showed the mechanical lift hit the resident's right arm. The note showed Resident #1 was assessed after the incident and had no bruising or fracture indicated after an x-ray was acquired. An initial/final incident report received at the OSDH for Resident #1, dated 02/03/26, showed an allegation of abuse was made when Resident #1 reported to adult protective services they were injured during a transfer on 01/29/26 by CNA #1. Written statements, dated 02/03/26, showed CNA #1, CNA #2, CNA #8, CNA #9, and RN#1 were interviewed regarding the lift and alleged fall. A care plan for Resident #1, revised 02/11/26, showed they required two staff to assist with the mechanical lift for bed transfers. A quarterly assessment for Resident #1, dated 05/05/26, showed they had a BIMS score of 15 indicating their cognition was intact. The assessment showed Resident #1 had diagnoses which included type 2 diabetes, anxiety disorder, and neurogenic bladder. The assessment showed Resident #1 was bedfast. On 06/09/26 at 9:57 a.m., Resident #1 stated CNA #1, CNA #2, CNA #8, and CNA #9 were using a mechanical lift to transfer Resident #1 from the bed to a wheelchair on an undisclosed date prior to survey. Resident #1 stated the mechanical lift tipped over, and they came to rest in their wheelchair. Resident #1 stated they were laughed at by CNA #1 after the lift tipped and they fell into the wheelchair. Resident #1 stated they had reported the incident to APS and was upset CNA #1 had laughed at them. On 06/09/26 at 12:52 p.m., RN #1 stated CNA #1 was suspended on 02/03/26 after they received notice Resident #1 had reported to APS that the resident stated they felt CNA #1 dropped them intentionally and had laughed after the incident on 01/29/26. On 06/09/26 at 3:22 p.m., the DON stated they did not have documentation showing Resident #1 was interviewed on 02/03/26 regarding the alleged abuse on 01/29/26.On 06/09/26 at 4:12 p.m., the administrator stated Resident #1 should have been interviewed, and the ombudsman was not contacted. On 06/10/26 at 8:51 a.m., the ombudsman stated they were not notified of the abuse allegation involving Resident #1 on 02/03/26.

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, record review, and interview, the facility failed to conduct a complete and thorough investigation of abuse for 1 (#1) of 3 sampled residents reviewed for abuse. The administrator identified 38 residents resided in the facility. Findings:On 06/09/26 at 9:57 a.m., Resident #1 was observed lying in a bariatric bed with the head of bed elevated. Resident #1 was alert and oriented to person, place, and situation. A policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised 09/2022, read in part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft, or misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management are documented and reported.9. The investigator notifies the ombudsman that an abuse investigation is being conducted. A nurse's note for Resident #1, dated 01/29/26, showed CNAs were transferring Resident #1 from the bed to a wheelchair with a mechanical lift. The note showed when the CNA pulled the mechanical sling pad, the mechanical lift tipped and the resident came to rest in the wheelchair. The note showed the mechanical lift hit the resident's right arm. The note showed Resident #1 was assessed after the incident and had no bruising or fracture indicated after an x-ray was acquired. An initial/final incident report received at the OSDH for Resident #1, dated 02/03/26, showed an allegation of abuse was made when Resident #1 reported to adult protective services they were injured during a transfer on 01/29/26 by CNA #1. Written statements, dated 02/03/26, showed CNA #1, CNA #2, CNA #8, CNA #9, and RN#1 were interviewed regarding the lift and alleged fall. There was no documentation Resident #1 was interviewed regarding the abuse allegation on 02/03/26. A care plan for Resident #1, revised 02/11/26, showed they required two staff to assist with the mechanical lift for bed transfers. A quarterly assessment for Resident #1, dated 05/05/26, showed they had a BIMS score of 15 indicating their cognition was intact. The assessment showed Resident #1 had diagnoses which included type 2 diabetes, anxiety disorder, and neurogenic bladder. The assessment showed Resident #1 was bedfast. On 06/09/26 at 9:57 a.m., Resident #1 stated CNA #1, CNA #2, CNA #8, and CNA #9 were using a mechanical lift to transfer Resident #1 from the bed to a wheelchair on an undisclosed date prior to survey. Resident #1 stated the mechanical lift tipped over, and they came to rest in their wheelchair. Resident #1 stated they were laughed at by CNA #1 after the lift tipped and they fell into the wheelchair. Resident #1 stated they had reported the incident to APS and was upset CNA #1 had laughed at them. On 06/09/26 at 12:52 p.m., RN #1 stated CNA #1 was suspended on 02/03/26 after they received notice Resident #1 had reported to APS that the resident stated they felt CNA #1 dropped them intentionally and had laughed after the incident on 01/29/26. On 06/09/26 at 3:22 p.m., the DON stated they did not have documentation showing Resident #1 was interviewed on 02/03/26 regarding the alleged abuse on 01/29/26.On 06/09/26 at 4:12 p.m., the administrator stated Resident #1 should have been interviewed.

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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. Based on record review and interview, the facility failed to ensure care plan interventions were comprehensive for 1 (#2) of 12 sampled residents reviewed for comprehensive care plans. The administrator identified 38 residents resided in the facility; Findings:A policy titled Care Plans, Comprehensive Person-Centered, revised 03/2022, read and part, 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the residents, problem areas, and their causes, and relevant clinical decision-making.10. When possible, interventions addressed the underlying sources of the problem areas, not just symptoms or triggers. A baseline care plan for Resident #2, dated 11/28/23, read in part, toileting assist of 2 .bathing assist of 2. A care plan for Resident #2, initiated on 11/29/23, showed a focus the resident had an ADL (activities of daily living), self-care performance deficit due to activity intolerance and fatigue.The interventions read in part, TOILET USE: [Resident #2] requires dependent with toileting.TRANSFER: [Resident #2] is dependent with all transfers.Bed Mobility: [Resident #2] is dependent with rolling from one side to back and back again in bed. The care plan interventions did not show how Resident #2's needs would have been met. A significant change assessment for Resident #2, dated 05/01/25, showed they had a BIMS score of 6, which indicated the resident was severely impaired in cognition for daily decision making. The assessment showed the resident had diagnoses which included heart failure, hypertension, and seizure disorder. The assessment showed Resident #2 was dependent for bed mobility, transfers, and toileting. On 06/09/26 at 12:11 p.m., the DON was shown the care plan for Resident #2, revised on 04/07/25. The DON stated the care plan was not comprehensive due to not specifying the resident was a two person assist for perineal care, transfers, and repositioning with a draw sheet. The DON stated Resident #2 weighed 250 lbs. and would require two persons for repositioning, transfers, and perineal care.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure hair nets were worn in the kitchen during food preparation for 1 of 2 food preparation observations. The DON identified 38 residents received nutrition from the kitchen. Findings: On 06/05/26 at 12:00 p.m., dietary aide #1 was observed walking through the food preparation area to the dish area in the kitchen. Dietary aide #1 was observed washing dishes and not wearing a hair net.On 06/05/26 at 12:00 p.m., cook #1 was observed with a long beard and not wearing a beard net while preparing food in the kitchen.A facility policy titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, revised 11/2022, read in part, 15. Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens.On 06/05/26 at 12:02 p.m., dietary aide #1 stated they should have been wearing a hair net while working in the kitchen.On 06/05/26 at 12:06 p.m., cook #1 stated they were preparing food and forgot to wear a beard net. They stated the facility policy was to wear a hair and beard net while preparing food.On 06/05/26 at 12:07 p.m., the certified dietary manager stated everyone should wear a hair net and/or a beard net if needed while working in the kitchen.On 06/05/26 at 12:10 p.m., the administrator stated all people working in the kitchen should have been wearing a beard net and/or hair net.