

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 03/17/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>30267</p> <p>Based on record review and interview, the facility failed to provide informed consent for medications for 1 (#27) of 5 sampled residents whose clinical records were reviewed for unnecessary medications.</p> <p>The administrator identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #27 had diagnoses which included aphasia following a cerebral infarction and vascular dementia.</p> <p>The physician's monthly summary, dated 03/05/25, showed the resident received the following medications:</p> <ul style="list-style-type: none"> a. Depakote (an anti-seizure medication) 125mg twice daily for anxiety; b. Sertraline (an antidepressant) 25mg daily; and c. Zyprexa (an antipsychotic) 5mg at bedtime. <p>The resident's clinical record was reviewed. There was no documentation of informed consent for medications or provided care.</p> <p>The quarterly MDS assessment, dated 03/09/25, showed the resident's cognition was severely impaired with a BIMS score of 03.</p> <p>On 03/17/25 at 12:25 p.m., the POA stated there was no communication about care plan meetings, medications, medication risk verses benefits, or possible alternatives to the medication treatment. The POA stated the facility staff would sometimes contact them regarding the resident falling. The POA stated when they went to visit the resident and asked for an update, the staff would tell them the resident was fine, but provided no details.</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/17/25 at 1:33 p.m., the MDS coordinator stated they documented any communication with family in the electronic medical record, in the progress notes, under the sub-category of Communication with Family. The MDS coordinator reviewed the resident's clinical record and stated there was no documentation they reviewed the risk and benefits with the resident/resident's representative, but would continue to look. The MDS coordinator stated if there was no note in the resident's electronic medical record, then they did not do it.</p> <p>No further documentation was provided by end of survey.</p>		

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<p>F 0600</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to prevent abuse for 1 (#20) of 3 sampled residents reviewed for abuse. This deficient practice resulted in harm to Resident #20 who experienced psychosocial harm as a result of the abuse.</p> <p>The administrator identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>1. On 03/03/25 at 12:16 p.m., Resident #20 was observed crying and visibly traumatized while conveying the incident which occurred on 02/23/25.</p> <p>A facility policy titled Identifying Types of Abuse, revised 09/2022, read in part, the following situations are recognized as those that are likely to cause psychosocial Harm, which may take months or years to manifest and have long-term effects on the resident and [their]relationship with others: a. Sexual assault.</p> <p>A facility policy titled Resident - Resident Altercations, revised 09/2022, read in part, If two residents are involved in an altercation, staff: .</p> <p>c. notify each resident's representative and attending physician of the incident;</p> <p>d. review the events with the nursing supervisor and director of nursing services, and evaluate the effectiveness of the interventions meant to address distressed behaviors for one or both residents;</p> <p>e. consult with attending physical to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem;</p> <p>f. make any necessary changes in the care plan approaches to any and all involved individuals; and</p> <p>g. document in the residents' clinical record all interventions and theory effectiveness;</p> <p>icons psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for interventions and management as necessary, as may be recommended by the attending physician or interdisciplinary care planning team.</p> <p>Resident #20 was admitted to the facility on [DATE] with diagnoses which included acute and hypoxic respiratory failure and major depressive disorder.</p> <p>Resident #20's admission assessment, dated 01/28/25, showed their BIMS score was 15 and their cognition was fully intact.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #20's progress note, dated 02/23/25 at 1:35 p.m., read in part, A [gender withheld] resident [Resident # 44] went into [Resident #20's] room on Sunday 02/23/25. [They] stood in front of [their] wheel chair and pulled their pants down and was humping in front of [Resident #20]. [Resident #20] yelled for [Resident #44] to get out of their room, [Resident #44] did not leave so [Resident #20] turned on their call light and started screaming and [Resident #44] left.</p> <p>A review of Resident #20's electronic health record did not document the following after the incident of sexual abuse on 02/23/25:</p> <ul style="list-style-type: none"> a. Resident #20's physician was notified after the incident; b. interventions were addressed by the nursing supervisor after the incident; c. the attending physician was consulted to identify treatable conditions such as psychosis; d. any changes made to the care plan after the incident; e. documentation of interventions and their effectiveness; and f. psychiatric services was consulted as needed for assistance in assessing the resident. <p>On 03/03/25 at 12:16 p.m., Resident #20 stated Resident #44 came into their room naked and straddled their legs while they were sitting in their wheel chair in the afternoon. Resident #20 stated they shut their eyes and yelled for help until staff came. Resident #20 stated Resident #44 ran from their room when they yelled for help. Resident #20 stated they were fearful during and after the incident and had difficulty falling asleep since the incident. Resident #20 stated their physician was not notified of the incident.</p> <p>On 03/06/25 9:27 a.m., Resident #20 stated their counselor, which was previously established by their family representative, was not made aware of the incident and they had not received any psychological assessment since the incident on 02/23/25. Resident #20 stated they were having trouble sleeping since the incident due to recalling the traumatic incident when they closed their eyes. Resident #20 stated they reported to nursing staff and nurse aides they were fearful of the opposite sex and was having trouble sleeping since the incident on 02/23/25.</p> <p>On 03/06/25 at 10:17 a.m., Resident #20's family representative was asked how Resident #20 was doing since the incident on 02/23/25. They stated Resident #20 had difficulty sleeping since the incident, was afraid to have the door closed, was fearful of the opposite sex, and was afraid to be alone since the incident. They stated the facility did not set up any psychological counseling for the resident.</p> <p>On 03/06/25 at 11:15 a.m., the DON stated they would have to contact the family representative to determine if the Resident #20 had a psychological services referral made.</p> <p>2. Resident #44 admitted on [DATE] with diagnoses which included acute kidney failure, morbid obesity, and cellulitis.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #44's progress note, dated 02/10/25 at 7:34 p.m., showed Resident #44 alerted staff another resident who was screaming out was bothering them. The note showed Resident #44 stated they would take care of it themselves. The note showed Resident #44 was redirected and added to the seventy two hour focused charting due to threatening harm to others.</p> <p>Resident #44's admission assessment, dated 02/11/25, showed the resident's BIMS score was 13, their cognition was mildly impaired, they had physical behaviors directed toward others one to three days, and wandered one to three days during a seven day look back period.</p> <p>Resident #44's progress note, dated 02/12/25 at 12:37 a.m., showed Resident #44 was making statements about a nurse making them feel some type of way when they came around. Resident #44 was redirected and the CNA reported to nursing staff the resident's behaviors.</p> <p>Resident #44's progress note, dated 02/13/25 at 5:19 a.m., showed Resident #44 was seated in the dining room and was talking to themselves loudly. The note showed Resident #44 was redirected for cussing and yelling by staff. The note showed all redirections and reorientations were unsuccessful.</p> <p>Resident #44's progress note, dated 02/13/25 at 12:29 p.m., showed Resident #44 was expressing concerns that someone was poisoning them. The note showed Resident #44 expressed they were being poisoned by their guardian.</p> <p>Resident #44's progress note, dated 02/14/25, showed Resident #44 was in dining room early and was continuing to yell out and have conversations with self.</p> <p>Resident #44's progress note, dated 02/17/25 at 11:12 p.m., showed Resident #44 refused medication and accused a day time nurse of poisoning them. The note showed the DON was notified of the behavior.</p> <p>Resident #44's progress note, dated 02/19/25 at 5:40 a.m, showed Resident #44 was pacing the halls, repeatedly pulling call lights in in bathrooms, attempting to wander down other halls, accusing staffing of poisoning them, got agitated with redirections, and refused to go to bed.</p> <p>Resident #44's progress note, dated 02/20/25 at 9:55 p.m., showed Resident #44 was in the day room slapping themselves in the head and the furniture hard repeatedly while having a conversation with themselves. The note showed Resident #44 was redirected due to scaring other residents. The note showed during the same shift Resident #44 had to be redirected because they were wandering through the corridors and looking into other residents' rooms. The note showed redirection was met with agitation.</p> <p>Resident #44's progress note, dated 02/21/25 at 4:19 a.m., showed Resident #44 was in common area slapping themselves on the thighs, head, and the arms of the chair. The note showed the Resident #44 continued to wander the dining area talking to themselves, then went to their room, and was pacing in circles.</p> <p>Resident #44's progress note, dated 02/21/25 at 8:40 p.m., showed Resident #44 attempted to follow a visitor out the door with a bag of clothes. The note showed Resident #44 was redirected back to their room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #44's care plan, dated 02/21/25, read in part, Disturbed thought processes related to altered perceptual state as evidenced by delusions, hallucinations, and disorganize thinking .</p> <p>a. establish reality based communication;</p> <p>b. Monitor and document thought content; and</p> <p>c. refer to mental health services prn.</p> <p>Resident #44's clinical record did not show their physician was notified prior to 02/23/25 when behaviors were documented starting on 02/11/25 and it did not show Resident #44 was referred to mental health services.</p> <p>Resident #44's progress note, dated 02/23/25 at 1:01 p.m., read in part, resident reported this resident was in a [gender withheld] residents room with [their] pants down trying to 'hump' resident. Family, DON, and ADON notified.</p> <p>An OSDH form 283, dated 02/23/25, showed Resident #44 went into Resident #20's room naked and straddled Resident #20 while holding their private parts in their hand. The form showed Resident #20 screamed for help.</p> <p>Resident #44's progress note, dated 02/23/25 at 12:15 p.m., read in part, I let [them] know that [they] went into a [gender withheld] resident's room and pulled [their] pants down, [they] were standing in front of the resident and was humping. The note showed Resident #44 was transported by EMS to the hospital, family was notified, and an emergency discharge was issued.</p> <p>On 03/06/25 at 9:00 a.m., the DON stated they were informed of the incident on 02/23/25 involving Resident #44 going into Resident #20's room naked and straddling Resident #20 while naked and masturbated. The DON stated Resident #20 knew they were okay because they were aware Resident #44 had impaired cognition. The DON stated Resident #20 was not assessed for psychosocial injury, was not referred to psych services after the incident, and was not assessed by nursing or a physician after the incident. The DON was asked to review the facility's Resident - Resident Altercations policy. The DON stated the policy was not followed.</p> <p>On 03/11/25 at 8:49 a.m., CNA #9 was asked about the incident on 02/23/25. They stated a resident notified them there was another resident that went into another residents room naked with their pants down. CNA #9 identified Resident #20 as the victim and Resident #44 as the aggressor. CNA #9 stated the agency nurse named never assessed the resident or got up out of their chair. CNA #9 was asked if Resident #20 had any changes since the incident. CNA #9 stated sometime mid week after the incident Resident #20 asked for help to be put to bed. CNA #9 stated an hour later Resident #20 was screaming and stated they saw Resident #44 when they closed their eyes.</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to assess the use of a geriatric chair to ensure the device was not a restraint for 1 (#3) of 2 sampled residents reviewed for restraints.</p> <p>The ADON identified four residents utilized geriatric chairs in the facility.</p> <p>Findings:</p> <p>On 03/03/25 at 12:05 p.m., Resident #3 was observed in the dining room in a geriatric chair with bruising on their face under both eyes and cheeks.</p> <p>A facility policy titled Use of Restraints, revised 04/2017, read in part, Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom to determine if there are less restrictive interventions parentheses (programs, devices, referrals, etc. [et cetra]) that may improve the symptoms.</p> <p>Resident #3 was admitted on [DATE] with diagnoses which included cerebral infarction, type 2 diabetes mellitus, and chronic kidney disease.</p> <p>Resident #3's annual assessment, dated 01/13/25, showed the resident's BIMS score was 00 indicating their cognition was significantly impaired, they had upper and lower functional limitation of range of motion impairments, was dependent for chair to bed transfers, ambulated with a wheel chair, and required partial to moderate assistance with a wheel chair mobility.</p> <p>Resident #3's physician orders, dated 02/28/25, showed Resident #3 could use a geriatric chair for poor balance/trunk control.</p> <p>Resident #3's electronic health record did not document Resident #3 was assessed for the use of a geriatric chair prior to implementing the use of the chair.</p> <p>Resident #3's Pt [Physical Therapy] Evaluation form, dated 03/06/25, showed the resident was evaluated on 03/06/25 by a physical therapist for the use of a geriatric chair.</p> <p>On 03/11/25 at 2:15 p.m., LPN #2 was asked if Resident #3 was assessed for the use of a geriatric chair as a restraint. LPN #2 stated the resident was not assessed properly for the use of a geriatric chair, so they had to be taken out of the geriatric chair on 03/05/25 until they were assessed on 03/06/25.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/11/25 at 2:20 p.m., the administrator was asked what the policy was for assessing a resident for the use of the geriatric chair. The administrator stated there had to be a pre-restraining assessment done prior to using a geriatric chair. The administrator was asked if Resident #3 was assessed before placement in a geriatric chair. They stated there was no assessment completed prior to the use of a geriatric chair for Resident #3 to ensure it was safe and not a restraint.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>On 03/06/25 at 5:40 p.m., an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to implement their abuse policy and procedure by not:</p> <ul style="list-style-type: none"> a. consulting with the attending physician to identify treatable conditions such as acute psychosis; b. making any changes to care plan approaches to any and all involved individuals; c. documenting in the residents clinical record all attempted interventions and their effectiveness; and d. consulting psychiatric services for assistance in assessing the resident, identifying causes, and developing a care plan for interventions and management necessary or as may be recommended by the attending physician or interdisciplinary team after a allegation of sexual abuse. <p>A facility policy titled Resident - Resident Altercations, revised September 2022, read in part, If two residents are involved in an altercation, staff: .</p> <ul style="list-style-type: none"> c. notify each resident's representative and attending physician of the incident; d. review the events with the nursing supervisor and director of nursing services, and evaluate the effectiveness of the interventions meant to address distressed behaviors for one or both residents; e. consult with attending physical to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem; f. make any necessary changes in the care plan approaches to any and all involved individuals; g. document in the residents' clinical record all interventions and their effectiveness; <p>icons psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for interventions and management as necessary, as may be recommended by the attending physician or interdisciplinary care planning team.</p> <p>1. Resident #20 was admitted to the facility on [DATE] with diagnoses which included acute and hypoxic respiratory failure and major depressive disorder.</p> <p>Resident #20's admission assessment, dated 01/28/25, showed Resident #20's BIMS score was 15 and their cognition was fully intact.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #20's progress note, dated 02/23/25 at 1:35 p.m., read in part, A [gender withheld] resident [Resident # 44] went into [Resident #20's] room on Sunday 02/23/25. [They] stood in front of [their] wheel chair and pulled their pants down and was humping in front of [Resident #20]. [Resident #20] yelled for [Resident #44] to get out of their room, [Resident #44] did not leave so [Resident #20] turned on their call light and started screaming and [Resident #44] left.</p> <p>An OSDH form 283, dated 02/23/25, showed Resident #44 went into Resident #20's room naked and straddled Resident #20 while holding their private parts in their hand. The form showed Resident #20 screamed for help.</p> <p>A review of Resident #20's electronic health record did not document the following after the incident of sexual abuse on 02/23/25:</p> <ul style="list-style-type: none"> a. Resident #20's physician was notified after the incident; b. interventions were addressed by the nursing supervisor after the incident; c. the attending physician was consulted to identify treatable conditions such as psychosis; d. any changes made to the care plan after the incident; e. documentation of interventions and their effectiveness; and f. psychiatric services was consulted as needed for assistance in assessing the resident. <p>On 03/03/25 at 12:16 p.m., Resident #20 stated Resident #44 came into their room naked and straddled their legs while they were sitting in their wheel chair in the afternoon. Resident #20 stated they shut their eyes and yelled for help until staff came. Resident #20 stated Resident #44 ran from their room when they yelled for help. Resident #20 stated they were fearful during and after the incident and had difficulty falling asleep since the incident. Resident #20 stated their physician was not notified of the incident.</p> <p>On 03/06/25 9:27 a.m., Resident #20 stated their counselor, which was previously established by their family representative, was not made aware of the incident and they had not received any psychological assessment since the incident on 02/23/25. Resident #20 stated they were having trouble sleeping since the incident due to recalling the traumatic incident when they closed their eyes. Resident #20 stated they reported to nursing staff and nurse aides they were fearful of the opposite sex and was having trouble sleeping since the incident on 02/23/25.</p> <p>On 03/06/25 at 10:17 a.m., Resident #20's family representative was asked how Resident #20 was doing since the incident on 02/23/25. They stated Resident #20 had difficulty sleeping since the incident, was afraid to have the door closed, was fearful of the opposite sex, and was afraid to be alone since the incident. They stated the facility did not set up any psychological counseling for the resident.</p> <p>On 03/06/25 at 11:15 a.m., the DON stated they would have to contact the family representative to determine if the Resident #20 had a psychological services referral made.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. Resident #44 admitted on [DATE] with diagnoses which included acute kidney failure, morbid obesity, and cellulitis.</p> <p>Resident #44's admission assessment, dated 02/11/25, showed the resident's BIMS score was 13, their cognition was mildly impaired, they had physical behaviors directed toward others one to three days, and wandered one to three days during a seven day look back period.</p> <p>Resident #44's progress note, dated 02/23/25 at 12:15 p.m., read in part, I let [them] know that [they] went into a [gender withheld] resident's room and pulled [their] pants down, [they] were standing in front of the resident and was humping.</p> <p>On 03/06/25 at 6:41 a.m., the dietary manager stated Resident #20 told them another resident went into their room and exposed themselves and asked if they wanted some of this. The dietary manager stated Resident #20 reported to them they were having trouble sleeping since the incident.</p> <p>On 03/06/25 at 9:00 a.m., the DON stated they were informed of the incident on 02/23/25 involving Resident #44 going into Resident #20's room naked and straddling Resident #20 while naked and masturbated. The DON stated Resident #20 knew they were okay because they were aware Resident #44 had impaired cognition. The DON stated Resident #20 was not assessed for psychosocial injury, was not referred to psych services after the incident, and was not assessed by nursing or a physician after the incident. The DON was asked to review the facility's Resident - Resident Altercations policy. The DON stated the policy was not followed.</p> <p>On 03/11/25 at 8:49 a.m., CNA #9 was asked about the incident on 02/23/25. They stated a resident notified them there was another resident that went into another residents room naked with their pants down. CNA #9 identified Resident #20 as the victim and Resident #44 as the aggressor. CNA #9 stated the agency nurse named never assessed the resident or got up out of their chair. CNA #9 was asked if Resident #20 had any changes since the incident. CNA #9 stated sometime mid week after the incident Resident #20 asked for help to be put to bed. CNA #9 stated an hour later Resident #20 was screaming and stated they saw Resident #44 when they closed their eyes.</p> <p>On 03/06/25 at 5:35 p.m., the OSDH office was notified and verified the existence of the IJ situation.</p> <p>On 03/06/25 at 5:40 p.m., the administrator was notified of the presence of an immediate jeopardy situation related to not implementing the abuse policy and procedure. The IJ template was provided to the administrator.</p> <p>On 03/07/25 at 10:56 a.m., an acceptable plan of removal was approved by OSDH. The plan of removal, read in part, [name of facility withheld] [address withheld] Plan of Removal for IJ at '[name of facility withheld]'. The likelihood of any other serious harm or event of abuse, neglect or misappropriation no longer exist after this plan has been completed as of 03/06/25. The plan of removal included the following components;</p> <p>a .Resident #20 was assessed on 03/06/25 by APRN [advanced practical registered nurse] for any signs of sexual abuse and orders to be followed for further treatment or evaluation,</p> <p>b. Resident #44 is no longer in the facility,</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Community Health Care of Gore		STREET ADDRESS, CITY, STATE, ZIP CODE 503 South Main Street Gore, OK 74435	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>c. the [name of police agency with held] police department was notified of an allegation of sexual abuse on 02/23/25 at 11:55 a.m.,</p> <p>d. all nursing staff were in-serviced on the abuse, neglect, and misappropriation policies and procedures and ensure residents are free from abuse, neglect, and misappropriation by midnight on 3/6/25. Any nursing staff not currently in the facility will be in-serviced before returning to work,</p> <p>e. staff members were interviewed regarding any allegations of sexual abuse on 02/24/25 and there were no allegations reported,</p> <p>f. interviews were conducted with 5 residents with BIMS of 9 or higher on 02/24/25 and no allegations were reported,</p> <p>g. interviews conducted with all residents with BIMS of 9 or higher on 03/06/25 and no allegations were reported,</p> <p>H. all licensed staff were in-serviced on consulting with physician on behaviors such as acute psychosis and psychosocial needs,</p> <p>I. residents who were not able to be interviewed were assessed for any signs of abuse,</p> <p>J. follow up assessments were initiated every shift for resident #20 daily until no signs of negative outcomes and no negative psychosocial needs,</p> <p>K. resident #20 was referred to psych services for ongoing evaluation related to any negative outcomes from event on 02/23/25 and any other psychosocial needs,</p> <p>L. the facility in-service all staff on documentation of events related to abuse including any interventions in the clinical record and the effectiveness of interventions will be monitored by staff daily until compliance is achieved and appropriate practitioners including psych daily and after each visit until compliance is achieved, and</p> <p>M. the likelihood of any other serious harm or event of abuse, neglect or misappropriation no longer exists after this plan has been completed as of 03/06/25.</p> <p>On 03/07/25 at 5:30 p.m., the IJ was lifted when all components of the plan of removal were completed. The following documentation was reviewed:</p> <p>a. Resident #20's psychological assessment dated [DATE];</p> <p>b. Residents #44's discharge summary;</p> <p>c. nursing in- service documentation on abuse;</p> <p>d. Resident #20's follow up assessments;</p> <p>e. Resident #20's psych referral; and</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>f. safe survey interviews with residents.</p> <p>The deficient practice remained at an isolated level with the potential for more than minimal harm.</p> <p>Based on observation, record review, and interview, the facility failed to ensure their abuse policy and procedure was implemented for 1 (#20) of 3 sampled residents reviewed for abuse.</p> <p>The administrator identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>1. On 03/03/25 at 12:16 p.m., Resident #20 was observed crying and visibly traumatized while conveying the incident which occurred on 02/23/25.</p> <p>A facility policy titled Identifying Types of Abuse, revised 09/2022, read in part, the following situations are recognized as those that are likely to cause psychosocial harm, which may take months or years to manifest and have long-term effects on the resident and his or her relationship with others: a. Sexual assault.</p> <p>A facility policy titled Resident - Resident Altercations, revised September 2022, read in part, If two residents are involved in an altercation, staff: .</p> <p>c. notify each resident's representative and attending physician of the incident;</p> <p>d. review the events with the nursing supervisor and director of nursing services, and evaluate the effectiveness of the interventions meant to address distressed behaviors for one or both residents;</p> <p>e. consult with attending physical to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem;</p> <p>f. make any necessary changes in the care plan approaches to any and all involved individuals;</p> <p>g. document in the residents' clinical record all interventions and theory effectiveness;</p> <p>icons psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for interventions and management as necessary, as may be recommended by the attending physician or interdisciplinary care planning team.</p> <p>Resident #20 was admitted to the facility on [DATE] with diagnoses which included acute and hypoxic respiratory failure and major depressive disorder.</p> <p>Resident #20's admission assessment, dated 01/28/25, showed Resident #20's BIMS score was 15 and their cognition was fully intact.</p> <p>An OSDH form 283, dated 02/23/25, showed Resident #44 went into Resident #20's room naked and straddled Resident #20 while holding their private parts in their hand. The form showed Resident #20 screamed for help.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of Resident #20's electronic health record did not document the following after the incident of sexual abuse on 02/23/25:</p> <ul style="list-style-type: none"> a. Resident #20's physician was notified after the incident; b. interventions were addressed by the nursing supervisor after the incident; c. the attending physician was consulted to identify treatable conditions such as psychosis; d. any changes made to the care plan after the incident; e. documentation of interventions and their effectiveness; and f. psychiatric services was consulted as needed for assistance in assessing the resident. <p>Resident #20's progress note, dated 02/23/25 at 1:35 p.m., read in part, A [gender withheld] resident [Resident # 44] went into [Resident #20's] room on Sunday 02/23/25. [They] stood in front of [their] wheel chair and pulled their pants down and was humping in front of [Resident #20]. [Resident #20] yelled for [Resident #44] to get out of their room, [Resident #44] did not leave so [Resident #20] turned on their call light and started screaming and [Resident #44] left.</p> <p>On 03/03/25 at 12:16 p.m., Resident #20 stated Resident #44 came into their room naked and straddled their legs while they were sitting in their wheel chair in the afternoon. Resident #20 stated they shut their eyes and yelled for help until staff came. Resident #20 stated Resident #44 ran from their room when they yelled for help. Resident #20 stated they were fearful during and after the incident and had difficulty falling asleep since the incident. Resident #20 stated their physician was not notified of the incident.</p> <p>On 03/06/25 9:27 a.m., Resident #20 stated their counselor, which was previously established by their family representative, was not made aware of the incident and they had not received any psychological assessment since the incident on 02/23/25. Resident #20 stated they were having trouble sleeping since the incident due to recalling the traumatic incident when they closed their eyes. Resident #20 stated they reported to nursing staff and nurse aides they were fearful of the opposite sex and was having trouble sleeping since the incident on 02/23/25.</p> <p>On 03/06/25 at 10:17 a.m., Resident #20's family representative was asked how Resident #20 was doing since the incident on 02/23/25. They stated Resident #20 had difficulty sleeping since the incident, was afraid to have the door closed, was fearful of the opposite sex, and was afraid to be alone since the incident. They stated the facility did not set up any psychological counseling for the resident.</p> <p>On 03/06/25 at 11:15 a.m., the DON stated they would have to contact the family representative to determine if the Resident #20 had a psychological services referral made.</p> <p>2. Resident #44 admitted on [DATE] with diagnoses which included acute kidney failure, morbid obesity, and cellulitis.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #44's admission assessment, dated 02/11/25, showed the resident's BIMS score was 13, their cognition was mildly impaired, they had physical behaviors directed toward others one to three days, and wandered one to three days during a seven day look back period.</p> <p>Resident #44's progress note, dated 02/12/25 at 12:37 a.m., showed Resident #44 was making statements about a nurse making them feel some type of way when they came around. Resident #44 was redirected and the CNA reported to nursing staff the resident's behaviors.</p> <p>Resident #44's progress note, dated 02/13/25 at 5:19 a.m., showed Resident #44 was seated in the dining room and was talking to themselves loudly. The note showed Resident #44 was redirected for cussing and yelling by staff. The note showed all redirections and reorientations were unsuccessful.</p> <p>Resident #44's progress note, dated 02/13/25 at 12:29 p.m., showed Resident #44 was expressing concerns that someone was poisoning them. The note showed Resident #44 expressed they were being poisoned by their guardian.</p> <p>Resident #44's progress note, dated 02/14/25, showed Resident #44 was in dining room early and was continuing to yell out and have conversations with self.</p> <p>Resident #44's progress note, dated 02/17/25 at 11:12 p.m., showed Resident #44 refused medication and accused a day time nurse of poisoning them. The note showed the DON was notified of the behavior.</p> <p>Resident #44's progress note, dated 02/19/25 at 5:40 a.m, showed Resident #44 was pacing the halls, repeatedly pulling call lights in in bathrooms, attempting to wander down other halls, accusing staffing of poisoning them, got agitated with redirections, and refused to go to bed.</p> <p>Resident #44's progress note, dated 02/20/25 at 9:55 p.m., showed Resident #44 was in the day room slapping themselves in the head and the furniture hard repeatedly while having a conversation with themselves. The note showed Resident #44 was redirected due to scaring other residents. The note showed during the same shift Resident #44 had to be redirected because they were wandering through the corridors and looking into other residents' rooms. The note showed redirection was met with agitation.</p> <p>Resident #44's progress note, dated 02/21/25 at 4:19 a.m., showed Resident #44 was in common area slapping themselves on the thighs, head, and the arms of the chair. The note showed the Resident #44 continued to wander the dining area talking to themselves, then went to their room, and was pacing in circles.</p> <p>Resident #44's progress note, dated 02/21/25 at 8:40 p.m., showed Resident #44 attempted to follow a visitor out the door with a bag of clothes. The note showed Resident #44 was redirected back to their room.</p> <p>Resident #44's care plan, dated 02/21/25, read in part, Disturbed thought processes related to altered perceptual state as evidenced by delusions, hallucinations, and disorganize thinking .</p> <p>a. establish reality based communication;</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>b. Monitor and document thought content; and</p> <p>c. refer to mental health services prn.</p> <p>Resident #44's clinical record did not show their physician was notified prior to 02/23/25 when behaviors were documented starting on 02/11/25 and it did not show Resident #44 was referred to mental health services.</p> <p>Resident #44's progress note, dated 02/23/25 at 1:01 p.m., read in part, resident reported this resident was in a [gender withheld] residents room with [their] pants down trying to 'hump' resident. Family, DON, and ADON notified.</p> <p>Resident #44's progress note, dated 02/23/25 at 12:15 p.m., read in part, I let [them] know that [they] went into a [gender withheld] resident's room and pulled [their] pants down, [they] were standing in front of the resident and was humping. The note showed Resident #44 was transported by EMS to the hospital, family was notified, and an emergency discharge was issued.</p> <p>On 03/06/25 at 9:00 a.m., the DON stated they were informed of the incident on 02/23/25 involving Resident #44 going into Resident #20's room naked and straddling Resident #20 while naked and masturbated. The DON stated Resident #20 knew they were okay because they were aware Resident #44 had impaired cognition. The DON stated Resident #20 was not assessed for psychosocial injury, was not referred to psych services after the incident, and was not assessed by nursing or a physician after the incident. The DON was asked to review the facility's Resident - Resident Altercations policy. The DON stated the policy was not followed.</p> <p>On 03/11/25 at 8:49 a.m., CNA #9 was asked about the incident on 02/23/25. They stated a resident notified them there was another resident that went into another residents room naked with their pants down. CNA #9 identified Resident #20 as the victim and Resident #44 as the aggressor. CNA #9 stated the agency nurse named never assessed the resident or got up out of their chair. CNA #9 was asked if Resident #20 had any changes since the incident. CNA #9 stated sometime mid week after the incident Resident #20 asked for help to be put to bed. CNA #9 stated an hour later Resident #20 was screaming and stated they saw Resident #44 when they closed their eyes.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>30267</p> <p>Based on record review and interview, the facility failed to report an allegation of neglect to the OSDH within two hours of the knowledge of the allegation for three (#9, 36 and #147) of three residents sampled for grievances.</p> <p>The administrator identified 44 residents who resided in the facility.</p> <p>Findings:</p> <p>A facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, showed all reports of abuse and neglect were reported to local, state, and federal agencies as required by current regulations and thoroughly investigated by facility management. The policy showed findings of all investigations were documented and reported. The policy showed the administrator or individual making the allegation immediately reported their suspicion to the state licensing/surveying agency (OSDH or State agency). The policy showed immediately was defined as within two hours of an allegation involving abuse or within 24 hours of an allegation if it did not involve abuse.</p> <p>A State reportable incident report, dated 03/13/25, showed an allegation of neglect involving CMA #2 and unidentified residents. The incident report showed the DON had informed the administrator CMA #2 was not punching out the medications, but was checking the medications off as given on the medication administration record and the medications were still in the medication card in the cart. The incident report showed CMA #2 was called into the office on 02/10/25 and told of the investigation. The incident report showed CMA #2 denied the accusation and stated they did pass the medications. The incident report showed the DON stated CMA #2 had not administered the medications and they were offering the CMA a CNA position which was declined. The incident report showed the administrator instructed the DON (on 02/10/25) to complete a State reportable incident report to report the allegation and subsequent investigative findings.</p> <p>The facility's State reportable incident reports for year 2025 were reviewed. There was no State reportable incident report located for CMA #2 failing to administer doses of medications to Resident #9, Resident#36, and Resident #147 until 03/13/25.</p> <p>On 03/07/25 at 6:33 a.m., employee #1 stated the facility hired CMA #2 to work weekend doubles. Employee #1 stated Resident #9, Resident #36, and Resident #147 reported they were not receiving their medications or were not receiving their medications as ordered. Employee #1 stated to resolve the issue, the DON moved the medications on 400 hall from CMA #2's cart to the other medication cart for that CMA to administer. Employee #1 stated CMA #2 was later terminated.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/12/25 at 1:51 p.m., the ADON stated after every weekend CMA #2 worked, the residents on 400 hall would complain they were not getting their medications. The ADON stated CMA #1 had noticed certain narcotics were not signed out on the narcotic count sheet, but were charted as given in the resident's medical record. The ADON stated there were other discrepancies besides the the narcotic medications. The ADON stated CMA #2 was charting the medications as given, but the resident never received them. The ADON stated the CMA would chart on the medication administration record that the narcotic was given, but not sign out the medication in the narcotic record book. The ADON stated the narcotic record book and the physical count of the narcotic medication matched, but the count did not correlate with the number of times the medication was documented as administered on the resident's medication administration record. The ADON stated the medications for Resident #9, Resident #36, and Resident #147 were moved to a different cart so a different CMA could give the medications on the weekend and the grievances were resolved for the three residents. The ADON stated all this was reported to the DON and the DON terminated CMA #2 immediately. The ADON stated the multiple medication errors should have been reported to the State agency and the residents physician.</p> <p>On 03/13/25 at 8:25 a.m., Employee #1 stated what drew their attention to CMA #2 was when they returned to work, the residents had increased behaviors and Resident #36 complained of increased pain. Employee #1 stated this occurred over at least three weeks and was reported to the charge nurse and DON. Employee #1 stated every week Resident #9, Resident #36, and Resident #147 would complain they did not receive their medications. Employee #1 stated it was then the DON moved the three residents' medications for the other CMA to administer.</p> <p>On 03/13/25 at 10:54 a.m., employee #3 stated there were complaints back in December 2024 residents were not receiving their medications over the weekend. Employee #3 stated this was reported to the DON. Employee #3 stated in February 2025 residents again complained they were not receiving their medications. Employee #3 stated Resident #9, Resident #36, and Resident #147 were all cognitively intact and knew their medications and when they were to receive them. Employee #3 stated that was when the medications for Resident #9, Resident #36, and Resident #147 were moved so another CMA would administer their medications. Employee #3 stated they saw behavioral changes/increased behaviors in the confused residents. Employee #3 stated CMA #2 would stand at the medication cart all day (implying they did not enter resident rooms to administer medications), was not charting the administered medications, and spent time in empty resident rooms. Employee #3 stated CMA #2 was given a certified nurse aide position.</p> <p>On 03/13/25 at 12:22 p.m., the MDS coordinator stated CMA #2 was terminated due to grievances that residents were not receiving their medications on time. The MDS coordinator stated they knew the DON had investigated the allegation because the DON removed all the cognitively intact residents from CMA #2's cart and placed them on the other medication cart for the other CMA to administer. The MDS coordinator stated the DON reviewed the medication cards and found that medications were not administered. The MDS coordinator stated the DON felt CMA #2 was not up to par. The MDS coordinator stated if residents did not receive their medications, they could have increased pain, or behaviors, increased anxiety, or fall. The MDS coordinator stated the physician should be informed of the medication errors in case there was a negative outcome to the residents. The MDS coordinator stated the administrator instructed the DON to report the matter to the State agency, but was unaware if the DON did so.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/13/25 at 1:05 p.m., the DON stated they worked a weekend and people complained CMA #2 was slow. The DON stated the CMA needed to administer medications in the allotted time frames. The DON stated there was an ordered antibiotic which CMA #2 stated they gave, but another CMA stated CMA #2 did not administer the medication. The DON stated a long employed CMA stated CMA #2 was not giving all the medications. The DON stated the CMA stated they were looking at the medication card and felt like CMA #2 was not administering the medications. The DON stated they did not investigate the allegation because they did not feel the CMA reporting the allegation was credible and none of the residents voiced concerns. The DON stated the CMA had no proof CMA #2 did not administer the medications. The DON stated when they received the allegation, they removed CMA #2 from the cart, but could not corroborate the information that was given. The DON stated Resident #36 complained they did not receive their Remeron (an antidepressant). The DON stated they reviewed the resident's medications with the resident and educated them on their medications. The DON stated CMA #2 was pulled from the medication cart because they were slow, behind, and would not allow help.</p> <p>The DON stated they were made aware there was an allegation against CMA #2 was not giving the resident their medications as ordered. The DON stated they went over it and did not think it was a concern because the resident was happy. The DON stated there was another resident who complained of pain and stated CMA #2 pulled Tylenol (pain reliever) from their pocket. The DON stated the investigation was documented somewhere in their former office.</p> <p>The DON stated Resident #36 did report they were not getting their medications. The DON stated the allegation could be considered neglect or abuse. The DON stated they reported it to the administrator who asked if the CMA was in-serviced on the matter. The DON stated allegations of neglect/abuse should be reported to the State agency within two hours. The DON stated they did not report the allegation to the State agency because they gathered the details first and determined it was not neglect, but a patient education issue. The DON stated they in-serviced CMA #2 to explain what they were administering, but that did not suffice for Resident #36 and they requested CMA #2 no longer administer their medications.</p> <p>The DON was asked what should happen if a medication administration error or diversion was reported. The DON stated the allegation needed to be investigated, and the family, doctor, administrator, pharmacist, and State agency needed to be notified.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/13/25 at 2:37 p.m., administrator #1 stated they had a meeting with the DON about CMA #2 not passing medications on time. Administrator #1 stated some time later, it was reported by Resident #9 and Resident #36 that CMA #2 pulled medications from their pocket to administer to the residents. Administrator #1 stated the DON noticed when they would return from their weekend off, the residents were more hyped up and more crazy than usual. Administrator #1 stated the DON marked some of the medication cards on the medication cart that CMA #2 was assigned on for the weekend of 02/08/25 and 02/09/25. Administrator #1 stated the DON was able to determine from the marking that CMA #2 was charting they administered medications, but had not removed the medications from the cart. Administrator #1 stated the DON indicated it was routine medications and that most residents only missed a few of their medications and there was no pattern to what was missed. Administrator #1 stated on 02/10/25 they and the DON contacted CMA #2 who denied not administering medications. Administrator #1 stated the DON informed CMA #2 they had marked some of the residents' medication cards to determine if medications were administered. Administrator #1 stated the CMA continued to deny not administering medications and was demoted and offered a CNA position which the CMA declined. Administrator #1 stated they informed the DON this situation was a State reportable incident, but did not know if the DON filed the State reportable incident. Administrator #1 stated the incident was neglect and the CMA should have been reported to the Nurse Aide Registry and the incident reported to Adult Protective Services, the police, and the State agency within two hours.</p>		

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 03/17/2025
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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>30267</p> <p>Based on record review and interview, the facility failed to provide a copy of the facility's bedhold policy to 2 (#9 and #147) of 2 sampled residents who were transferred out of the facility with the intention of returning to the facility.</p> <p>The administrator identified 44 residents residing in the facility.</p> <p>Findings:</p> <p>A facility policy titled Bed-Holds and Returns, revised October 2022, read in part, All residents/representative are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave).</p> <p>1. Resident #9 had diagnoses which included urinary tract infection.</p> <p>A review of the resident's electronic medical record showed the resident had a hospitalization in February 2025, but no documentation the resident received a copy of the facility bedhold policy.</p> <p>2. Resident #147 had diagnoses which included urinary tract infection.</p> <p>A review of the resident's electronic medical record indicated the resident had a hospitalization in March of 2025, but no documentation the resident received a copy of the facility bedhold policy.</p> <p>On 03/03/25 at 3:45 p.m., the administrator stated they were unaware they were to provide the bed hold policy to residents when they left the facility.</p> <p>On 03/12/25 at 2:50 p.m., the ADON stated when a resident was sent to the hospital, the staff sent two copies of the face sheet, two copies of the resident's medication list, a copy of the power of attorney, and a copy of the resident's do-not-resuscitate. The ADON denied staff sent a copy of the facility's bedhold policy.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on record review and interview, the facility failed to ensure a significant change assessment was conducted after a resident was discharged from hospice services for 1 (#2) of 16 sampled residents reviewed for significant change assessments.</p> <p>The administrator identified 44 residents resided in the facility and three residents received hospice services.</p> <p>Findings:</p> <p>A facility policy titled facility's Comprehensive Assessment, revised 10/2023, read in part, Significant Change in Status Assessments (SCSA) - the SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an admission assessment, and it's completion date depend on the date that the IDT determination was made that the resident had a significant change .a significant change is a major decline or improvement in a residence status.</p> <p>Resident #2 was admitted on [DATE] with diagnoses which included chronic kidney disease, anxiety disorder, and acute kidney failure.</p> <p>Resident #2's physician order, dated 04/23/24, read in part, Admit to [name of hospice withheld] Hospice:Dx ESRD [end stage renal disease] Verbal Active 04/23/2024.</p> <p>Resident #2's quarterly assessment, dated 02/02/25, showed Resident #2's cognition was intact with a BIMS score was 14 and was receiving hospice services.</p> <p>Resident #2's physician order, dated 02/27/25, showed Resident #2 was discharged from hospice services on 02/27/25 and listed the reason as no longer appropriate.</p> <p>On 03/03/25 at 1:25 p.m., Resident #2 stated they were no longer receiving hospice services.</p> <p>On 03/17/25 11:46 a.m., the MDS coordinator was asked what the policy was for conducting a significant change assessment when a resident discharged from hospice services. The MDS coordinator stated they had two weeks by policy to do a significant change assessment for residents discharged from hospice.</p> <p>On 03/17/25 at 1:08 p.m., the ADON stated Resident #2 was admitted to hospice on discharged from hospice services 02/27/25.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/17/25 at 1:20 p.m., the MDS coordinator was asked what date did Resident #2 discontinued hospice services. They stated Resident #2 was on hospice services, but they could not find any orders for hospice or discharge from hospice orders. The MDS coordinator was asked when was Resident #2's hospice orders discontinued. The MDS coordinator stated if Resident #2 was off hospice on 02/27/25, the significant change assessment was past due, and there was no order for hospice or it being discharged .</p> <p>On 03/17/25 at 2:00 p.m., the MDS coordinator was provided the physician order, dated 02/27/25, which showed Resident #2 discharged from hospice services on 02/27/25. The MDS coordinator stated they were not aware Resident #2 was discharged from hospice services.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on record review and interview, the facility failed to ensure MDS assessments were accurate for 2 (#3 and #13) of 16 sampled residents reviewed for accurate MDS assessments.</p> <p>The administrator identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy titled Comprehensive Assessments, revised 10/2023 read in part, The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the resident Assessment Instrument specified by CMS [Centers for Medicare and Medicaid Services].</p> <p>1. Resident #3 was admitted on [DATE] with diagnoses which included type 2 diabetes mellitus, syncope and collapse, and chronic kidney disease.</p> <p>Resident #3's quarterly assessment, dated 10/11/24, showed Resident #3 had one fall with no injury, two or more falls with minor injury, and falls since admission or prior assessment.</p> <p>Resident #3's annual assessment, dated 01/13/25, showed Resident #3 did not have any falls since admission/entry or reentry or prior assessment and their BIMS score was 00 indicating their cognition was impaired.</p> <p>Resident #3's care plan, revised on 02/12/25, read in part,</p> <p>a.be sure [Resident #3] call light and frequently use items are within reach and encourage [them] to use call for assistance as needed. [Resident #3] needs prompt response to all request for assistance. Date initiated 07/11/23;</p> <p>b. follow facility fall protocol Date initiated 07/11/23;</p> <p>c. for fall noted 10/20/24, staff to monitor positioning when bed to ensure that [they] are in the center of the bed. Date initiated 10/21/24;</p> <p>e. for fall noted 10/21/24, Q 2 hour safety checks when in bed Date initiated 10/22/24;</p> <p>f. for fall noted 10/23/23 , ensure [Resident #3] is wearing non-slip footwear Date initiated 01/30/24;</p> <p>g. for fall noted 11/13/23, Encouraged [Resident] to stay in common areas when out of bed Date initiated 01/30/24;</p> <p>h. for fall noted 11/22/23, Encourage assist [Resident #3] to lie down following lunch date initiated 01/30/24;</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>i. for fall noted 11/07/23, monitor [Resident #3] for needs and respond promptly to any needs noted date initiated 01/30/24;</p> <p>j. for fall noted 04/04/24, monitor resident for fatigue and encourage [them] to take rest date initiated 4/5/24;</p> <p>k. for fall noted 08/18/24, fall mat in place when in bed date initiated 11/8/24;</p> <p>l. for fall noted 09/10/24, ensure that bed is in lowest position when resident is in bed date initiated 11/8/24; and</p> <p>m. for fall noted 09/03/24, Q 1 hour safety checks times 30 days date initiated 9/3/24.</p> <p>On 03/05/25 8:50 a.m., the MDS coordinator was asked what dates did Resident #3 fall since their quarterly assessment dated [DATE]. They stated on 10/21/24, 11/03/24, 12/29/24, 02/08/25, and 02/22/25.</p> <p>On 03/06/25 at 12:40 p.m., the MDS coordinator was asked if Resident #3's annual assessment completed on 01/13/25 was accurate based upon section L stating there were no previous falls. The MDS coordinator stated the assessment was not accurate.</p> <p>2. On 03/03/25 at 3:00 p.m., Resident #13 was observed with broken and missing teeth.</p> <p>Resident #13 was admitted on [DATE] with diagnoses which included dysphagia following cerebral infarction and nocturnal enuresis.</p> <p>Resident #13's annual assessment, dated 01/17/25, showed Resident #13's BIMS score was 15 indicating their cognition was fully intact. The assessment showed Resident #13 did not have tooth fragments and had all their natural teeth.</p> <p>On 03/03/25 at 3:00 p.m., Resident #13 stated they had broken teeth and tooth pain. Resident #13 stated they had not been to a dentist since admission and stated they would of liked to see a dentist, but one was not offered.</p> <p>On 03/13/25 at 12:15 p.m., the MDS coordinator was shown Resident #13's annual assessment, dated 01/17/25, section L. The MDS coordinator stated they did not assess the resident and did not look in their mouth. The MDS coordinator was asked what did the Resident Assessment Tool manual say to do. The MDS coordinator stated there needed to be a visual assessment. The MDS coordinator was asked if Resident #13 was missing teeth. The MDS coordinator stated, I don't know, I did not look. The MDS coordinator was asked what happened when the MDS was not correct and how did that effect resident care. The MDS coordinator stated the resident care areas were missed on the care plan.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on record review and interview, the facility failed to ensure a level I PASARR was completed after a new mental health diagnosis for 1 (#3) of 5 sampled residents reviewed for PASARRs.</p> <p>The ADON identified 22 residents had a mental health diagnosis.</p> <p>Findings:</p> <p>Resident #3 was admitted on [DATE] with diagnoses which included cerebral infarction and dementia.</p> <p>Resident #3's electronic health record showed Resident #3 was diagnosed with bipolar disorder on 12/03/24.</p> <p>On 03/04/25 at 10:41 a.m., the MDS coordinator was asked about the level I PASARR completed for Resident #3 after a new diagnosis of bipolar on 12/03/24. The MDS coordinator stated there was not a PASARR completed after the new bipolar diagnosis and one should of been completed after the new diagnosis.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>30267</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan for 2 (#9 and #27) of 5 sampled residents whose clinical records were reviewed for unnecessary medications.</p> <p>The administrator identified 44 residents residing in the facility.</p> <p>Findings:</p> <p>1. Resident #9 had diagnoses which included anxiety.</p> <p>The quarterly assessment, dated 12/11/24, showed the resident had an anxiety disorder and received an anti-anxiety medication.</p> <p>The resident's care plan, dated 12/18/24, did not address the resident's anxiety disorder or the use of the anti-anxiety medication.</p> <p>The physician's monthly summary, dated 03/17/25, showed the resident received Buspar (an anti-anxiety medication) twice daily to treat their anxiety disorder.</p> <p>On 03/17/25 at 1:35 p.m., the MDS coordinator stated the resident's care plan should have addressed the resident's diagnosis of anxiety and addressed the use of an anti-anxiety medication.</p> <p>2. Resident #27 had diagnoses which included psychotic disturbance.</p> <p>A physician's order, dated 05/18/23, showed the resident was to receive Zyprexa (an antipsychotic) 5mg at night for vascular dementia with other behavioral disturbances.</p> <p>The quarterly assessment, dated 12/07/24, showed the resident received an antipsychotic medication.</p> <p>The resident's care plan, updated 02/13/25, did not address the resident's diagnosis of psychotic disturbance nor address the use of an antipsychotic medication.</p> <p>The quarter assessment, dated 03/09/25, showed the resident received an antipsychotic medication.</p> <p>On 03/17/25 at 1:35 p.m., the MDS coordinator stated the resident's care plan should have addressed the resident's diagnosis of psychotic disturbance and addressed the use of an antipsychotic medication.</p>

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<p>F 0657</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. care plans were updated/revised for 1 (#3) of 16 sampled residents reviewed for updated/revised care plans; and</p> <p>b. the participation of the resident/resident's representative and the interdisciplinary team in the revision of the care plan for 1 (#12) of 16 sampled residents whose care plan were reviewed for participation of a resident/resident's representative and the interdisciplinary team in the revision of the care plan . This deficient practice resulted in a harm to Resident #3 after the resident experienced a fall with injury.</p> <p>The administrator identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy titled Falls and Fall Risk, Managing, revised 03/2018, read in part, Based on previous evaluations and current data, the staff will identify interventions related to the residents, specific risk and causes to try and prevent the resident from falling and try to minimize complications from falling .the staff, with input of the attending physician, will implement a resident - centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls .if falling recurs, despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.</p> <p>A facility policy titled Care Plans, Comprehensive Person- Centered, revised 03/2022, read in part, The comprehensive care, person centered care plan .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being.Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the residence, problem areas, and their causes, and relevant clinical decision making. when possible, interventions addressed the underlying sources of the problem areas, not just the symptoms or triggers.</p> <p>A facility policy, titled Care Planning - Interdisciplinary Team and revised March 2022, showed the interdisciplinary team was responsible for the development of resident care plans and consisted of the resident's attending physician, a registered nurse with responsibility for the resident, a nursing assistant with responsibility for the resident, a member of the food and nutrition services staff, to the extent practicable, the resident and/or the resident's representative, and other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. The policy showed the resident, the resident's family and/or the resident's legal representative/guardian or surrogate were encouraged to participate in the development of and revisions to the resident's care plan and care plan meetings were scheduled at the best time of the day for the resident and family when possible.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #3 was admitted on [DATE] with diagnoses which included type 2 diabetes mellitus, syncope and collapse, and chronic kidney disease.</p> <p>A witnessed fall report, dated 08/18/24, read in part, Focus charting related to this nurse was walking past residents room and observed resident attempting to self transfer. Landing on their right side onto the floor, skin tear noted to right shin measuring 1 cm x 3 cm, and skin tear below left knee measuring 1.5 cm x 1.5 cm, move limbs appropriately. Resident denies pain discomfort, did not hit their head, assisted resident into wheelchair, denies pain or discomfort at this time Physician notified with orders to dress skin tears, resident unable to give description. The report showed predisposing physiological factors related to the falls included, confused, drowsy, gait imbalance, impaired memory, and weakness/fainted.</p> <p>There was no documentation the care plan was updated with new specific interventions after the fall until 11/08/24 when a fall mat was added to the care plan.</p> <p>An un-witnessed fall report, dated 11/03/24, read in part, Resident was found laying on the floor mat next to bed dirty from bowel movement. Residence [sic] range of motion is WNL for resident right side. Weakness is norm. Small bruise noted to left upper thigh and left lower leg. No other visible injuries noted at this time. The report showed incontinence was the only predisposing physiological factors contributing to the fall.</p> <p>There was no documentation the care plan was updated with new specific interventions after the fall.</p> <p>An un-witnessed fall report, dated 12/29/24, read in part, Call to residents room by CMA. Resident noted to be laying on right side with head on the floor. Small bruising noted to the right eyebrow. Clean and implied stair strips, small skin tear noted to right hand, clean and applied stair strips. Resident assisted up off the floor by this nurse and CMA. No other injuries noted. The report showed predisposing physiological factors were resident was confused, incontinent, and had impaired memory. The report showed predisposing situation factors as ambulating with without assist.</p> <p>There was no documentation the care plan was updated with new specific interventions after the fall.</p> <p>Resident #3's comprehensive assessment, dated 01/13/25, showed Resident #3 did not have any falls since admission/entry or reentry or prior assessment and their BIMS score was 00 indicating their cognition was severely impaired.</p> <p>An un-witnessed fall report, dated 02/08/25, read in part, Nurse was notified by CNA staff that resident was on floor in resident room. Upon entering the room resident was lying on the right side with pillow under head for support placed by CNA staff. Resident vital signs taken and BP 150/180 obtained per manual cuff. Resident denies pain at this time, but is unable to state what happened. Resident assisted from floor to sitting position by nursing staff and then assisted from sitting position to wheelchair. Resident assessed for injury and noticed a small knot on the back of residents head. Resident also had some bruising to right lower leg and some redness to right hip. Resident denies pain at this time. Resident placed in bed by nursing staff after evaluation and clothes changed. The report showed predisposing environmental factors of furniture. The report showed predisposing physiological factor such as incontinent, gait imbalance, and impaired memory.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documentation the care plan was updated with new specific interventions after the fall.</p> <p>Resident #3's care plan, revised on 02/12/25, read in part,</p> <p>a. be sure [Resident #3] call light and frequently use items are within reach and encourage [them] to use call for assistance as needed. [Resident #3] needs prompt response to all request for assistance. Date initiated 07/11/23;</p> <p>b. follow facility fall protocol Date initiated 07/11/23;</p> <p>c. for fall noted 10/20/24, staff to monitor positioning when bed to ensure that she is in the center of the bed. Date initiated 10/21/24;</p> <p>e. for fall noted 10/21/24, Q 2 hour safety checks when in bed Date initiated 10/22/24;</p> <p>f. for fall noted 10/23/23 , ensure [name of Resident withheld] is wearing non-slip footwear Date initiated 01/30/24;</p> <p>g. for fall noted 11/13/23, Encouraged [name of resident withheld] to stay in common areas when out of bed Date initiated 01/30/24;</p> <p>h. for fall noted 11/22/23, Encourage assist [Resident #3] to lie down following lunch date initiated 01/30/24;</p> <p>i. for fall noted 11/7/23, monitor [Resident #3] for needs and respond promptly to any needs noted date initiated 01/30/24;</p> <p>j. for fall noted 04/04/24, monitor resident for fatigue and encourage her to take rest date initiated 04/05/24;</p> <p>k. for fall noted 08/18/24, fall mat in place when in bed date initiated 11/8/24;</p> <p>l. for fall noted 09/10/24, ensure that bed is in lowest position when resident is in bed date initiated 11/08/24; and</p> <p>m. for fall noted 09/03/24, Q 1 hour safety checks times 30 days date initiated 09/3/24.</p> <p>An un-witnessed fall report, dated 02/22/25, read in part, Called by CMA to common area to see resident laying in the floor on their right side. The resident was bleeding from their nose and forehead. Staff quickly started putting cool compresses on them to stop the bleeding. Called place to 911 for transfer to [name of hospital withheld]. Resident had a knot on their forehead, and their nose was swollen. EMS and nursing home staff transferred patient to stretcher after C collar was applied. The physician, DON, and family notified. The report showed predisposing physiological factors as confused, incontinent, gait imbalance, and impaired memory.</p> <p>There was no intervention added to the care plan.</p> <p>(continued on next page)</p>		

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 03/17/2025
NAME OF PROVIDER OR SUPPLIER Community Health Care of Gore		STREET ADDRESS, CITY, STATE, ZIP CODE 503 South Main Street Gore, OK 74435	

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<p>F 0657</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An OSDH 283 report, dated 02/22/25, read in part, Resdient [Resident #3] had an unwitnessed fall in the dayroom. [They] were sent to [name of hospital withheld] for an evaluation. Resident returned the following day with a dx of nasal bone fracture.</p> <p>Resident #3's admission hospital records, dated 02/22/25, showed Resident #3 was sent to the emergency room with a head injury caused by a fall and diagnoses was a frontal scalp edema/hematoma and nasal bone fracture.</p> <p>Resident #3's physician order, dated 02/28/25, read in part, May use Geri chair for poor balance and trunk control. The ordered did not have a start date and the intervention was not in the care plan.</p> <p>On 03/05/25 8:50 a.m., the MDS coordinator stated they were responsible for updating the care plans. The MDS coordinator was asked what should happen after a resident had a fall. The MDS coordinator stated after the resident was assessed, there would be an intervention right away in the incident report, and an intervention would be added after each fall in the care plan. The MDS coordinator was asked what dates did Resident #3 have falls. The MDS coordinator stated 01/10/23, 11/07/23, 11/22/23, 11/23/23, 04/04/24, 08/18/24, 09/03/24, 09/10/24, 10/21/24, 11/03/24, 12/29/24, 02/08/25, and 02/22/25. The MDS coordinator was asked what interventions were added to the care plan for the falls on 11/03/24,12/29/24, 02/08/25, and 02/22/25. The MDS coordinator stated no interventions were added to the care plan after the falls. The MDS coordinator was asked if the policy and fall protocol was followed. The MDS coordinator stated, No, I get busy and sometimes I'm not always communicated a fall. The MDS coordinator was asked if Resident #3 was significantly harmed in any of the falls. The MDS coordinator stated, The last one [they] fell and broke [their] nose causing bruises to the face.</p> <p>On 03/05/25 at 9:23 a.m., CNA #9 was asked how they knew what interventions were in place to prevent falls for Resident #3. CNA #9 stated they are told verbally mostly for new residents and they used the care plan. CNA #9 stated there should be a chair alarm in Resident #3's wheel chair, they laid the resident down when they were sleepy, and used a fall mat. CNA #9 was asked if there were any other interventions for Resident #3 to prevent falls. They stated, Not that I know of.</p> <p>On 03/06/25 at 12:40 p.m., the MDS coordinator was asked if Resident #3's annual assessment, dated 01/13/25 was accurate based upon stating there were no previous falls. The MDS coordinator stated the assessment was not accurate.</p> <p>On 03/06/25 at 8:24 a.m., the DON was asked how they knew if CNAs and agency staff were aware of what interventions were in place for residents to prevent falls. The DON stated, The care plan mostly and verbal communications in the morning meeting. The DON was asked what interventions were added to the care plan after the falls on 11/03/24,12/29/24, 02/08/25, and 2/22/25. The DON stated, None , they did not follow our policies.</p> <p>30267</p> <p>2. Resident #12 had diagnoses which included a history of stroke without residual deficits.</p> <p>Resident #12's quarterly assessment, dated 01/04/25, showed the resident's cognition was intact with a BIMS score of 14.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The care plan, revised 01/10/25, did not identify what interdisciplinary team members participated in the revision of the care plan.</p> <p>A late entry note, with an effective date of 01/10/25, showed a CNA reported the resident's activities of daily living remained stable with the resident requiring various levels of assistance. The progress note showed laboratory results were forwarded to the resident's physician, but there were no new orders related to the laboratory results. The progress note showed the resident was cognitively intact, vocalized understanding of the care plan, and denied any questions or concerns.</p> <p>The progress note did not identify which CNA participated in the care plan process, nor address other members of the interdisciplinary team such as: the attending physician, the registered nurse with responsibility for the resident; a member of food and nutrition services staff, and the participation of the resident's representative.</p> <p>On 03/03/25 at 4:21 p.m., Resident #12 stated they had not participated in a care plan meeting.</p> <p>On 03/17/25 at 5:19 p.m., the MDS coordinator stated they documented the care plan meeting in the progress notes, including who participated in the interdisciplinary team. The MDS coordinator stated they did not document the name of the CNA who participated. The MDS coordinator stated they went to activities, social services, and dietary, and asked if there were any updates to the resident's care plan. The MDS coordinator stated they then went to the resident and reviewed the care plan. The MDS coordinator stated the resident did not voice any concerns. The MDS coordinator stated if there were concerns, they would have returned to the department heads, and asked for a response. The MDS coordinator stated only the MDS coordinator and the resident were present during their interview. The MDS coordinator stated they were unable to identify which CNA participated in the care plan meeting because they did not document who participated. The MDS coordinator stated there was no documentation social services, activities, or dietary participated in the care plan meeting.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>On 03/05/25, an immediate Jeopardy was determined to exist related to the facility's failure to implement fall interventions for Resident #3 who had severe cognitive impairment and was a high fall risk.</p> <p>A quarterly MDS assessment, dated 10/11/24, showed Resident #3 had one non injury fall and two or more falls with injury.</p> <p>Resident #3's Morse Fall Scale assessment, dated 09/24/24, showed Resident #3 was a high fall risk.</p> <p>On 11/03/24, Resident #3 fell from the bed with no injury.</p> <p>Resident #3's Morse Fall Scale assessment, dated 12/03/24, showed Resident #3 was a high fall risk.</p> <p>On 12/29/24, Resident #3 had an un-witnessed fall from their bed and had a small bruising noted to the right eyebrow and a small skin tear noted to their right hand.</p> <p>Resident #3's Morse Fall Scale assessment, dated 12/31/24, showed Resident #3 was a high fall risk.</p> <p>On 02/08/25, Resident #3 had a fall from the bed with no injury.</p> <p>On 02/22/25, Resident #3 had an unwitnessed fall from their wheel chair resulting in Resident #3 being transported to the ER and diagnosed with blunt head trauma, nasal bone fracture, and contusion.</p> <p>There were no additional interventions added to Resident #3's care plan after the falls on 11/03/24, 12/29/24, 02/08/25, and 02/22/25.</p> <p>On 03/05/25 at 10:50 a.m., the Oklahoma State Department of Health was notified and verified the existence of a IJ situation.</p> <p>On 03/05/25 at 12:28 p.m., the administrator was notified of the IJ situation and provided the IJ template.</p> <p>On 03/06/25 at 12:28 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The actions to remove the immediacy of the alleged deficient practice, read in part,</p> <p>a. facility will ensure that all residents are free from certain injuries and that proper interventions are in place and documented;</p> <p>b. Resident # 3 was assessed on 03/05/25 by physician for any signs of injury related to certain injury;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>c. Resident #3 will be placed into increased observation to monitor for ongoing risk for certain injury;</p> <p>d. all nursing staff will be in-serviced on assessment of certain injury and implementation of interventions and policy and procedure related to falls and fall intervention;</p> <p>e. all residents with a fall within the last 30 days will be assessed for proper interventions;</p> <p>f. facility implemented a procedure on 03/05/25 and notified all staff of interventions of the Falling Star Program. The Director of Nursing has and will oversee the program and update accordingly and will hang at head of bed and write interventions on the back and document on careplan;</p> <p>g. all interventions have been documented on all resident's careplan and will be monitored by director of nursing daily until compliance is achieved;and</p> <p>h. plan is complete, likelihood of serious injury or harm will no longer exist as of 03/06/25.</p> <p>The IJ was lifted, effective 03/07/25 at 5:30 p.m., when all components of the plan of removal had been verified as completed. The following documents were reviewed for removal of the IJ situation:</p> <p>a. Resident #3's assessment on 03/05/25;</p> <p>b. in- service documentation for an assessment of certain injury and implementation of interventions and policy and procedure related to falls and fall intervention;</p> <p>c. all high fall risk residents' care plans for updated fall interventions; and</p> <p>d. falling stars above high fall residents' beds for interventions.</p> <p>The deficient practice remained isolated with the potential for more than minimal harm.</p> <p>Based on observation, record review and interview, the facility failed to implement interventions after falls to prevent accidents for 1 (#3) and failed to assess a resident who smoked for safety to prevent accidents for 1 (#30) of 3 residents sampled reviewed for accident hazards.</p> <p>The ADON identified 10 residents were high fall risk and seven residents who smoked.</p> <p>Findings:</p> <p>1. On 03/03/25 at 12:05 p.m., Resident #3 was observed in dining room being assisted with eating in a geriatric chair with bruising on their face under both eyes and cheeks. The resident was unresponsive to questions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Falls and Fall Risk, Managing, revised 03/2018, read in part, Based on previous evaluations and current data, the staff will identify interventions related to the residence, specific risk and causes to try and prevent the resident from falling and try to minimize complications from falling .the staff, with input of the attending physician, will implement a resident - centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of fall .if falling recurs, despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.</p> <p>A facility policy titled Care Plans, Comprehensive Person- Centered, revised 03/2022, read in part, The comprehensive care, person centered care plan: .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being .Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the residence, problem areas, and their causes, and relevant clinical decision making . when possible, interventions addressed the underlying sources of the problem areas, not just the symptoms or triggers.</p> <p>Resident #3 was admitted on [DATE] with diagnoses which included type 2 diabetes mellitus, syncope and collapse, and chronic kidney disease.</p> <p>Resident #3's Morse Fall Scale assessment, dated 06/03/24, showed Resident #3 was a high fall risk.</p> <p>A witnessed fall report, dated 08/18/24, read in part, Focus charting related to this nurse was walking past residents room and observed resident attempting to self transfer. Landing on their right side onto the floor, skin tear noted to right shin measuring 1 cm x 3 cm, and skin tear below left knee measuring 1.5 cm x 1.5 cm, move limbs appropriately. Resident denies pain discomfort, did not hit their head,assisted resident into wheelchair, denies pain or discomfort at this time Physician notified with orders to dress skin tears, resident unable to give description. The report showed predisposing physiological factors related to the falls included, confused, drowsy, gait imbalance, impaired memory, and weakness/fainted.</p> <p>There was no documentation the care plan was updated with new specific interventions after the fall until 11/08/24 when a fall mat was added to the care plan.</p> <p>Resident #3's Morse Fall Scale assessment, dated 09/24/24, showed Resident #3 was a high fall risk.</p> <p>An un-witnessed fall report, dated 11/03/24 read in part, Resident was found laying on the floor mat next to bed dirty from bowel movement. Residence range of motion is WNL for resident right side. Weakness is norm. Small bruise noted to left upper thigh and left lower leg. No other visible injuries noted at this time. The report showed incontinence was the only predisposing physiological factors contributing to the fall.</p> <p>There was no documentation the care plan was updated with new specific interventions after the fall.</p> <p>Resident #3's Morse Fall Scale assessment, dated 12/03/24, showed Resident #3 was a high fall risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #3's Morse Fall Scale assessment, dated 12/31/24, showed Resident #3 was a high fall risk.</p> <p>An un-witnessed fall report, dated 12/29/24, read in part, Call to residents room by CMA. Resident noted to be laying on right side with head on the floor. Small bruising noted to the right eyebrow. Clean and implied stair strips, small skin tear noted to right hand, clean and applied stair strips. Resident assisted up off the floor by this nurse and CMA. No other injuries noted. The report showed predisposing physiological factors were resident was confused, incontinent, and had impaired memory. The report showed predisposing situation factors as ambulating with without assist.</p> <p>There was no documentation the care plan was updated with new specific interventions after the fall.</p> <p>Resident #3's comprehensive assessment dated [DATE], showed Resident 3's BIMS score was 00 indicating their cognition was severely impaired and they did not have any falls since admission/entry or reentry or prior Assessment.</p> <p>An un-witnessed fall report, dated 02/08/25, read in part, Nurse was notified by CNA staff that resident was on floor in resident room. Upon entering the room resident was lying on the right side with pillow under head for support placed by CNA staff. Resident vital signs taken and BP 150/180 obtained per manual cuff. Resident denies pain at this time, but is unable to state what happened. Resident assisted from floor to sitting position by nursing staff and then assisted from sitting position to wheelchair. Resident assessed for injury and noticed a small knot on the back of residents head. Resident also had some bruising to right lower leg and some redness to right hip. Resident denies pain at this time. Resident placed in bed by nursing staff after evaluation and clothes changed. The report showed predisposing environmental factors of furniture and predisposing physiological factor such as incontinent, gait imbalance, and impaired memory.</p> <p>There was no documentation the care plan was updated with new specific interventions after the fall.</p> <p>Resident #3's care plan, revised on 02/12/25, read in part,</p> <p>a.be sure [Resident #3] call light and frequently use items are within reach and encourage [them] to use call for assistance as needed. [Resident #3] needs prompt response to all request for assistance. Date initiated 07/11/23;</p> <p>b. follow facility fall protocol Date initiated 07/11/23;</p> <p>c. for fall noted 10/20/24, staff to monitor positioning when bed to ensure that [they] are in the center of the bed. Date initiated 10/21/24;</p> <p>e. for fall noted 10/21/24, Q 2 hour safety checks when in bed Date initiated 10/22/24;</p> <p>f. for fall noted 10/23/23 , ensure [Resident #3] is wearing non-slip footwear Date initiated 01/30/24;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>g. for fall noted 11/13/23, Encouraged [Resident] to stay in common areas when out of bed Date initiated 01/30/24;</p> <p>h. for fall noted 11/22/23, Encourage assist [Resident #3] to lie down following lunch date initiated 01/30/24;</p> <p>i. for fall noted 11/07/23, monitor [Resident #3] for needs and respond promptly to any needs noted date initiated 01/30/24;</p> <p>j. for fall noted 04/04/24, monitor resident for fatigue and encourage [them] to take rest date initiated 4/5/24;</p> <p>k. for fall noted 08/18/24, fall mat in place when in bed date initiated 11/8/24;</p> <p>l. for fall noted 09/10/24, ensure that bed is in lowest position when resident is in bed date initiated 11/8/24; and</p> <p>m. for fall noted 09/03/24, Q 1 hour safety checks times 30 days date initiated 9/3/24.</p> <p>An un-witnessed fall report, dated 02/22/25, read in part, Called by CMA to common area to see resident laying in the floor on their right side. The resident was bleeding from their nose and forehead. Staff quickly started putting cool compresses on them to stop the bleeding. Called place to 911 for transfer to [name of hospital withheld]. Resident had a knot on their forehead, and their nose was swollen. EMS and nursing home staff transferred patient to stretcher after C collar was applied. The physician, DON, and family notified. The report showed predisposing physiological factors as confused, incontinent, gait imbalance, and impaired memory.</p> <p>An OSDH 283 report, dated 02/22/25, read in part, Resident [Resident #3] had an unwitnessed fall in the dayroom. [They] were sent to [name of hospital withheld] for an evaluation. Resident returned the following day with a dx of nasal bone fracture.</p> <p>Resident #3's admission hospital records, dated 02/22/25, showed Resident #3 was sent to the ER with a head injury caused by a fall and diagnoses was a frontal scalp edema/hematoma and nasal bone fracture.</p> <p>Resident #3's physician order, dated 02/28/25, read in part, May use Geri chair for poor balance and trunk control. The ordered did not have a start date and the intervention was not in the care plan.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 03/05/25 8:50 a.m., the MDS coordinator stated they were responsible for updating the care plans. The MDS coordinator was asked what should happen after a resident had a fall. The MDS coordinator stated after the resident was assessed, there would be an intervention right away in the incident report, and an intervention would be added after each fall in the care plan. The MDS coordinator was asked what dates did Resident #3 have falls. The MDS coordinator stated 01/10/23, 11/07/23, 11/22/23, 11/23/23, 04/04/24, 08/18/24, 09/03/24, 09/10/24, 10/21/24, 11/03/24, 12/29/24, 02/08/25, and 02/22/25. The MDS coordinator was asked what interventions were added to the care plan for the falls on 11/03/24,12/29/24, 02/08/25, and 02/22/25. The MDS coordinator stated no interventions were added to the care plan after the falls. The MDS coordinator was asked if the policy and fall protocol was followed. The MDS coordinator stated, No, I get busy and sometimes I'm not always communicated a fall. The MDS coordinator was asked if Resident #3 was significantly harmed in any of the falls. The MDS coordinator stated, The last one [they] fell and broke [their] nose causing bruises to the face.</p> <p>On 03/05/25 at 9:23 a.m., CNA #9 was asked how they knew what interventions were in place to prevent falls for Resident #3. CNA #9 stated they are told verbally mostly for new residents and they used the care plan. CNA #9 stated there should be a chair alarm in Resident #3's wheel chair, they laid the resident down when they were sleepy, and used a fall mat. CNA #9 was asked if there were any other interventions for Resident #3 to prevent falls. They stated, Not that I know of.</p> <p>On 03/06/25 at 12:40 p.m., the MDS coordinator was asked if Resident #3's annual assessment, dated 01/13/25 was accurate based upon stating there were no previous falls. The MDS coordinator stated the assessment was not accurate.</p> <p>On 03/06/25 at 8:24 a.m., the DON was asked how they knew if CNAs and agency staff were aware of what interventions were in place for residents to prevent falls. The DON stated, The care plan mostly and verbal communications in the morning meeting. The DON was asked what interventions were added to the care plan after the falls on 11/03/24,12/29/24, 02/08/25, and 2/22/25. The DON stated, None , they did not follow our policies.</p> <p>30267</p> <p>2. An undated facility policy titled Smoking Policy - Residents, read in part, Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: current level of tobacco consumption; method of tobacco consumption (traditional cigarettes, electronic cigarettes, pipe, etc.) desire to quit smoking; and ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues.</p> <p>Resident #30 had diagnoses which included dementia, shortness of breath, and chronic obstructive pulmonary disease.</p> <p>A care plan, revised 07/26/23, showed the resident was a smoker. The documented smoking interventions included:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. can smoke unsupervised;</p> <p>b. instructed about smoking risks, hazards, and about available smoking cessation aids,</p> <p>c. instructed about the facility policy on smoking, including: locations, times, and safety concerns;</p> <p>d. notify charge nurse immediately if resident was suspected of violating facility smoking policy; and,</p> <p>e. to observe clothing and skin for signs of cigarette burns.</p> <p>A quarterly assessment, dated 02/06/25, showed Resident #30's cognition was intact with a BIMS score of 13.</p> <p>On 03/04/25 at 11:30 a.m., Resident #30 stated they carried their own cigarettes and lighter and smoked whenever they wished and without supervision. Resident #30 denied having a smoking assessment performed or having been instructed by the facility on the risks, hazards, available smoking cessation aides, or smoking policy. Resident #30 stated they pretty well figured out all the information as to where to smoke and knew when to smoke depended on who was working and when.</p> <p>On 03/12/25 at 9:20 a.m., the administrator stated there were two residents who were independent with smoking and carried their own cigarettes and lighter. The administrator stated the assessments were in the computer under the assessment tab.</p> <p>The administrator stated the assessments should have been there under safety, but they would consult with the MDS coordinator to find out where the assessments were located.</p> <p>On 03/12/25 at 9:52 a.m., the administrator and MDS coordinator stated the smoking assessment was in with the care plan. The MDS coordinator stated they re-assessed the resident once a year and with any changes. The MDS coordinator stated they would re-assess the resident earlier if the resident incurred something like a stroke.</p> <p>On 03/17/25 at 1:35 p.m., the MDS coordinator stated the resident's smoking care plan did not have the necessary components of the smoking evaluation. The MDS coordinator stated there was no other documentation related to the resident's smoking evaluation/assessment.</p>		

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NAME OF PROVIDER OR SUPPLIER Community Health Care of Gore		STREET ADDRESS, CITY, STATE, ZIP CODE 503 South Main Street Gore, OK 74435	
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<p>F 0699</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to provide trauma informed care after an incident of sexual abuse for 1 (#20) of 5 sampled residents reviewed for trauma informed care which resulted in a harm to Resident #20.</p> <p>The ADON identified 44 residents resided in the facility and 22 residents received mental health medications in the facility.</p> <p>Findings:</p> <p>On 03/03/25 at 12:16 p.m., Resident #20 was observed crying and visibly traumatized while conveying the incident which occurred on 02/23/25.</p> <p>A facility policy titled Identifying Types of Abuse, revised 09/2022, read in part, the following situations are recognized as those that are likely to cause psychosocial harm, which may take months or years to manifest and have long-term effects on the resident and [their] relationship with others: a. Sexual assault.</p> <p>A facility policy titled Resident - Resident Altercations policy, revised September 2022, read in part, If two residents are involved in an altercation, staff: .</p> <p>c. notify each resident's representative and attending physician of the incident;</p> <p>d. review the events with the nursing supervisor and director of nursing services, and evaluate the effectiveness of the interventions meant to address distressed behaviors for one or both residents;</p> <p>e. consult with attending physical to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem;</p> <p>f. make any necessary changes in the care plan approaches to any and all involved individuals;</p> <p>g. document in the residents' clinical record all interventions and theory effectiveness;</p> <p>icons psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for interventions and management as necessary, as may be recommended by the attending physician or interdisciplinary care planning team.</p> <p>Resident #20 was admitted to the facility on [DATE] with diagnoses which included acute and hypoxic respiratory failure and major depressive disorder.</p> <p>Resident #20's admission assessment, dated 01/28/25, showed Resident #20's BIMS score was 15 and their cognition was fully intact.</p> <p>A review of Resident #20's electronic health record did not document the following after the incident of sexual abuse on 02/23/25:</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>a. Resident #20's physician was notified after the incident;</p> <p>b. interventions were addressed by the nursing supervisor after the incident;</p> <p>c. the attending physician was consulted to identify treatable conditions such as psychosis;</p> <p>d. any changes made to the care plan after the incident;</p> <p>e. documentation of interventions and their effectiveness; and</p> <p>f. psychiatric services was consulted as needed for assistance in assessing the resident.</p> <p>An OSDH form 283, dated 02/23/25, showed Resident #44 went into Resident #20's room naked and straddled Resident #20 while holding their private parts in their hand. The form showed Resident #20 screamed for help.</p> <p>Resident #44's progress note, dated 02/23/25 at 12:15 p.m., read in part, I let [them] know that [they] went into a [gender withheld] resident's room and pulled [their] pants down, [they] were standing in front of the resident and was humping.</p> <p>Resident #20's progress note, dated 02/23/25 at 1:35 p.m., read in part, A [gender withheld] resident [Resident # 44] went into [Resident #20's] room on Sunday 02/23/25. [They] stood in front of [their] wheel chair and pulled their pants down and was humping in front of [Resident #20]. [Resident #20] yelled for [Resident #44] to get out of their room, [Resident #44] did not leave so [Resident #20] turned on their call light and started screaming and [Resident #44] left.</p> <p>On 03/03/25 at 12:16 p.m., Resident #20 stated Resident #44 came into their room naked and straddled their legs while they were sitting in their wheel chair in the afternoon. Resident #20 stated they shut their eyes and yelled for help until staff came. Resident #20 stated Resident #44 ran from their room when they yelled for help. Resident #20 stated they were fearful during and after the incident and had difficulty falling asleep since the incident. Resident #20 stated their physician was not notified of the incident.</p> <p>On 03/06/25 at 9:00 a.m., the DON stated they were informed of the incident on 02/23/25 involving Resident #44 going into Resident #20's room naked and straddling Resident #20 while naked and masturbated. The DON stated Resident #20 knew they were okay because they were aware Resident #44 had impaired cognition. The DON stated Resident #20 was not assessed for psychosocial injury, was not referred to psych services after the incident, and was not assessed by nursing or a physician after the incident. The DON was asked to review the facility's Resident - Resident Altercations policy. The DON stated the policy was not followed.</p> <p>On 03/06/25 9:27 a.m., Resident #20 stated their counselor, which was previously established by their family representative, was not made aware of the incident and they had not received any psychological assessment since the incident on 02/23/25. Resident #20 stated they were having trouble sleeping since the incident due to recalling the traumatic incident when they closed their eyes. Resident #20 stated they reported to nursing staff and nurse aides they were fearful of the opposite sex and was having trouble sleeping since the incident on 02/23/25.</p> <p>(continued on next page)</p>		

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F 0699 Level of Harm - Actual harm Residents Affected - Few	<p>On 03/06/25 at 10:17 a.m., Resident #20's family representative was asked how Resident #20 was doing since the incident on 02/23/25. They stated Resident #20 had difficulty sleeping since the incident, was afraid to have the door closed, was fearful of the opposite sex, and was afraid to be alone since the incident. They stated the facility did not set up any psychological counseling for the resident.</p> <p>On 03/06/25 at 11:15 a.m., the DON stated they would have to contact the family representative to determine if the Resident #20 had a psychological services referral made.</p> <p>On 03/11/25 at 8:49 a.m., CNA #9 was asked about the incident on 02/23/25. They stated a resident notified them there was another resident that went into another residents room naked with their pants down. CNA #9 identified Resident #20 as the victim and Resident #44 as the aggressor. CNA #9 stated the agency nurse named never assessed the resident or got up out of their chair. CNA #9 was asked if Resident #20 had any changes since the incident. CNA #9 stated sometime mid week after the incident Resident #20 asked for help to be put to bed. CNA #9 stated an hour later Resident #20 was screaming and stated they saw Resident #44 when they closed their eyes.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>30267</p> <p>Based on record review and interview, the facility failed to perform a gradual dose reduction or document the rationale for not performing a gradual dose reduction of an antipsychotic medication for 1 (#27) of 5 sampled residents reviewed for unnecessary medications.</p> <p>The administrator identified 22 residents with a mental health diagnoses.</p> <p>Findings:</p> <p>Resident #27 had diagnoses which included vascular dementia with other behavioral disturbance, aphasia following a stroke, major depressive disorder, and anxiety.</p> <p>A physician's order, dated 05/18/23, showed the resident was to receive Zyprexa (an antipsychotic medication) 5mg at bedtime for vascular dementia.</p> <p>A pharmacy recommendation, dated 05/07/24, showed the resident was on Zyprexa 5mg at bedtime and asked to consider a gradual dose reduction to Zyprexa 2.5mg at bedtime. The physician's response showed the resident had failed a prior gradual dose reduction.</p> <p>An annual assessment, dated 06/06/24, showed the resident was cognitively severely impaired (BIMS score 3), displayed no behaviors, and received and antipsychotic medication. The assessment showed no gradual dose reduction was attempted and there was no documented rationale as to why a gradual dose reduction was contraindicated.</p> <p>A quarterly assessment, dated 12/07/24, showed the resident was cognitively severely impaired (BIMS score 2), displayed no behaviors, and received and antipsychotic medication. The assessment showed no gradual dose reduction was attempted and there was no documented rationale as to why a gradual dose reduction was contraindicated.</p> <p>A pharmacy recommendation, dated 02/12/25, showed the resident was on Zyprexa 5mg at bedtime and asked to consider a gradual dose reduction to Zyprexa 2.5mg at bedtime. The physician's response showed the resident had failed a prior gradual dose reduction.</p> <p>On 03/05/25 through 03/07/25, 03/10/25 through 03/13/25, and 03/17/25, the administrator and MDS coordinator were asked for documentation of a prior gradual dose reduction of Zyprexa or a clinical rationale for the contraindication of a gradual dose reduction of Zyprexa for Resident #27.</p> <p>The quarterly assessment, dated 03/09/25, showed the resident was cognitively severely impaired (BIMS score 3), displayed no behaviors, and received and antipsychotic medication. The assessment showed no gradual dose reduction was attempted and there was no documented rationale as to why a gradual dose reduction was contraindicated.</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/17/25 at 9:00 a.m., the administrator was informed of a possible deficiency related to unnecessary medications.</p> <p>On 03/17/25 at 10:30 a.m., the administrator stated they did not see a clinical rationale for not performing a gradual dose reduction but would continue to look for additional documentation.</p> <p>On 03/17/25 at 11:29 a.m., the administrator stated they contacted the resident's physician and they would provide the documented rationale for why the gradual dose reduction for Zyprexa was contraindicated.</p> <p>No further documentation was provided by the end of survey.</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to offer dental services for 1 (#13) of 16 sampled residents reviewed for dental services offered.</p> <p>The administrator identified 44 residents resided in the center.</p> <p>Findings:</p> <p>On 03/03/25 at 3:30 p.m., Resident #13 was observed with broken and missing teeth.</p> <p>The facility's Dental Services policy and procedure, dated 12/06/23, read in part, [name of dental provider withheld] call our residents responsible party to agree they want services. This is part of a program with Medicaid.</p> <p>Resident #13 was admitted on [DATE], with diagnoses which included dysphagia following cerebral infarction and nocturnal enuresis.</p> <p>Resident #13's care plan, dated 01/25/24, showed Resident #13 required partial to moderate assistance X 1 staff with personal hygiene and oral care.</p> <p>Resident #13's care plan did not document they had broken or missing teeth or the need for dental services.</p> <p>Resident #13's annual assessment, dated 01/17/25, showed Resident #13's BIMS score was 15 indicating their cognition was fully intact. The assessment showed Resident #13 did not have tooth fragments and had all their natural teeth.</p> <p>On 03/03/25 at 3:30 p.m., Resident #13 stated they had broken teeth and tooth pain. Resident #13 stated they had not been to a dentist since admission and stated they would of liked to see a dentist, but one was not offered.</p> <p>On 03/12/25 at 5:20 p.m., the SSD was asked how they determined if a resident needed dental services. The SSD stated all residents should get some kind of dental services if they wanted it. The SSD stated the dental service had a social security income program. The SSD stated the dental service had access to their census and they contacted the responsible party or the resident to schedule services. The SSD was asked what the policy was for offering and setting up dental services for residents. The SSD stated the facility did not offer dental services to the residents. The SSD stated they left it up to dental services.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/13/25 at 12:15 p.m., the MDS coordinator was shown Resident #13's annual assessment, dated 01/17/25, section L. The MDS coordinator stated they did not assess the resident and did not look in their mouth. The MDS coordinator was asked what did the Resident Assessment Tool manual say to do. The MDS coordinator stated there needed to be a visual assessment. The MDS coordinator was asked if Resident #13 was missing teeth. The MDS coordinator stated, I don't know, I did not look. The MDS coordinator was asked what happened when the MDS was not correct and how did that effect resident care. The MDS coordinator stated the resident care areas were missed on the care plan.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30267</p> <p>Based on observation and interview, the facility failed to maintain the ice machine in a sanitary manner.</p> <p>The dietary manager identified 44 residents who utilized ice from the kitchen.</p> <p>Findings:</p> <p>On 03/03/25 at 1:30 p.m., an observation of the ice machine was conducted with the dietary manager. There was a slimy black and brown substance in the crevices, along the edges, and around the pump of the water reservoir.</p> <p>On 03/03/25 at 1:30 p.m., the dietary manager stated there was something brownish black and slimy looking along the edges of the water reservoir. The dietary manager stated they cleaned the ice bin weekly, but did not know who cleaned the mechanical area of the ice machine.</p> <p>On 03/10/25 at 3:15 p.m., the administrator stated the ice machine should be on a regular cleaning schedule for the maintenance department to perform.</p>