

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Blue River Healthcare, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 East Main Tishomingo, OK 73460	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34333</p> <p>Based on observation and interview, the facility failed to ensure air vents were clean and in good repair for three (#1, 2, and #3) of three sampled residents reviewed for a clean and homelike environment.</p> <p>The administrator identified 45 residents resided in the facility.</p> <p>Findings:</p> <p>A Cleaning and Disinfecting Residents' Rooms policy, dated August 2013, read in part, .Environmental surfaces will be disinfected (or cleaned) on a regular basis .and when surfaces are visibly soiled .Clean curtains, window blinds, and walls when they are visibly soiled or dusty .</p> <p>1. On 09/25/24 at 12:53 p.m., Resident #1 was observed in their room (room [ROOM NUMBER]). The air vent closest to the resident was observed to be slightly open and covered with dust.</p> <p>On 09/26/24 at 11:50 a.m., the air vents in Resident #1's room were observed to be covered with dust and rust spots. The resident stated maintenance could not adjust the flow of air because the vent was stuck.</p> <p>2. On 09/25/24 at 1:03 p.m., Resident #2 was interviewed in their room (room [ROOM NUMBER]). The resident stated they had recently been moved from another room. The resident's current room was observed to have an air vent above the bed which was covered with dust. The resident reported they had previously been in room [ROOM NUMBER]. room [ROOM NUMBER] was observed and found to have air vents covered with dust.</p> <p>On 09/26/24 at 11:45 a.m., Resident #2 was observed to be out of their room. The air vent above the resident's bed was observed to be covered with dust. A second vent in the resident's room was observed to have rust spots and gaps around the edges between the vent and ceiling.</p> <p>3. On 09/25/24 at 1:07 p.m., the air vent in Resident #3's room (room [ROOM NUMBER]) was observed to be covered with dust. Resident #3 stated they were not aware of the vent ever being cleaned.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/26/24 at 11:40 a.m., Resident #3 was observed lying in bed. The vent above the bed was observed to be covered with dust. A second vent in the resident's room was observed to be rusted with gaps between the vent and ceiling.</p> <p>On 09/26/24 at 12:17 p.m., maintenance staff stated they were aware the air vents needed to be replaced. They stated they had a specific budget and it might take some time, but they felt all of the vents in the facility should be replaced. They stated housekeeping staff would be responsible for cleaning the dust and dirt on the vents in resident rooms.</p> <p>On 09/26/24 at 12:27 p.m., the housekeeping supervisor stated vents in the resident rooms were normally cleaned every Tuesday. They stated the administrator had recently purchased new extendable dusters to be used on the vents and stated they had noticed some vents needed to be cleaned twice a week.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>34333</p> <p>Based on observation, record review, and interview, the facility failed to prevent an inappropriate relationship between a staff member and resident, and ensure a resident was free from abuse for one (#1) of one sampled resident reviewed for abuse.</p> <p>The administrator identified 45 residents resided in the facility. They stated there was one allegation of abuse in the past 30 days.</p> <p>Findings:</p> <p>An Abuse Investigation and Reporting policy, dated July 2017, read in part, .The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident .Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator .</p> <p>Resident #1 was admitted to the facility with diagnoses which included schizoaffective disorder, depression, anxiety, and chronic pain.</p> <p>An MDS assessment, dated 08/13/24, documented the resident was cognitively intact and exhibited no behaviors. The assessment documented the resident was independent with activities of daily living.</p> <p>An incident report form, dated 09/20/24, documented Resident #1 had gone to the administrator's office and stated a staff member had sent nude pictures to their cell phone. The staff member was not in the facility at the time and was immediately suspended.</p> <p>On 09/25/24 at 12:53 p.m., Resident #1 was interviewed and stated they felt safe and did not report an incident of abuse.</p> <p>On 09/25/24 at 3:15 p.m., the administrator stated there was not a police report related to the allegation of abuse involving Resident #1. The administrator stated when the two police officers came to the facility the resident did not want to give a report and did not want to press charges.</p> <p>On 09/25/24 at 3:40 p.m., the corporate nurse stated the investigation was ongoing. They stated more information had been obtained from Resident #1 related to social media interactions over the past year between the resident and CMA #1.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/26/24 at 11:50 a.m., Resident #1 was interviewed in their room. The resident's roommate was out of the room and they asked for their door to be shut. They stated they had more than a friendship with CMA #1. They stated they had shown the administrator months of texts back and forth between them and CMA #1. They stated when CMA #1 sent nude pictures to them they became increasingly anxious and was very uncomfortable when the CMA worked. They stated when they became uncomfortable they reported the pictures to the administrator. They stated then a couple of days later they shared the numerous text messages. The resident was asked if the relationship was consensual. They stated it was okay for a long time. They stated they had a mutual understanding, but the nude pictures made them very uncomfortable. They stated that is when they reported the situation to the administrator.</p> <p>On 09/26/24 at 1:55 p.m., the administrator stated Resident #1 initially came to them on 09/20/24 to report CMA #1 had sent nude pictures to the resident's cell phone. The administrator stated they immediately started the abuse investigation which included required notification to authorities, appropriate reporting, interviews with staff and residents, and staff in-services. The administrator stated Resident #1 came to them again on 09/24/24 and shared months of social media messages between the resident and CMA #1. The administrator stated the abuse investigation had been completed and the allegation of abuse was substantiated.</p>		