

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Cherokee County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 North Cedar Avenue Tahlequah, OK 74464	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270</p> <p>Based on record review and interview, the facility failed to report an injury of unknown origin to the OSDH for 1 (#6) of 5 sampled residents reviewed for abuse.</p> <p>The DON reported 97 residents resided at the facility.</p> <p>Findings:</p> <p>A facility policy titled Abuse, Neglect, Misappropriation and Exploitation Investigation and Reporting Policy, dated 10/18/22, read in part, All facility personnel, including all employees and any physician, the owner and the Administrator, must immediately report all incidents of alleged, witnessed or suspected resident maltreatment, including abuse, sexual abuse, neglect, misappropriation of resident property and exploitation of resident to the Administrator or Administrator's Designee, who will report events as required by State law or regulation.</p> <p>Res #6 had diagnoses which included dementia and down syndrome.</p> <p>On 03/04/25 at 2:09 p.m., the DON stated they had been informed by the administrator of a report by a family member of Res #6 the resident had bruising on their face. They stated they believed they were told of the report on either 08/29/24 or 08/30/24.</p> <p>On 03/05/25 at 8:49. a.m., LPN #3 stated they had conducted an assessment of Res #6 when they had returned to the facility on [DATE]. They stated there was no documentation of bruising in their note that day because they had not observed any bruising. They stated about two days later they had been told by someone of bruises on Res #6. They stated they could not recall who had told them. They stated they then went a looked at the resident and did see a purple colored bruise on the resident's left cheek. They stated the bruise was such that anyone would have noticed it if they saw it. They stated after witnessing the bruise they had not reported what they saw to administration because the felt they already knew, but they did pass it on to the next crew during the next shift change.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/05/25 at 9:12 a.m., the DON stated they had not reported the bruising on Res #6 to OSDH or anyone else because they felt the injuries had occurred when the resident was under the care of others. They stated LPN #3 had conducted an assessment of the resident when they had returned from a hospital, but they did not document the assessment. They stated they had not conducted a formal investigation into the origin of the bruises when they had become aware of them. They stated the did ask some staff about it, but did not document those discussions.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to investigate an injury of unknown origin for 1 (#6) of 5 sampled residents reviewed for abuse.</p> <p>The DON reported 97 residents resided at the facility.</p> <p>Findings:</p> <p>A facility policy titled Abuse, Neglect, Misappropriation and Exploitation Investigation and Reporting Policy, dated 10/18/22, read in part, The Administrator or Administrative Designee will conduct an immediate investigation of all incidents of alleged, witnessed or suspected resident maltreatment, including abuse, sexual abuse, neglect, misappropriation of resident property and exploitation of residents.</p> <p>Res #6 had diagnoses which included dementia and down syndrome.</p> <p>A progress note titled, Nsg [nursing]-Admission Summary, dated 08/17/24 at 8:03 p.m., showed Res #6 had been readmitted to the facility from a hospital stay. The note showed LPN #3 had written the note. The note did not include observations of a bruise on the resident.</p> <p>On 03/04/25 at 2:01 p.m., the DON stated they had been told by the administrator about a family member's report of bruising on Res #6. They stated they were told on either 08/29/24 or 08/30/24, but was unable to be more exact.</p> <p>On 03/04/25 at 2:09 p.m., family member #1 stated they had observed a bruise on Res #6's face during a visit on 08/17/24. They stated they had visited the resident at a hospital on 08/16/25 and had not seen any bruises then. They stated they informed the administrator via text about the bruising, but could not recall the exact date.</p> <p>On 03/04/25 at 2:45 p.m., the DON stated on the day the facility administrator had informed them of the report of bruising on Res #6 they had asked various staff if they were aware of the bruising. The DON stated they did not write down what they had asked, who they asked, or their responses. They stated they had not interviewed any residents. They stated they had not located any investigative material regarding the bruising on Res #6.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34270</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control practices were followed during resident care for 1 (#9) of 3 sampled residents reviewed for PEG tube care.</p> <p>The infection preventionist identified three residents in the facility had PEG tubes.</p> <p>Findings:</p> <p>On 03/04/25 at 9:11 a.m., CMA #4 was observed providing medication administration to Res #9. During the care CMA #4 made contact with multiple items that would be considered dirty without changing their gloves. After entering the resident's room, CMA #4 did the following in order written:</p> <ol style="list-style-type: none"> a. cleaned their hands in the resident's sink; b. dried their hands with a fabric towel that had been stored in the open air in the resident's room; c. refolded and placed the used towel in a container with other clean towels; d. put on exam gloves; e. put on a protective gown; f. disconnected and removed feeding and water containers from an IV pole; g. pulled down the stained bedding that covered the resident; h. readjusted a stained towel that was on top of the resident and under the bedding; i. disconnected the PEG tubing and rubbed the ends with their fingers as if removing something; j. rummaged through supplies that were next to the resident's sink and found new water and feeding solution bottles; k. filled the feeding solution container; l. filled the water container with water from the resident's sink where they had washed their hands; m. hung the new water and feeding solution containers on an IV pole; n. administered Flonase spray into the resident's nose; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>o. rummaged through the supplies located next to the resident's sink and removed a syringe from its package;</p> <p>p. connected the syringe to the PEG tube and administered the resident's medication; and</p> <p>q. CMA #4 then removed their gloves and gown then washed their hands.</p> <p>A facility policy and procedure titled Enteral Feedings, Administration via Gastrostomy, dated 11/22/16, showed the use of hand washing and glove changes were required between steps of the care.</p> <p>Res #9 had diagnoses which included encounter for attention to gastrostomy and fistula of stomach and duodenum.</p> <p>On 03/04/25 at 9:48 a.m., CMA #4 stated they thought they had changed their gloves once during the care. They stated they should have changed their gloves after touching items that would be considered to be dirty.</p> <p>ON 03/04/25 at 10:23 a.m., the DON stated CMA #4 should have changed gloves after touching the dirty items. They stated they should not have used the fabric towel in the room since they were not covered. They stated they felt it was appropriate to use the sink water for the PEG tube water container.</p>