STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375340	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Grove Care & Rehab Center	1001 South George Nigh Expressway McAlester, OK 74501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 49701 Based on record review and interview, the facility failed to ensure a resident had access to their trust account money on nights and weekends for 1 (#1) of 1 sampled resident reviewed for access to their trust account money. The BOM identified 12 residents who had money in the trust account. Findings: An undated Policy and Procedure of Resident Trust Fund, read in part, The management of the trust shall be managed by the business office or it's designees and ensure that proper accounting principals are followed . but not to exclude State and Federal regulations. A review of the trust account ledgers for Resident #1 contained no entries of money being withdrawn at night or on the weekends. On 02/24/25 at 12:26 p.m., Resident #1 reported over the weekend they wanted a coke and was told they did not have any money. On 02/27/25 at 10:04 a.m., the BOM stated they worked at the facility Monday through Friday. They stated if residents wanted money they would need to request it from them on Friday and keep it on their person. They stated the facility did not keep petty cash. They stated, I guess they wouldnt when asked directly how residents would get their money if they wanted it at night or on the weekends. On 02/27/25 at 10:17 a.m. RN #1 stated they worked Tuesday through Saturday and they did not deal with the money. They stated if a resident asked for money on the weekend, they would have to contact the BOM. They stated if a resident requested money on a Friday, they would have to keep it on their person.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49701 On 02/27/24, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect Resident #45 from verbal and psychosocial abuse. On 02/27/25 at 2:06 p.m., Resident #45 reported over the weekend staff blamed them for turning on the call light. Resident #45 stated CNA #1 came to their room to answer the call light and Resident #45 told CNA #1 they needed assistance with incontinent care. Resident #45 stated CNA #1 told them they were assisting another resident and would come back when they could. Resident #45 stated when CNA #1 returned they yelled at them and stated they would be there in a minute and to stay off the light. Resident #45 stated they had not activated the call light again, that CNA #1 had not turned the call light off from the first interaction. Resident #45 stated they were so upset they started crying. Resident #45 stated they called the nurses station and reported the occurrence to the charge nurse/ LPN #4. Resident #45 stated they were so upset they wanted to leave the facility. On 02/27/25 at 2:12 p.m., the administrator stated on Monday 02/24/25, CNA #2 tattle-tailed on about three things, one of which were concerns about CNA #1 regarding verbal abuse over the weekend. The administrator stated it was reported CNA #1 wasn't very nice to Resident #45. The administrator stated they did not interview the resident or conduct an investigation. On 02/27/25 at 2:19 p.m., charge nurse/LPN #4 stated Resident #45 reported the incident to them and the resident was so upset they started crying. The LPN stated they removed CNA #1 from the resident's hall and placed them on another hall. LPN #4 stated they had not heard anything more regarding the incident. LPN #4 stated they should have reported the incident to the administrator and did not. There was no documentation the incident occurred. There were no progress notes, no staff or resident interviews, and there was no incident report submitted to the Oklahoma Department of Health. On 02/27/25 at 7:41 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 02/27/25 at 8:01 p.m., the administrator, DON, and regional RN were notified of the presence of an immediate jeopardy situation related to Resident #45 not being free from verbal abuse. The IJ template was provided to the administrator. On 02/27/25 at 8:47 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read, Walnut Grove IJ Abatement 02/27/25. Resident #45 was interviewed by Social Services on 2/27/25 and was offered counseling to help [them] with this situation. The resident states [they] feel safe, and very secure, it was just the one incident that made [them] feel disrespected. On 2/27/25 the Administrator self-reported to the state of Oklahoma. On 2/27/25 Certified Nursing Assistant #1 was placed on suspension pending investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/27/25 all residents in the facility were interviewed by Director of Nursing and Administrator for any concerns or reports of rude behavior by CNA #1 while [they] were taking care of them. With no concerns found. On 2/27/25 the Regional Nurse Consultant interviewed staff that worked with Certified Nursing Assistant #1, no concerns were noted apart from Certified Nursing Assistant #2. On 2/27/25 All staff educated by Regional Nurse Consultant and Director of Nursing on the Policy for abuse and neglect and importance of notifying supervisor immediately of any allegations. No staff member will work until they are educated. All new employees will be educated on Abuse and Neglect policy. On 2/27/25 Regional Nurse Consultant educated the Administrator on the policy of Abuse and Neglect and reporting any allegations to the State of Oklahoma per education of timelines and doing an immediate investigation. All completed on 02/27/25 [at 8:47] p.m. Signed by the administrator. On 02/27/25 at 8:47 p.m., the IJ was lifted when all components of the plan of removal were completed. The deficient practice remained at a level of no actual harm with a potential for more than minimal harm. Based on record review and interview, the facility failed to protect a resident's right to be free from verbal abuse for 1 (#45) of 16 sampled residents reviewed for abuse. The administrator identified 59 residents who resided in the facility. Findings: On 02/27/25 at 2:06 p.m., Resident #45 reported over the weekend, staff blamed them for turning on the call light. Resident #45 stated CNA #1 came to their room to answer the call light and Resident #45 told CNA #1 they needed assistance with incontinent care. Resident #45 stated CNA #1 told Resident #45 they were assisting another resident and would come back when they could. Resident #45 stated when CNA #1 returned they yelled at them and stated they would be there in a minute and to stay off the light. Resident #45 stated they had not activated the call light again, that CNA #1 had not turned the call light off from the first interaction. Resident #45 stated they were so upset that they started crying. Resident #45 stated they called the nurses station and reported the occurrence to the charge nurse/ LPN #4. Resident #45 stated they were so upset they wanted to leave the facility. Resident #45 had diagnoses which included cognitive communication deficit, need for assistance with personal care and generalized anxiety. An admission MDS assessment, dated 12/10/24, showed Resident #45 was cognitively intact with a BIMS of 15, but was dependent on staff for bathing, lower body dressing, transfers, and toileting hygiene. The assessment showed Resident #45 required max assist with bed mobility, moderate assistance with upper body dressing. The assessment showed walking did not occur. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/27/25 at 2:12 p.m., the administrator stated on Monday 02/24/25, CNA #2 tattle-tailed on about three things, one of which were concerns about CNA #1 regarding verbal abuse over the weekend. The administrator stated it was reported CNA #1 wasn't very nice to Resident #45. The administrator stated they did not interview the resident or investigate in any way. On 02/27/25 at 2:19 p.m., charge nurse/LPN #4 stated Resident #45 reported the incident to them and the resident was so upset they started crying. The LPN stated they removed CNA #1 from the resident's hall and placed them on another hall. LPN #4 stated they had not heard anything more regarding the incident. LPN #4 stated they should have reported the incident to the administrator and did not. On 02/27/25 at 3:54 p.m., CNA #1 stated they worked on B hall for about 30 minutes. They stated there were a lot of call lights and they told Resident #45 they would get to them as fast as they could. CNA #1 stated Resident #45 kept hitting the call light, they were busy and Resident #45 became upset. CNA #1 stated they walked out. CNA #1 stated the nurse moved them to E hall. On 02/27/25 at 3:57 p.m., CNA #2 stated they were not there at the time the incident actually occurred, but was informed by evening shift that CNA #1 made Resident #45 cry and also had an attitude with Resident #215. CNA #2 stated they went to talk to Resident #45 and they identified CNA #1 as the staff that made them cry. CNA #2 stated they told the administrator about the incident on Monday morning and the administrator stated they would handle it. On 02/27/25 at 6:58 p.m., Resident #215 whom resided on E hall, stated they received good care Monday through Friday, but the weekends were terrible. Resident #215 stated last weekend a staff member told them they were short on staff and to stay off the call light. Resident #215 was unable to remember the staff members name. Resident #215 stated the staff member then left and did not even help them. Resident #215 stated, When they sent the [other staff] in here they were good to me. Resident #215 stated they did not know who to tell so they did not report it. Resident #215 stated the staff member did not return to their room, but they did not want to use the call light when that staff member was there.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49701 Based on record review, and interview, the facility failed to report an allegation of abuse to the state agency for 1 (#45) of 1 sampled resident reviewed for abuse. The administrator identified 59 residents resided in the facility. Findings: An undated Abuse Prevention Program policy, undated, read in part, It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property .Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator .The Administrator is the Abuse Coordinator .IF YOU SUSPECT ABUSE .Notify a Supervisor/Nurse Immediately .Notify the Administrator and Director of Nursing .The Administrator or designee utilizing the state specific Incident Reporting System will immediately notify the Department of Health by the Incident Reporting System .Investigation .All incidents will be documented, whether or not abuse occurred, was alleged or suspected .Any incident or allegation involving abuse or mistreatment will result in an abuse investigation .All personnel must promptly report any incident or suspected incident of abuse, mistreatment or neglect, including injuries of unknown origin. Resident #45 had diagnoses which included cognitive communication deficit, need for assistance with personal care and generalized anxiety. An admission MDS assessment, dated 12/10/24, showed Resident #45 was cognitively intact with a BIMS of 15, but was dependent on staff for bathing, lower body dressing, transfers, and toileting hygiene. The assessment showed Resident #45 required max assist with bed mobility, moderate assistance with upper body dressing. The assessment showed walking did not occur. On 02/27/25 at 2:06 p.m., Resident #45 reported over the weekend, staff blamed them for turning on the call light. Resident #45 stated CNA #1 came to their room to answer the call light and Resident #45 told CNA #1 they needed assistance with incontinent care. Resident #45 stated CNA #1 told Resident #45 they were assisting another resident and would come back when they could. Resident #45 stated when CNA #1 returned they yelled at them and stated they would be there in a minute and to stay off the light. Resident #45 stated they had not activated the call light again, that CNA #1 had not turned the call light off from the first interaction. Resident #45 stated they were so upset that they started crying. Resident #45 stated they called the nurses station and reported the occurrence to the charge nurse/ LPN #4. Resident #45 stated they were so upset they wanted to leave the facility. On 02/27/25 at 2:12 p.m., the administrator stated on Monday 02/24/25, CNA #2 tattle-tailed on about three things, one of which were concerns about CNA #1 regarding verbal abuse over the weekend. The administrator stated it was reported CNA #1 wasn't very nice to Resident #45. The administrator stated they did not interview the resident or conduct an investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/25 at 2:19 p.m., charge nurse/LPN #4 stated Resident #45 reported the incident to them and the resident was so upset they started crying. The LPN stated they removed CNA #1 from the resident's hall and placed them on another hall. LPN #4 stated they had not heard anything more regarding the incident. LPN #4 stated they should have reported the incident to the administrator and did not.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49701 Based on record review, and interview, the facility failed to investigate an allegation of abuse for 1 (#45) of 1 sampled resident reviewed for abuse. The administrator identified 59 residents resided in the facility. Findings: There was no documentation that this incident even occurred. There were no progress notes, no staff or resident interviews, no facility-initiated report provided to Oklahoma Department of Health. An undated Abuse Prevention Program policy, undated, read in part, It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property .Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator .Any incident or allegation involving abuse or mistreatment will result in an abuse investigation .All personnel must promptly report any incident or suspected incident of abuse, mistreatment or neglect, including injuries of unknown origin. Resident #45 had diagnoses which included cognitive communication deficit, need for assistance with personal care and generalized anxiety. An admission MDS assessment, dated 12/10/24, showed Resident #45 was cognitively intact with a BIMS of 15, but was dependent on staff for bathing, lower body dressing, transfers, and toileting hygiene. The assessment showed Resident #45 required max assist with bed mobility, moderate assistance with upper body dressing. The assessment showed walking did not occur. On 02/27/25 at 2:06 p.m., Resident #45 reported over the weekend, staff blamed them for turning on the call light. Resident #45 stated CNA #1 came to their room to answer the call light and Resident #45 told CNA #1 they needed assistance with incontinent care. Resident #45 stated CNA #1 told Resident #45 they were assisting another resident and would come back when they could. Resident #45 stated when CNA #1 returned they yelled at them and stated they would be there in a minute and to stay off the light. Resident #45 stated they had not activated the call light again, that CNA #1 had not turned the call light off from the first interaction. Resident #45 stated they were so upset that they started crying. Resident #45 stated they called the nurses station and reported the occurrence to the charge nurse/ LPN #4. Resident #45 stated they were so upset they wanted to leave the facility. On 02/27/25 at 2:12 p.m., the administrator stated on Monday 02/24/25, CNA #2 tattle-tailed on about three things, one of which were concerns about CNA #1 regarding verbal abuse over the weekend. The administrator stated it was reported CNA #1 wasn't very nice to Resident #45. The administrator stated they did not interview the resident or conduct an investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/25 at 2:19 p.m., charge nurse/LPN #4 stated Resident #45 reported the incident to them and the resident was so upset they started crying. The LPN stated they removed CNA #1 from the resident's hall and placed them on another hall. LPN #4 stated they had not heard anything more regarding the incident. LPN #4 stated they should have reported the incident to the administrator and did not.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46653 Based on observation, record review and interview, the failed failed to ensure medication carts were secured when not in use for 2 of 7 medication carts observed. The administrator identified 59 residents resided in the facility. Findings: On 02/27/25 at 8:33 p.m., medication carts for halls A/B and E/F and on the North side of the nursing station were observed unlocked and unattended with keys in the lock. On 02/27/25 at 8:34 p.m., nursing was staff observed sitting at the nurses station and medication carts A/B and E/F were observed unlocked and unattended. An undated Medication Storage in the Facility policy, read in part,Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. On 02/27/25 at 8:35 p.m., the licensed practical nurse #3 stated medication carts A/B and E/F were supposed to be locked and attended by staff who were assigned to the medication carts. On 02/28/25 at 11:06 a.m., the director of nursing stated it was policy for medication carts A/B and E/F to be attended to and locked at all times.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46653 Based on observation, record review, and interview, the facility failed to ensure the low temperature warewasher had the appropriate amount of chemical to sanitize dishes for the facility. The administrator identified 55 residents ate meals from the kitchen. Findings: On 02/24/25 at 11:26 a.m., the CDM was observed using test strips for sanitizer in the low temperature warewasher and the sanitizer was not pumping through to release the chemical into the warewasher. An undated chemical company instruction manual, read in part,Test paper must read at least 50 parts per million. A policy titled Warewasher revised date 12/18/24, read in part, The dish machine, if low temp, shall use a detergent, a rinse drying agent, and a sanitizer .The sanitizing temperature to activate the sanitizer per manufactuers' instructions .Low temperature dish machine log Sanitizer greater than 50 part per million. On 02/24/25 at 11:27 a.m., the CDM stated the sanitizer was reading 25 ppm and it should be at 50 ppm.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49701 Based on observation, record review, and interview, the facility failed to ensure infection control was maintained and EBP were followed during the administration of medications. The administrator identified seven residents required enhanced barrier precautions. Findings: On 02/25/25 at 8:41 a.m., LPN #3 was observed providing crushed medications through a PEG tube to a resident that required EBP. LPN #3 washed their hands and wore gloves, but did not wear a gown while providing care to the indwelling device. An Enhanced Barrier Precautions policy, copyright date 2025, read in part, Many residents in nursing homes are at increased risk of becoming colonized and developing infections with multi-drug resistant organisms . This facility utilizes Enhanced Barrier Precautions .as a strategy to decrease transmission of CDC [Centers for Disease Control and Prevention]-targeted and epidemiologically important MDROs when Contact Precautions do not apply .Enhanced Barrier Precautions: An infection control intervention designed to reduce transmissions of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE [personal protective equipment] to donning of gown and gloves during high contact care activities that provide opportunities for transfer of MDROs to staff hands and clothing .Indications .Wounds and/or indwelling medical devices even if the resident is not know to be infected or colonized with an MDRO . Indwelling devices include, but are not limited to, feeding tubes. On 02/25/25 at 8:46 a.m., LPN #3 stated EBP included a gown, gloves, and a mask. They stated they would have worn a gown if they would have thought about it. They stated they were not wearing a gown while providing medication through a percutaneous endoscopic gastrostomy tube. On 02/26/25 4:51 p.m., the DON stated they would have to look up the actual policy, but essentially a gown, gloves, and mask should be worn when the resident had something contagious.