| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375344 | A. Building<br>B. Wing | 07/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sequoyah Pointe Living Center | 8515 North 123rd East Avenue<br>Owasso, OK 74055 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>30267<br><br>Based on record review and interview, the facility failed to ensure the residents' right to be free of abuse for two (#1 and #2) of three residents reviewed for abuse.<br><br>The facility's Resident List Report documented 44 residents lived in the facility.<br><br>Findings:<br><br>A resident abuse, neglect, exploitation, and misappropriation prevention program policy, revised April 2021, documented the policy's objectives were:<br><br>- to protect residents from abuse by anyone, including facility staff and other residents;<br><br>- to establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems; and<br><br>-to protect residents from any further harm during the investigations.<br><br>1. Resident #2 had diagnoses which included encephalopathy, dementia, and stroke.<br><br>The quarterly assessment, dated 06/03/24, documented Resident #2 was severely impaired in cognition and utilized a wheelchair for mobility.<br><br>A State Reportable Incident Report, dated 07/28/24, read in part the facility staff observed Resident #1 had their hand down the pants of Resident #2. The report documented both residents were severely impaired in cognition and utilized a wheelchair for mobility.<br><br>The report documented the two residents were seperated, Resident #2 was assessed for injury/distress, and a staff member was assigned to stay with Resident #1 until the resident was transported from the facility.<br><br>The report documented the investigation included interviews with staff and review of video surveillance which showed Resident #1 had their hand on the thigh of Resident #2.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The report documented the facility staff were in-serviced on the facility abuse protocol/policy/procedure and identifying sexual abuse. The report documented the staff were given a multiple choice testing tool to ensure understanding of the information provided in the in-service.<br><br>The report documented the facility staff were to be in-serviced on abuse on hire and quarterly thereafter.<br><br>The report documented the facility staff would routinely interview residents to ensure they were comfortable with reporting concerns or issues with staff.<br><br>2. Resident #1 had diagnoses which included cognitive social and emotional deficit following a stroke, impulsiveness, dysphagia, hydrocephalus, depression, disorientation, and dementia with behaviors.<br><br>A second State Reportable Incident Report, dated 07/28/24, documented the charge nurse alerted administration a CNA had observed LPN #1 smack the chest of Resident #1 while they were in the common room.<br><br>The report documented the LPN was suspended and the resident was assessed for injury/distress.<br><br>The report documented an investigation was initiated. The report documented interviews were conducted with staff and residents.<br><br>The report documented CNA #1 observed LPN #1 tell Resident #1 not to touch them and then slapped Resident #1 in the chest pretty hard.<br><br>The report documented video surveillance showed Resident #1 pinching LPN #1 on the buttocks at which time LPN #1 turned and made contact with Resident #1's chest with their open hand thus pushing him away.<br><br>The report documented LPN #1 was terminated and the appropriate agencies notified of the allegation and the results of the investigation.<br><br>The report documented the facility staff were in-serviced on the facility abuse protocol/policy/procedure and identifying staff on resident abuse. The report documented the staff were given a multiple choice testing tool to ensure understanding of the information provided in the in-service.<br><br>The report documented the facility staff were to be in-serviced on abuse on hire and quarterly thereafter.<br><br>The report documented another intervention to abuse was the facility staff would routinely interview residents to ensure they were comfortable with reporting concerns or issues with staff.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 07/31/24 at 1:30 p.m., the administrator stated the two State Reportable Incident Reports documented related incidents which quickly happened one after the other. The administrator stated the allegation was Resident #1 was overheard making inappropriate comments to Resident #2 and then Resident #1 was observed with their hand down the pants of Resident #2. The administrator stated LPN #1 was observed to start to remove Resident #2 from the area when Resident #1 pinched LPN #1 on their buttocks who then turned and, with an open hand, made contact with the chest of Resident #1, pushing them backward in their wheelchair.<br><br>The administrator stated through review of surveillance and interviews, the facility was able to substantiate that Resident #1 had their hand on the thigh of Resident #2 and that LPN #1 had made willful contact with Resident #1.<br><br>The administrator stated the allegations of abuse were substantiated but the facility staff followed their facility abuse protocol after the two events occurred by protecting both residents from further abuse, investigating the two allegations and providing in-services/training. The administrator stated abuse was added to their quality assurance program and would be routinely monitored through the education of staff, testing the staff knowledge of the abuse protocols/procedures, interviewing residents, and vigilant monitoring. |