

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Seminole Pioneer Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 Boren Blvd Seminole, OK 74868	

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 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were free from abuse for 2 (#1 and #3) of 3 sampled residents reviewed for abuse.</p> <p>The administrator identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>An undated facility policy titled 'Allegations of Abuse, Neglect, Exploitation or Mistreatment,' read in part, Definitions: 'Abuse' is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.</p> <p>1. An undated admission record showed Res #1 had diagnoses which included schizoaffective disorder, mild cognitive impairment, and major depressive disorder.</p> <p>A quarterly assessment, dated 03/10/25, showed the resident was cognitively intact and had a BIMS of 15. The assessment showed the resident did not have verbal or physical behaviors directed toward others.</p> <p>An OSDH incident report, dated 05/12/25, showed Res #1 stated Res #2 had grabbed their breasts. The report showed no staff witnessed the incident. The report showed Res #2 had been in staff line of site over the past few days due to manic behaviors.</p> <p>On 05/15/25 at 12:45 p.m., Res #1 was sitting in the lobby area for the lunch meal. The resident stated they did not want to eat in the dining room because Res #2 was in the dining room and they were loud and disruptive. The resident stated they would leave the area or go to their room if Res #2 entered the area.</p> <p>On 05/15/25 at 2:30 p.m., the DON stated Res #2 was monitored per the incident report line of site. The stated they could not provide documentation regarding the line of site monitoring. The DON stated per the investigation the facility could not substantiate the incident regarding Res #2 grabbing Res #1's breasts.</p> <p>On 05/19/25 at 2:03 p.m., the care plan coordinator stated the care plan for Res #2 should have been updated with new behavior interventions after each incident and was not.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Seminole Pioneer Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 Boren Blvd Seminole, OK 74868	
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2. An undated admission record showed Res #3 had diagnoses which included vascular dementia with behavioral disturbances, schizoaffective disorder bipolar type, mood affective disorder, and moderate intellectual disabilities.</p> <p>A quarterly assessment, dated 04/22/25, showed Res #3 was moderately impaired for daily decision making. The assessment showed the resident did not have verbal or physical behaviors directed toward others.</p> <p>An OSDH incident report, dated 05/10/25, showed a facility CMA witnessed Res #2 hit Res #3 in the face unprovoked. The report showed the other resident was redirected. The report showed the police were notified and spoke with Res #3 and staff.</p> <p>An incident note, dated 05/10/25 at 7:25 a.m., showed Res #3 was sitting in the lobby when another resident hit them in the face.</p> <p>3. An undated admission record showed Res #2 had diagnoses which included dementia with behavioral disturbances, mood disorder, psychosis, schizophrenia, and major depressive disorder.</p> <p>A discharge return anticipated assessment, dated 04/17/25, showed the resident was modified independent for daily decision making. The assessment showed the resident had verbal behaviors directed toward others.</p> <p>An OSDH incident report, dated 05/10/25, showed Res #2 hit Res #3 in the face. The report showed the police arrived and spoke with Res #2 and staff. The report showed the police had been called to the facility before regarding other incidents regarding Res #2.</p> <p>A incident note, dated 05/10/25 at 7:25 a.m., showed Res #2 was pacing around in the lobby area. The note showed the resident hit another resident in the face who was sitting in the lobby area.</p> <p>A behavior note, dated 05/10/25 at 7:40 a.m., showed the police were present in the facility regarding the incident. The note showed after the police left the facility, Res #2 was pacing the hallways, rammed the front door with their shoulder, kicking a trash can, yelling, and cussing. The note showed the resident was disruptive to residents and staff. The note showed the resident was redirected, but was only effective for short periods of time. The note showed the police were notified again at 7:40 p.m. due to the resident yelling, cussing, and kicking the wall.</p> <p>A behavior note, dated 05/11/25 at 4:02 p.m., showed Res #2 was in the lobby yelling, cussing, hitting the wall, and kicking the front door. The note showed attempts to calm the resident was unsuccessful. The note showed the facility notified the APRN and the resident's antipsychotic medication was adjusted.</p> <p>A behavior note, dated 05/11/25 at 9:08 p.m., showed Res #2 was more calm with occasional outbursts.</p> <p>A behavior note, dated 05/12/25 at 10:19 a.m., showed Res #2 had been instigating arguments and verbal altercations with peers. The note showed the resident had to be separated from peers and redirected to a different area.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Seminole Pioneer Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 Boren Blvd Seminole, OK 74868	
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 Level of Harm - Actual harm Residents Affected - Few	A behavior note, dated 05/12/25 at 2:38 p.m., showed the resident continued with erratic behavior an unable to redirect. The note showed disruption to peers environment, was asked not to get in faces of others or in their personal space. The note showed continued rambling, delusions, and hallucinations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Seminole Pioneer Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 Boren Blvd Seminole, OK 74868	
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>Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the state agency within the 2 hour required time frame for 1 (#3) of 3 sampled residents reviewed for abuse</p> <p>The administrator identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>An undated facility policy titled Allegations of Abuse, Neglect, Exploitation or Mistreatment, read in part, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made. All alleged violations, whether oral or in writing, must be immediately reported to the Administrator of this facility and to other officials in accordance with State law through established procedures.</p> <p>An undated admission record showed Res #3 had diagnoses which included vascular dementia with behavioral disturbances, schizoaffective disorder bipolar type, mood affective disorder, and moderate intellectual disabilities.</p> <p>A quarterly assessment, dated 04/22/25, showed Res #3 was moderately impaired for daily decision making. The assessment showed the resident did not have verbal or physical behaviors directed toward others.</p> <p>An OSDH incident report, dated 05/10/25, showed a facility CMA witnessed Res #2 hit Res #3 in the face unprovoked. The report showed the other resident was redirected. The report showed the local police were notified at 7:25 a.m. and were present in the facility at 7:40 a.m.</p> <p>A fax transmittal page showed the state agency was notified of the incident occurring on 05/10/25 at 4:05 p.m.</p> <p>The facility failed to report to the State Agency within the two hour time frame for the incident on 05/10/25 after the police waere notified at 7:25 a.m.</p> <p>On 05/19/25 at 10:55 a.m., the DON stated the incident on 05/10/25 happened over the weekend. The DON stated the OSDH incident report was submitted by the weekend charge nurse. The DON stated it was not reported within the two hour required time frame. The DON stated the administrator was unable to be contacted.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Seminole Pioneer Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 Boren Blvd Seminole, OK 74868	
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 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>Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for 1 (#3) of 3 sampled residents reviewed for abuse.</p> <p>The administrator identified 44 residents resided in the facility.</p> <p>Findings:</p> <p>An undated facility policy titled Abuse Prevention Program, read in part, This facility has developed comprehensive policies and procedures to prevent abuse, neglect, exploitation, or mistreatment of residents. The abuse prevention program provides policies and procedures that govern, as a minimum: .f. Development of investigative protocols governing resident abuse, theft/misappropriation of resident property, resident-to-resident abuse, and resident to staff abuse, etc. g. Timely and thorough investigations of all reports and allegations of abuse.</p> <p>An undated admission record showed Res #3 had diagnoses which included vascular dementia with behavioral disturbances, schizoaffective disorder bipolar type, mood affective disorder, and moderate intellectual disabilities.</p> <p>A quarterly assessment, dated 04/22/25, showed the resident was moderately impaired for daily decision making. The assessment showed the resident did not have verbal or physical behaviors directed toward others.</p> <p>An OSDH incident report, dated 05/10/25, showed a facility CMA witnessed Res #2 hit Res #3 in the face unprovoked. The report showed the other resident was redirected. The report showed the local police were notified and were present in the facility at 7:40 a.m.</p> <p>A review of the investigation documentation regarding the incident on 05/10/25 for Res #3 was completed. There were no staff or resident statements regarding the incident.</p> <p>On 05/15/25 at 2:30 p.m., the DON stated the incident on 05/10/25 did not have staff or resident statements documenting what occurred. The DON stated it was not a thorough investigation.</p>		