

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2024
NAME OF PROVIDER OR SUPPLIER  South Pointe Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5725 South Ross Oklahoma City, OK 73119	

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>43023</p> <p>Based on record review and interview, the facility failed to implement their abuse policy by immediately reporting abuse for two (#1 and #2) of three residents reviewed for abuse.</p> <p>The DON reported 171 residents resided in the facility.</p> <p>Findings:</p> <p>A facility Abuse Prevention policy, dated 10/21/22, read The Administrator and Director of Nursing must be promptly notified of suspected abuse or incidents of abuse.</p> <p>A State Incident Investigation Report, dated 05/17/24, documented the DON received a call reporting CNA #2 had been abusive to residents #1 and #2. The reports documented that LPN #1 was made aware of the issue and had not reported it to the DON or facility administration.</p> <p>Res #1 admitted to the facility with diagnoses of dementia, psychosis, and other specified depressive episodes.</p> <p>Res #2 admitted to the facility with diagnoses of cerebral infarction, insomnia, major depressive disorder, and anxiety.</p> <p>On 07/16/24 at 1:00 p.m., the DON reported LPN #1 reported she had handled the allegation herself and did not report it to the DON. The DON reported LPN #1 was terminated for not following the facility's abuse policy and CNA #2 was terminated for sleeping on the job.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>43023</p> <p>Based on record review and interview, the facility failed to ensure allegations of abuse were thoroughly investigated for two (#1 and #2) of three residents reviewed for abuse investigations.</p> <p>The DON reported 171 residents resided in the facility.</p> <p>Findings:</p> <p>The facility policy Abuse Prevention, dated 10/21/22, read in part, . Any allegation of abuses, or neglect, misappropriation of property, or mistreatment shall be thoroughly investigated.</p> <p>A report to the Oklahoma State Department of Health, dated 05/17/24, documented an allegation of abuse from CNA #1 who alleged CNA #2 was abusive to Residents #1 and #2. The report documented CNA #1 had reported the allegation to LPN #1 and nothing had been done.</p> <p>A review of the investigation of the allegation contained interviews with the three staff members involved.</p> <p>On 07/16/24 at 1:00 p.m., the DON reported they had only interviewed the three staff members directly involved. Reported they should have interviewed other staff that worked with the three staff members involved.</p>