

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024
NAME OF PROVIDER OR SUPPLIER Golden Age Nursing Home of Guthrie, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 419 East Oklahoma Guthrie, OK 73044	
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 - Immediate jeopardy to resident health or safety Residents Affected - Many	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47453</p> <p>On 07/15/24, a past noncompliance was determined for facilities failure to ensure residents are free from abuse and neglect when staff is providing personal care to residents. The residents had pictures and/or videos taken during personal care.</p> <p>The Oklahoma State Department of Health verified the existence of the past noncompliance IJ related to the facility's failure to ensure residents were free from abuse and neglect.</p> <p>At 3:58 p.m., the administrator and DON were informed of the past noncompliance IJ related to the facility's failure to ensure the residents were free from abuse and neglect that existed on 04/05/24, when the initial report to OSDH was reported regarding photos and/or videos of a resident being taken by CNA while giving personal care. On 04/05/24 the staff was inserviced on abuse, reporting abuse, the use of cell phones while caring for residents, and taking pictures and videos of residents and posting on social media.</p> <p>The in-service conducted on 04/05/24, documented, topic was Prohibition of abuse prevention, reporting abuse, video taping and photographs policy, and cell phone use.</p> <p>Based on record review, and interview, the facility failed to ensure residents were free from abuse and neglect for five (#1, 7, 8, 9, and #10) of five residents investigated for abuse. This resulted in a past noncompliance for abuse when the CNA's took compromising photos of the residents.</p> <p>Findings:</p> <p>The facilities Abuse Prohibition policy, revised March 2023, read in part, each individual resident has the right to be free from any form of abuse. This facility strictly prohibits any verbal, sexual, physical, mental abuse.</p> <p>The facilities Electronic Devices and Social Media policy, undated, read in part, personal use of electronic devices (such as cell phone, tablets, cameras, laptops, smart phones) is strictly prohibited in the facility and must be kept elsewhere during working hours. Reads in part, Violation of this policy can result in disciplinary action up to and including termination.</p> <p>1. Res. #1 had diagnoses which included dementia with other behavioral disturbance, depression</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 375374	Facility ID: 375374 If continuation sheet Page 1 of 3

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>2. Res. #7 had diagnosis which included dementia</p> <p>A Brief Interview for Mental Status dated 05/07/24, Resident #7 BIMS score was ten</p> <p>3. Res. #8 had diagnosis which included dementia</p> <p>A Brief Interview for Mental Status dated 05/28/24, Resident #8 BIMS score was eight</p> <p>4. Res. #9 had diagnosis which included vascular dementia, anxiety.</p> <p>A Brief Interview for Mental Status dated 04/25/24, Resident #9 BIMS score was ninety nine, and</p> <p>5. Res. #10 had diagnosis which included dementia</p> <p>A Brief Interview for Mental Status dated 06/17/24, Resident #10 BIMS score was ninety nine</p> <p>A facility incident report, dated 04/05/24 at 8:41 a.m., an initial Incident Report documented CNA #1, 2, and #3 took compromising photos/video of resident #1 and posted on social media. All those involved were suspended until the investigation was complete. CNA #1 was separated from employment on 04/08/24, CNA #2 was separated from employment on 04/08/24, and CNA #3 was separated from employment on 04/08/24. All named staff members were reported to Oklahoma Nurse Aide Registry.</p> <p>On 04/05/24 an in-service and training was initiated by management to all staff members at the facility on abuse, neglect, reporting abuse, cell phone use while caring for residents, and posting pictures and/or videos on social media.</p> <p>On 04/05/24 management completed the in-service and training for all staff members at the facility. The facility was in past non compliance after completing a QAPI meeting, dated 04/22/24, which discussed the outcome of the State Reportable Incident(s) interventions.</p> <p>A. facility incident report, dated 06/06/24 at 3:56 p.m., a second follow up Incident Report was faxed to OSDH documenting the local law enforcement contacted the facility with additional information regarding an additional four residents (#7, 8, 9, and #10) pictures/videos found on alleged staff named in initial Incident Report.</p> <p>An In-servicesign in sheet, dated 04/05/24, included documentation of an in-service for staff on prohibition of Abuse, abuse prevention, reporting abuse, and video and picture taking.</p> <p>Cell phone random audit forms, dated 04/08/24 through 06/10/24, to ensure no cell phones being used while on shift or being used in resident care areas.</p> <p>A form titled Golden Age Nursing Home, LLC Quarterly QA Meeting, dated 04/22/24, documented, reviewed abuse policy and procedures, reviewed neglect, reviewed cell phone policy and reviewed video policy.</p> <p>On 07/15/24 at 11:26 a.m., Res #8 was observed resting in their bed. Res #8 was unable to be interviewed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 07/15/24 at 11:37 a.m., Res. #1 was observed resting in their bed. Res. #1 was unable to be interviewed.</p> <p>On 07/15/24 at 11:43 a.m., Res. #7 was not in their room and in a facility activity. Res. #7 was unable to be interviewed.</p> <p>On 07/15/24 at 1:08 p.m., Res. #10 was resting in chair in their room. Res. #10 was unable to be interviewed.</p> <p>On 07/15/24 at 1:19 p.m., Res. #9 was unable to answer questions due to severe dementia. Attempted to place call to Res. #9 POA, un-successful attempt.</p> <p>On 07/15/24 at 1:21 p.m., placed call to Res. #8 family member on record, family member stated they could not answer any questions regarding staff mistreating resident.</p> <p>On 07/15/24 at 11:45 a.m., LPN #1 was asked what the facility policy on abuse. They stated report to the DON. They were then asked what the facility policy is for using cell phones. They stated only to use them on break. They were then asked if they had seen any staff taking pictures or using cell phones while caring for residents. They stated not while caring for residents. They were then asked if they had been in-inserviced on abuse and neglect. They stated yes.</p> <p>On 07/15/24 at 11:48 a.m., CNA #4 was asked what the facility policy on abuse. If we suspect abuse to report it immediately. They were then asked what the facility policy is for using cell phones. They stated they are not suppose to use cell phones while on duty. They were then asked if they had seen any staff taking pictures or using cell phones while caring for residents. They stated not while caring for residents. They were then asked if they had been in-inserviced on abuse and neglect. They stated yes</p> <p>On 07/15/24 at 11:55 a.m., CMA #1 was asked what the facility policy on abuse. They stated go straight to administrator and DON. They were then asked what the facility policy is for using cell phones. They stated that cell phones are not aloud in the building. They were then asked if they had seen any staff taking pictures or using cell phones while caring for residents. They stated not for a while. They were then asked if they had been in-inserviced on abuse and neglect. They stated yes</p> <p>On 07/15/24 at 12:00 p.m., CNA #5 was asked what the facility policy on abuse. They stated if you suspect it tell the nurse. They were then asked what the facility policy is for using cell phones. They stated that cell phones are not aloud, only on break. They were then asked if they had seen any staff taking pictures or using cell phones while caring for residents. They stated not while caring for residents. They were then asked if they had been in-inserviced on abuse and neglect. They stated yes</p> <p>On 07/15/24 at 12:10 p.m., the DON stated the facility did audits after the incident to ensure all cell phones were not being used while giving personal care, and in-serviced immediately on 04/05/24 regarding abuse/exploitation for all staff. The DON stated they also included this incident and the results of the monitoring at the next QA committee meeting.</p>		