

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Southern Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 4th Street Pawnee, OK 74058	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on record review and interview, the facility failed to ensure an alleged incident of sexual abuse was reported to:</p> <ul style="list-style-type: none"> a. the Oklahoma State Department of health, b. Adult Protective Services, c. the police, d. and the nurse aide registry within two hours of the allegation for one(#1) of three sampled residents reviewed for abuse. <p>The corporate nurse identified 38 residence resided in the facility.</p> <p>Findings:</p> <p>The facility's Abuse Investigation and Reporting policy, revised 07/2017, read in part, All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, and misappropriation of property will be reported by the facility, administrator, or his/her designee. The policy also read, An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than two hours if the alleged violation involves abuse.</p> <p>A OSDH 283 Incident Report Form, dated 07/28/24, documented an alleged incident of sexual abuse occurred on was reported to the Administrator on 07/28/24.</p> <p>A hand written statement, dated 07/28/24, documented, LPN #1 reported incident of alleged sexual abuse on 07/28/24.</p> <p>Two hand written notes, dated 07/28/24, documented CNA #1 and CNA #2 submitted statements of the alleged events on 07/28/24.</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facsimile cover sheet, dated 07/30/24, documented, the 283 Incident Report Form, dated 07/28/23 , was sent by FAX on 07/30/24 at 12:51 p.m. to OSDH and {Name of Local Law Enforcement withheld} was notified on 07/30/24 at 12:40 p.m The OSDH form 283 did not document Adult Protective Services and the Nurse Aide Registry were notified.</p> <p>A Notification of Nurse Aide/Non Technical Service Worker Abuse, Neglect, Mistreatment of Misappropriation of Property OSDH form # 718, documented the Nurse Aide Registry was notified by Fax on 08/02/24 at 1:27 p.m.</p> <p>A facsimile cover sheet, dated 08/02/24 at 2:40 p.m., documented, OSDH 283 Incident Report Form final, documented Adult Protective Services and the Nurse Aide Registry was notified.</p> <p>On 08/06/24 at 10:08 a.m., {Name of Staffing Agency with held} Director of Staffing stated CNA #1 worked 07/28/24 and returned to the facility on [DATE] with restrictions.</p> <p>On 08/06/24 at 10:23 a.m., the Corporate nurse was asked what the policy was for reporting sexual abuse. They corp nurse stated that a report should of been done within two hours to OSDH, Adult protective Services, and the police. The Corporate Nurse stated the Nurse aide registry should of been notified within 24 hours. The corporate was asked nurse to identify the noncompliance. They stated the Administrator did not report timely to OSDH, the Nurse Aide Registry, APS, and local law enforcement.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702</p> <p>Based on observation, record review, and interview, the facility failed to ensure food temperature monitoring policy was followed during one of one kitchen observations for food temperature monitoring.</p> <p>The Corporate Nurse identified 37 residents received nutrition from the kitchen.</p> <p>Findings:</p> <p>The facility's Food Temperature policy, undated, read in part, Foods should be served at proper temperature to ensure food safety and palatability. The policy also read, Record reading on Food Temperature Chart (Form 401) at the beginning of tray line. If temperatures do not meet acceptable serving temperatures, reheat the product or chill the product to proper temperature. Take the temperature of each pan of product before serving.</p> <p>Resident #2 was admitted on [DATE] with diagnoses which included heart failure and unspecified cerebral infarction.</p> <p>A quarterly MDS assessment, dated 06/24/24 documented Resident #2's cognition was intact.</p> <p>On 08/05/24 at 10:30 a.m., Resident #2 was asked about the food. Resident #2 stated that the food was served cold in the dining room so he started eating in his room.</p> <p>On 08/05/24 at 11:45 a.m., during a kitchen observation, green beans were observed on the steam table. [NAME] #1 was asked where they documented the temperature of the green beans.</p> <p>Cook #1 stated they documented the temperature as 155 degrees in a temperature log. [NAME] #1 was asked to provide a copy of the temperature log.</p> <p>On 08/05/24 at 11:46 a.m., [NAME] #1 provided the facility's Food Temperature Log Holding Table form, dated 08/05/24. The form did not document food temperatures were monitored or recorded for the breakfast and lunch service on 08/05/24.</p> <p>On 08/05/24 at 11:47 a.m , [NAME] #1 was asked where the temperatures from breakfast and Lunch service were recorded since they were not logged in the required form. [NAME] #1 stated they were keeping all the temperatures from breakfast and lunch in their head and had not recorded them in the required log.</p> <p>On 08/05/24 at 11:50 a.m., the CDM overheard the conversation [NAME] #1 had with the surveyor. The CDM stated that if the documentation was not in place, then the temperature monitoring did not occur. The CDM stated that the temperatures should of been recorded at the time they were taken and the policy was not followed.</p>		