STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375387	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beare Manor	1300 North Drive Hartshorne, OK 74547

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. The following deficiency represents an incident of past non-compliance that was subsequently corrected prior to this survey. Based on interview, record review, document review, and facility policy review, the facility failed to ensure a certified nurse aide (CNA) immediately reported an allegation of suspected abuse to the Abuse Coordinator, Director of Nursing (DON) and/or the charge nurse for 1 (Resident #30) of 3 sampled residents reviewed for abuse. This deficiency represents non-compliance investigated under Complaint Number 3003056.Findings included: An undated facility policy titled, Abuse and/or Neglect, revealed, All healthcare workers are responsible for ensuring the safety of those under their care. It is the responsibility of our employees, facility consultants, attending physician, family members, and visitors to promptly report any incident or suspected incident of neglect or abuse, this also includes injuries of unknown source. The policy specified, Abuse is to be reported immediately to the abuse coordinator, the administrator in this case, if you can't get ahold of her let the DON or charge nurse know. A Mini Face Sheet indicated the facility admitted Resident #30 on 10/23/214. According to the Mini Face Sheet, the resident had a medical history that included a diagnosis of cellulitis. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/30/2026, revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The facility Incident Report Form completed by the Administrator indicated an allegation of abuse/mistreatment that occurred on 04/28/2026 in which CNA reported while assisting another CNA transfer that CNA screamed at resident and pushed [resident] on the bed. DON/Admin. [Administrator] spoke with resident regarding incident. Resident is able to answer yes or no questions. Resident stated that CNA did not scream at [him/her] or push [him/her] on the bed. No injuries noted. Per the Incident Report Form, [CNA #2] and DON came in administrator office on 4/29 [2026] at 3:10pm the next day after [CNA #2] witness the abuse. Administrator and DON discussed with [CNA #2] that since she did not report abuse immediately that she is just as responsible. Our policy states that you have to report abuse immediately to your charge nurse/supervisor. Follow your chain of command. Both employees put on suspension following investigation. [CNA #2] for failure to report in a timely matter and [CNA #1] for suspected abuse. Part C: During investigation resident that was involved in incident was interviewed. DON/Administrator were notified by staff member CNA that another CAN was ?rude and rough' when putting resident to bed. DON/Administrator went and spoke with resident. Resident denied any staff member being mean, rude or rough with [him/her] by answering yes and no questions. The Incident Report Form indicated, Statement was obtained from [CNA #2] who witness the allegation of abuse. [CNA #2] stated she was assisting [CNA #1] transfer resident to bed and that [CNA #1] screamed at [Resident #30] telling [him/her] [he/she] can walk and stand up. Then she stated [CNA #1] then pushed [Resident #30] on to the bed. [CNA #2] said she told [CNA #1] she didn't need to talk to [the resident] that way. [CNA #2] also stated she reported it to the charge nurse that day. [CNA #2's] shift is 2p-10p Monday thru Friday. Obtained statements from both 6a-6p and 6p-6a charge nurses for that day. They both stated she [CNA #2] did not report any type of abuse to them. During a telephone interview on 06/02/2026 at 2:37 PM, CNA #2 stated there had been an incident where she witnessed (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what she considered to be abuse. According to CNA #2, CNA #1 stood Resident #30 up and kind of threw the resident on the bed. CNA #2 stated she immediately left the room and told Licensed Practical Nurse (LPN) #3, in the presence of CNA #4 and CNA #5. During a telephone interview on 06/02/2026 at 6:38 PM, CNA #4 stated she did not witness the incident, but was present when CNA #2 told LPN #3. During an interview on 06/03/2026 at 10:28 AM, LPN #3 stated no one had every reported an allegation of abuse to her. LPN #3 stated she did not remember any time that CNA #2 came to her and said anything about another CNA treating a resident rough or being rude. During an interview on 06/03/2026 at 3:37 PM, the DON stated CNAs should report allegations of abuse to their charge nurse, who was to immediately notify her or the Administrator. The DON stated she first learned of the incident involving Resident #30 on 04/29/2026, the day after the alleged incident occurred. According to the DON, CNA #2 told her that she did not report the incident to the day shift charge nurse, LPN #6, on 04/28/2026 because CNA #1 and LPN #6 were friends, so she reported the incident to LPN #3 later. The DON stated CNA #2 was adamant that no one else was around when she reported the alleged incident to LPN #3. The DON stated she expected the staff to report allegations of abuse immediately. During a telephone interview on 06/04/2026 at 8:18 AM, CNA #5 stated all she knew about the alleged incident was that CNA #2 told her that she saw a resident being jerked by the other CNA and handled roughly. CNA #5 stated she told CNA #2 that if she did not report the allegation, she was just as guilty. According to CNA #5, CNA #2 told her that she would report the alleged incident in the morning because it was late at night. CNA #5 stated she was not present and never witnessed CNA #2 report the alleged incident to LPN #3. During an interview on 06/04/2026 at 8:46 AM, the Administrator stated CNA #2 informed her and the DON of the alleged incident on 04/29/2026 at 3:10 PM. The Administrator stated she asked CNA #2 if she reported the alleged incident to the charge nurse, and CNA #2 stated she did not report it to the charge nurses. The facility implemented the below listed corrective actions once they became aware of the alleged incident: Once the DON and Administrator became aware of the allegations of abuse, they immediately suspended CNA #1 who was identified as the alleged perpetrator of abuse against Resident #30. They also suspended CNA #2 once they determined that she waited almost 24 hours to report allegations of abuse. During the facility investigation, interviewable residents were interviewed to determine if any other residents were affected or abused who were cared for by CNA #1. The facility also completed skin assessments on non-interviewable residents who were cared for by CNA #1 to ensure there were no unexplained bruises or injuries. Resident #30 was also interviewed by the DON and Administrator and a skin assessment completed to ensure there were no injuries. All staff were retrained on abuse and the importance of reporting abuse. Staff were interviewed to verify that they received retraining on abuse. This retraining was completed 05/04/2026 when the facility completed their investigation into the allegation of abuse. CNA #1 was placed on suspension once the allegations of abuse was reported and remained on suspension until the completion of the investigation. CNA #1 submitted her resignation on 05/04/2026; however, she returned to work at the facility on 05/15/2026. CNA #1 received re-orientation upon rehire on abuse and the importance of reporting abuse. CNA #2 was suspended at the beginning of the investigation for not reporting allegations of abuse and was ultimately terminated for not reporting allegations of abuse immediately. The facility addressed the reporting of abuse during their quality assurance performance improvement meeting and no further issues had been identified. After review and verification of the facility's corrective actions, to include the facility's investigation, staff education, and interviews with staff, the survey team determined the facility implemented the above corrective actions beginning 04/29/2026 through 05/04/2026, and during the survey, there was no identified concerns, therefore, past noncompliance was cited.