STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375415	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Manor	226 E Monroe Street Jay, OK 74346

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. 34270 Based on record review and interview, the facility failed to report an allegation of abuse to the Oklahoma State Department of Health within the mandated time frame for one (#1) of three sampled resident reviewed for abuse. The DON reported the facility had a census of 39 residents. Findings: A facility policy titled, Prevention and Reporting of Abuse, Neglect, and Misappropriation of Resident Property, read in part, When possible the facility shall notify the State Department of Health within 12 hours of the incident. An incident report fax cover sheet documented a combined initial and final incident report regarding an allegation of verbal abuse by Resident #1 was faxed to OSDH on 05/20/24. The incident report documented the incident had occurred on 05/09/24. On 05/28/24 at 11:59 a.m., the DON stated they had witnessed a verbal interaction between Resident #1 and CMA #1 on 05/09/24. They stated the resident did not report feeling abused at that time and they did not believe what they had seen was abuse. They stated on 05/10/24 they received a phone call from the BOM who informed them that Resident #1 had reported they had been verbally abused. The DON stated they were on leave and informed the BOM the administrator would need to be informed and something needed to be done about the situation. They stated they reported back to work on 05/13/24. On 05/28/24 at 1:30 p.m. the Administrator stated that on 05/10/24, Resident #1 had informed them that they had been verbally abused by staff on 05/09/24. They stated they did not report the allegation to OSDH at that time as they believed the DON would do so when they returned from leave on 05/13/24. They stated they did not meet the 24-hour time limit for reporting. On 05/28/24 at 1:33 p.m. DON stated they sent an incident report to OSDH about the incident of 05/09/24 on 05/20/24.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to investigate an allegation of abuse and suspend an alleged perpetrator during the time of an investigation into the alleged abuse, for one (#1) of three sampled resident reviewed for abuse. The DON reported the facility had a census of 39 residents. Findings: A facility policy titled, Prevention and Reporting of Abuse, Neglect, and Misappropriation of Resident Property, read in part, It is the policy of [NAME] Manor to thoroughly investigate all allegations concerning resident abuse, neglect, and misappropriation of resident property, and to prevent further potential abuse, neglect, and misappropriation pending an investigation. An incident report, dated 05/20/24, documented an allegation of abuse by Resident #1 that allegedly occurred on 05/09/24. On 05/28/24 at 11:59 a.m., the DON stated they had witnessed a verbal interaction between Resident #1 and CMA #1 on 05/09/24. They stated the resident did not report feeling abused at that time and they did not believe what they had seen was abuse. They stated they did instruct CMA #1 and the nurse on duty that CMA #1 was not to work with Resident #1 after that day. They stated CMA #1 continued to work with other residents as usual and had not been suspended at any point since the incident. They stated on 05/10/24 they received a phone call from the BOM who informed them that Resident #1 had reported they had been verbally abused. The DON stated they were on leave and informed the BOM the administrator would need to be informed and something needed to be done about the situation. They stated they reported back to work on 05/13/24. They stated they believed an investigation had never been done. On 05/28/24 at 1:30 p.m., the Administrator stated that on 05/10/24 they and the BOM had visited with Resident #1 and the resident stated they had been verbally abused by staff. They stated they did perform an investigation at that time because they believed DON would do so when they returned from leave. They stated CMA #1 had not been suspended because the DON had previously instructed CMA #1 not to work with Resident #1 and after speaking with staff believed the CMA had followed those instructions. On 05/28/24 Aa 1:33 p.m. DON stated they sent an incident report to OSDH about the incident of 05/09/24 on 05/20/24. They stated they had not interviewed other residents about their interactions with CMA #1 or knowledge of the reported incident of 05/09/24. They stated an investigation should be conducted and the CMA should have been suspended during an investigation.