

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Tuttle Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 104 Southeast 4th Street Tuttle, OK 73089	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701</p> <p>Based on observation, record review, and interview, the facility failed to prevent physical abuse for one (#1) of six sampled residents reviewed for abuse allegations.</p> <p>The administrator identified 45 residents resided in the facility.</p> <p>Findings:</p> <p>A quarterly MDS, dated [DATE], documented Res #1 was cognitively intact, and was dependent on staff for most ADLs.</p> <p>An undated witness statement, documented CMA #1 had noticed a bruise on Resident #1's right hand and wrist. Resident #1 reported that CNA #1 pushed all their weight on their hand that was holding the bed rail, thereby smashing Resident #1's hand between the wall and handrail. CMA #1 heard Resident #1 tell CNA #1 they wanted someone else to feed them. CMA #1 stated when they went back to Resident #1's room approximately 15 minutes later, CNA #1 was still feeding Resident #1 even though they were saying please stop feeding me, I don't want anymore. CMA #1 reported they left the room.</p> <p>A witness statement, dated 07/11/24, documented that Resident #1 reported to CNA #4 that CNA #1 told them they would kill them.</p> <p>On 07/23/24 at 12:33 p.m., Resident #1 was observed in their bed. They were very hard to understand and mumbled quietly. When Resident #1 was asked about their hand, they put it up in the air and moved in back and forth to look at it but did not respond.</p> <p>On 07/23/24 at 1:44 p.m., the Administrator reported that CNA #1 was agency and the incident was reported to the agency, OSDH, and the police department. CNA #1 was put on the Do Not Return list.</p> <p>On 07/23/24 at 2:00 p.m., the Administrator reported that CNA #1 was not removed from the building during the shift because they were not notified of the incident until the next morning.</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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>49701</p> <p>Based on record review and interview, the facility failed to ensure an allegation of abuse was reported within 2 hours to OSDH for one (#1) of six sampled residents reviewed for allegations of abuse.</p> <p>The administrator identified 45 residents resided in the facility.</p> <p>Findings:</p> <p>A witness statement, dated 07/11/24, documented that Resident #1 reported to CNA #4 that CNA #1 told them they would kill them.</p> <p>An incident report was filed with OSDH on 07/12/24 at 3:10 p.m., the incident date was documented as 07/10/24.</p> <p>On 07/23/24 at 2:00 p.m., the Administrator reported they were not notified of the incident until the next morning. The staff completed Abuse training in June. Abuse training was provided again on July 12th in response to this incident.</p>