STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375466	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Drumright Nursing Home	701 N Bristow Ave Drumright, OK 74030

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 45583 Based on record review and interview, the facility failed to conduct a thorough investigation after an allegation of abuse from staff for 2 (#1 and #2) of 3 sampled residents reviewed for abuse. The administrator identified 45 residents resided in the facility. Findings: A Policy and procedure regarding prohibition for resident abuse including corporal punishment, neglect and exploitation, revised 10/2022, read in part, Interviewing by standers, witnesses et. as soon as possible .Staff will increase supervision .and all other residents that may be impacted . All staff are required to report . OSDH, law enforcement and/or adult protective services. 1. Resident #1 had diagnoses which included major depressive disorder, schizoaffective, and paranoid disorder. Resident #1's quarterly resident assessment, dated 02/24/25, showed a BIMS score of 15, indicating the resident's cognition was intact. An OSDH initial incident report form, dated 03/09/25, did not show adult protective services was notified of the allegation. An attachment to the initial incident report, dated 03/09/25, and labeled Part B; OSDH, showed statements from staff of Resident #1 stating Resident #1 was scared to go to bed because CNA #1 was rough and rushed them. An attachment to the initial incident, dated 03/10/25, signed by the administrator, showed they were notified and had interviewed Resident #1 about the allegation against CNA #1. The attachment showed there was no evidence of any specific abuse towards the resident. There were no other resident interviews located for the incident dated 03/09/25. On 03/17/25 at 6:12 p.m., Resident #1 stated they were not fearful of anyone and had not experienced abuse. 2. Resident #2 had diagnoses which included major depressive disorder. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 - Some	Resident #2's quarterly resident assessment, dated 01/03/25, showed a BIMS score of 9, indicating the resident's cognition was moderately impaired. An OSDH initial incident report form, dated 02/11/25, Part B, showed, the morning of 02/12/25 during evening rounds the night before the CNA for that hall came into Resident #2's room and stated they needed to check them. The report showed the resident stated they did not want to be changed. The report showed the CNA informed them they wanted to check them and proceeded to check them. The report showed Resident #2 was upset and wanted to report that they did not want to be changed or checked and did not want the CNA working their hall any longer. The initial incident report sent to OSDH on 02/11/25 did not show APS or Nurse Aide Registry notification of the allegation. On 03/17/25 at 6:20 p.m., Resident #2 stated they were not fearful of anyone and had not experienced abuse. On 03/17/25 at 8:06 p.m., CNA #2 stated Resident #2 was very particular with their care. They stated they had a fall out the other day because they were rushing that morning and Resident # 2 did not like that. They stated they apologized to Resident #2 and they were all good now. On 03/18/25 at 10:27 a.m., CNA #2 stated they went to check Resident #2 on rounds. CNA #2 stated Resident #2 had stated they were not wet. CNA #2 stated they asked the Resident #2 again and they stated they were not wet. CNA #2 stated Resident #2 made a vulgar statement so they thought the resident was joking. CNA #2 stated they proceeded to check the resident's pad with their hand. CNA #2 stated the Resident #2 then hit their hand and said they were going to report them. CNA #2 stated they had to write a statement and were not to go into Resident #2's room anymore. On 03/18/25 at 12:01 p.m., the DON stated the process for reporting abuse was for staff to call them immediately. The DON stated the administrator was the abuse coordinator and they typically did the report to state. The DON stated they contact the family, send to state, interview other residents, and interview the staff. The DON stated they interviewed a little bit of everybody. The DON stated they do not contact anyone outside of the facility except the family. On 03/18/25 at 12: 03 p.m., the DON stated APS was not notified about the allegation involving Resident #1 on 03/09/25 or Resident #2 on 02/11/25. The DON stated there were no resident interviews for the allegation/incident on 03/09/25 and there was no notification to the nurse aide registry for the allegation/incident on 02/11/25. The DON stated the investigations on 02/11/25 and 03/09/25 were not thoroughly completed.