STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375497	A. Building B. Wing	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell County Nursing Center, Inc	1402 Northwest 7th Street Stigler, OK 74462

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46909 Based on observation, record review, and interview, the facility failed to ensure hot water was provided for the residents for approximately a month. The DON identified 58 residents resided in the facility. Findings: An invoice dated 01/09/24, documented two inch pipes were replaced with gas line thread tape to prevent gas leaks. An invoice dated 01/15/24, documented the valve ball fitting was replaced and pipes were replaced again. An invoice dated 01/16/24, documented a water heater connector and pipe had to be replaced. An invoice dated 01/19/24, documented the couple fitting, pipes, copper caps, an adapter, and a lower and upper thermostat were replaced. An invoice dated 01/23/24, documented a lower and upper thermostat was replaced with a water heating element. An invoice dated 01/26/24, documented parts were purchased again to repair the old water heaters. The plumber replaced the water heater pump and the gate valve. Once the pump and gate valve were repaired then the valve that was replaced blew off causing damage again. The pump was replaced with copper adapter, and ball valve was replace. A gate valve was also replaced at this time. An invoice dated 01/27/24, documented a galvanized malleable pipe plug was replaced with a gate valve on the water heaters. Two invoices dated 01/30/24, documented more pipes and connectors, a p-trap fitting, and connectors were replaced on the water heaters. An invoice date 01/31/24, documented two commercial water heaters were purchased and delivered to the facility. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/31/24 at 11:07 a.m., an interview was conducted with the COO and they stated there was a problem with both water heaters in the building. Their company had purchased two commercial water heaters and they were going to install them as soon as the electrician was finished with rewiring to upgrade for commercial water heaters. On 01/31/24 at 12:07 p.m., an observation was made for hall #100/200 of shower temperatures at 90.3 to 90. 7 F. On 01/31/24 at 1:34 p.m., an interview was conducted with Res #3 and they stated they the water was always cold but they heard there was some new water heaters being put in. On 01/31/24 at 2:18 p.m., an observation was made of the old water heater on #100/200 hallway being removed and an electrician was working to upgrade the wiring for the new commercial water heater. On 02/01/24 at 11:43 a.m., an interview was conducted with Res #2 and they stated they refused to take a shower/bath many times related to the water being ice cold. On 02/05/24 at 1:22 p.m., an interview was conducted with the maintenance man and they stated one water heater was completely rewired and installed and they were working on the other water heater. On 02/05/24 at 1:24 p.m., an observation was made of hall #100/200 shower temperature at 108.0 F. On 02/06/24 at 10:54 a.m., an interview with the activity staff was conducted and they stated the water was never out but the plumber that was working on the old water heaters had to turn the water off and on when working to repair the old water heaters in the past weeks. On 02/07/24 at 11:49 a.m., an interview was conducted with the resident's representative and they stated Res #2 had not been given a shower/bath in almost four weeks. They also stated another family member had to take Res #2 to give them a shower and wash their hair.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46909 Based on record review and interview, the facility failed to ensure a resident was free from abuse for one (#1) of four residents sampled for abuse. On 08/06/23 CNA #1 sprayed Res #1 in the face for five seconds while the resident was screaming, yelled at the resident, and then sprayed her in the face again again per witness statement and interview. CNA #1 was terminated for abuse on 08/06/23 and rehired on 09/21/23. The administrator identified 58 residents residing in the facility. Findings: A document titled, [NAME] County Nursing Center, dated 01/11/23, signed by CNA #1, read in part, . Abuse/Incident Reporting/Investigations What is reportable and actions to be taken: 1. Abuse is defined in many ways in the nursing home setting. Abuse can be physical, emotional, mental, verbal, and sexual .4. The most important thing you do is make sure all residents are safe and notify your DON, ADON, and/or Administrator . Res #1 had diagnoses which included dementia, major depression disorder, anxiety disorder, and cerebrovascular disease. A statement by CNA #2, dated 08/06/23, documented while assisting CNA #1 with Res #1's shower, CNA #1 took the spray nozzle and ran it across the resident's hair and then stalled the nozzle on the resident's face for at least five seconds. The statement documented CNA #1 then pulled the sprayer off the resident's face and said [Res #1 name withheld] stop screaming, then when the resident resumed yelling, CNA#1 sprayed her in the face again. A warning notice form, signed by the DON on 08/06/23, documented CNA #1 was terminated and was not eligible for rehire. There was no investigation completed. There was no state notification of the allegation until 10/03/23. On 09/21/23, CNA #1 applied for employment again at the long term care facility and was rehired. Per OKScreen documentation, there was no notification of rehire and no screening conducted upon rehire for 09/21/23. On 10/03/23, the administrator faxed an incident report to the state agency related to the abuse allegation on 08/06/23. An annual assessment, dated 12/26/23, documented Res #1 was severly impaired and required total assistance with all ADLs. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 01/31/24 at 12:54, an interview was conducted with the resident's family member in regard to the abuse allegations. The family member stated they were notified of the shower incident and was informed CNA #1 was terminated. They then stated someone from the facility called them while they were out of town and inform them that CNA #1 was back in the facility working with the residents. The family member stated once they were back in town they came into the facility and voiced their concerns related to CNA #1 working in the facility after being terminated for abusing their parent. The family member stated their parent was confused and totally dependent on others to assist them. The family member also stated that CNA #1 had been reported to the district attorney's office for attacking their grandchild in a local restaurant and charges were pending against CNA #1 for assault and battery. On 02/01/24 at 12:59 p.m., the administrator stated they did not know about the incident on 08/06/23 until 10/03/23. They stated they reported the abuse incident to the state at that time. On 02/01/24 at 1:23 p.m., the DON stated the abuse was reported from CNA #2 and they immediately terminated CNA #1. The DON stated they did not know they were required to report the abuse to the state within two hours of the report given to them. They stated they did not know the regulations so the report was not reported to the state. The DON stated CNA #1 was rehired after being terminated for abuse in August. On 02/01/23 at 209 p.m., CNA #2 stated CNA #1 sprayed Res #1 in the face for about five seconds and then yelled at the resident and cursed them for screaming. CNA #2 stated CNA #1 sprayed the resident in the face again. CNA #2 stated they reported the abuse immediately to the DON and then wrote a statement. On 02/01/23 at 2:15 p.m., the ADON stated CNA #1 was rehired on 09/21/23 after being terminated on 08/06/23.

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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 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. 46909 Based on record review and interview, the facility failed to ensure all allegations of abuse were reported within two hours and a final report with five days for one (Res #1) of four residents sampled for abuse. The DON identified 58 residents residing in the facility. Findings: A facility policy, titled Abuse and Neglect - Clinical Protocol read in part, .15. The administrator will provide in a written report of the results of all abuse investigations and appropriate actions taken to the state survey and certification agency, the local police department, the ombudsman, and others as may be required by state or local laws, within five (5) working days of the reported incident . A statement by CNA #2, dated 08/06/23, documented while assisting CNA #1 with Res #1's shower, CNA #1 took the spray nozzle and ran it across the resident's hair and then stalled the nozzle on the resident's face for at least five seconds. The statement documented CNA #1 then pulled the sprayer off the resident's face and said [Res #1 name withheld] stop screaming, then when the resident resumed yelling, CNA#1 sprayed her in the face again. On 10/03/23, the administrator faxed an incident report to the state agency. On 02/01/24 at 1:23 p.m., the DON stated they received the abuse allegation statement from CNA #2 on 08/06/23. The DON provided documentation of CNA #1's termination letter with no rehire. The DON stated they did not know they had to file a state reportable within two hours of the allegation. On 02/01/24 at 1:54 p.m., an interview was conducted with the administrator, they stated they did not know about the abuse from CNA #1 until 10/03/23 and as soon as they found out about the abuse they initiated an investigation and reported the abuse to all the appropriated authorities. On 02/01/23 at 2:09 p.m., during a phone interview, CNA #2 stated they were being trained by CNA #1. CNA #2 stated they were helping CNA #1 provide a shower for Res #1. CNA #2 stated that CNA #1 sprayed Res #1 in the face for about five seconds and then yelled and cursed the resident for screaming, then CNA #1 sprayed the resident in the face again. CNA #2 stated she reported the abuse immediately to the charge nurse, ADON, then the DON. CNA #2 stated CNA #1 was terminated and was not to be rehired. CNA #2 stated the administrator knew about the abuse allegation on 08/06/23. CNA #2 stated two weeks later they came to work and CNA #1 was working at the facility again. CNA #2 stated they asked the ADON and the DON about CNA #1 being at work and they said it was above their head.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 46909 Based on observation, record review, and interview the facility failed to ensure residents received bathing as scheduled for four (#1, 2, 3, and #4) of four residents sampled for ADLs. The DON identified 58 residents who resided in the facility. Findings: 1. An annual assessment for Res #1, dated 12/26/23, documented the resident was severely cognitively impaired and required total assistance with ADLs. No recent bathing documentation was in medical record. 2. An annual assessment for Res #2, dated 11/01/23, documented the resident was cognitively intact and was independent with most ADLs. No recent bathing documentation was in medical record. On 02/01/24 at 11:43 a.m., Res #2 stated they refused to take a shower/bath many times related to the water being ice cold. On 02/07/24 at 11:49 a.m. an interview was conducted with a family member of Res #2. They stated the resident had not been given a shower/bath in almost four weeks. They also stated another family member had to take Res #2 to give them a shower and wash their hair. 3. A quarterly assessment for Res #3, dated 11/08/23, documented the resident's cognition was impaired and required total assistance with bathing. No recent bathing documentation was in medical record. On 01/31/24 at 1:38 p.m., the resident stated he had not had a shower as often as he would have liked. The resident stated the water is always cold. 4. A quarterly assessment for Res #4, dated 12/07/23, documented the resident was cognitively intact and required supervision with bathing. No recent bathing documentation was in medical record. On 01/31/24 at 11:07 a.m., an interview was conducted with the COO and they stated there was a problem with the both water heaters in the building. Their company had purchased two commercial water heaters and they were going to install them as soon as the electrician was finished with rewiring to upgrade for commercial water heaters. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/31/24 at 2:14 p.m., the DON was asked to provide documentation related to bathing for Res #1, #2, #3, and #4. The DON stated the documentation should be in the shower binder at the nurse station but had just looked for it and could not find any bathing documentation. On 02/05/24 at 1:22 p.m., an interview was conducted with the maintenance man and they stated one water heater was completely rewired and installed and they were working on the other water heater.