STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375504	A. Building B. Wing	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North County Center for Nursing and Rehabilitation	2300 West Broadway Collinsville, OK 74021

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 35474 Based on record review and interview, the facility failed to ensure the abuse policy was implemented for verbal abuse for one (#6) of five sampled residents who were reviewed for abuse. The administrator identified 46 residents who resided at the facility. Findings: The Abuse policy, dated 02/17/22, read in parts, .Verbal abuse: The use of oral, written, or gestured language that includes disparaging derogatory terms to a resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability .Identification .Administrative and licensed staff will be aware of potential situations of abuse during rounds and contact with staff, residents . Resident #6 had diagnoses which included impulse disorder and dementia. The Care Plan, dated 08/16/23, documented the resident could be moody if they did not get something they wanted. The Care Plan documented the resident liked to smoke, talk about things that made them happy, watch television, and staff should attempt those thing to change the resident's mood/behavior. A behavior note, dated 08/22/23 at 10:23 a.m., documented Resident #6 began cursing at and calling another resident names. The admission assessment, dated 08/24/23, documented Resident #6 was moderately impaired in cognition for daily decision making, expressed verbal behaviors towards others for one to three days of the seven day look back period, and the impact of the behaviors on others had significantly disrupted care or the living environment. The Care Plan, updated 08/29/23, documented at times Resident #6 had verbally abusive behaviors towards others and interventions included staff would document behaviors and response to interventions, guide Resident #6 away from source of distress, and engage them in conversation to help them calm down. A behavior note, dated 10/05/23 at 4:00 p.m., documented the resident had threatened to hit another resident and the DON and administrator were notified of the incident. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A social services note, dated 10/31/23 at 11:32 a.m., documented Resident #6 was yelling and cursing in the dining room asking resident and staff who wanted to fight. The note documented the administrator had contacted the POA for Resident #6. A behavior note, dated 11/11/23 at 8:32 a.m., documented Resident #6 called another resident derogatory names in the dining room. The note documented Resident #6 then went behind the other resident as they were walking down hall and shoved them. The staff intervened and the other resident was placed with the nurse. A behavior note, dated 11/11/23 at 9:30 a.m., documented Resident #6 was yelling at and threatened to hit another resident. The note documented the physician and DON were notified of the incident. A behavior note, dated 11/12/23 at 6:45 p.m., documented Resident #6 yelled and cursed at another resident in the front lobby. A behavior note, dated 11/14/23 at 3:00 a.m., as a late entry by the administrator, documented Resident #6 was cursing and yelling at the charge nurse who had redirected Resident #6 from yelling at other residents. The note documented Resident #6 called the other resident a liar. A behavior note, dated 11/14/23 at 11:23 a.m., documented Resident #6 yelled at other residents in the dining room, woke up another resident, held their middle finger up in the other resident's face and made derogatory comments to them. A behavior note, dated 11/14/23 at 1:43 p.m., by the DON documented they had been notified that Resident #6 was yelling and cursing at another resident in the dining room and they had notified the administrator of the incident. A nurse note, dated 01/01/24, at 6:47 p.m., documented Resident #6 grabbed another resident's shirt, yelled, threatened the other resident, and called them derogatory names. The note documented the physician and DON were notified. A nurse note, dated 01/14/24 at 5:25 p.m., documented Resident #6 was yelling derogatory names at another resident, grabbed the other resident's walker, and pushed it across the dining area. A social services note, dated 01/15/24 at 1:37 p.m., documented Resident #6 made derogatory statements toward and called another resident derogatory names in the dining room. On 01/25/24 at 1:57 p.m., the DON reviewed the documentation in the electronic clinical record for Resident #6 and stated they had not identified Resident #6 had been verbally abusive to other residents. They stated they reviewed a report of progress notes each day during the morning meetings. The DON stated they did not have experience with verbal abuse and did not implement the abuse policy for Resident #6 because they classified the incidents as behaviors, not as verbal abuse. They stated they should have implemented the facility's abuse policy with each incident. On 01/29/24 at 2:03 p.m., the administrator stated they should have implemented the abuse policy with the incidents involving Resident #6. They stated they reviewed the notes only as documentation of behaviors. The administrator stated, I should have done better.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35474 Based on record review and interview, the facility failed to ensure allegations of verbal abuse were reported to the administrator and OSDH for one (#6) of five sampled residents who were reviewed for abuse. The administrator identified 46 residents who resided at the facility. Findings: The Abuse policy, dated 02/17/22, read in parts, .Employees are required to report all incidents of possible abuse .immediately to their supervisor .The supervisor .shall immediately report to the Administrator or person on call .Nursing facility must report .immediately but not later than 2 hours after the allegation is made .The charge nurse will .Notify the Administrator or person on call, if after hours . Resident #6 had diagnoses which included impulse disorder and dementia. A behavior note, dated 08/22/23 at 10:23 a.m., documented Resident #6 began cursing at and calling another resident names. The note did not document the administrator or DON had been notified of the incident. The admission assessment, dated 08/24/23, documented Resident #6 was moderately impaired in cognition for daily decision making, expressed verbal behaviors towards others for one to three days of the seven day look back period, and the impact of the behaviors on others had significantly disrupted care or the living environment. A behavior note, dated 10/05/23 at 4:00 p.m., documented the resident had threatened to hit another resident and the DON and administrator were notified of the incident. A social services note, dated 10/31/23 at 11:32 a.m., documented Resident #6 was yelling and cursing in the dining room asking resident and staff who wanted to fight. The note documented the administrator had contacted the POA for Resident #6. A behavior note, dated 11/11/23 at 8:32 a.m., documented Resident #6 called another resident derogatory names in the dining room. The note documented Resident #6 then went behind the other resident as they were walking down hall and shoved them. The staff intervened and the other resident was placed with the nurse. A behavior note, dated 11/11/23 at 9:30 a.m., documented Resident #6 was yelling at and threatened to hit another resident. The note documented the physician and DON were notified of the incident. A behavior note, dated 11/12/23 at 6:45 p.m., documented Resident #6 yelled and cursed at another resident in the front lobby. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior note, dated 11/14/23 at 3:00 a.m., as a late entry by the administrator, documented Resident #6 was cursing and yelling at the charge nurse who had redirected Resident #6 from yelling at other residents. The note documented Resident #6 called the other resident a liar. A behavior note, dated 11/14/23 at 11:23 a.m., documented Resident #6 yelled at other residents in the dining room, woke up another resident, held their middle finger up in the other resident's face and made derogatory comments to them. A behavior note, dated 11/14/23 at 1:43 p.m., by the DON documented they had been notified that Resident #6 was yelling and cursing at another resident in the dining room and they had notified the administrator of the incident. A nurse note, dated 01/01/24, at 6:47 p.m., documented Resident #6 grabbed another resident's shirt, yelled, threatened the other resident, and called them derogatory names. The note documented the physician and DON were notified. A nurse note, dated 01/14/24 at 5:25 p.m., documented Resident #6 was yelling derogatory names at another resident, grabbed the other resident's walker, and pushed it across the dining area. A social services note, dated 01/15/24 at 1:37 p.m., documented Resident #6 made derogatory statements toward and called another resident derogatory names in the dining room. On 01/25/24 at 12:35 p.m., LPN #1 stated any abuse allegations should be reported to the administrator or the DON. They stated they reported incidents involving Resident #6 to the administrator but forgot to document the notification. They stated they were not responsible to submit reports to OSDH. On 01/25/24 at 1:57 p.m., the DON stated the administrator, RN #1, or themselves were responsible to submit allegations of abuse to OSDH within two hours of receiving the allegation. They stated any staff were to report allegations of abuse to them or the administrator. The DON reviewed the progress notes in the electronic clinical record and stated they had not reported the incidents to OSDH but they should have because Resident #6 was verbally abusive to other residents. On 01/29/24 at 12:51 p.m., LPN #2 stated they reported allegations of abuse to the administrator and DON for Resident #6 and had been instructed to document a behavior note of the incident. They stated they had not documented the notification to the administrator and the DON. On 01/29/24 at 2:03 p.m., the administrator stated allegations of abuse should be directly reported to them so they could investigate and submit a report to OSDH within two hours. The administrator stated they had not done a thorough job and had not submitted reports to OSDH for the verbal abuse for Resident #6.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 35474 Based on record review and interview, the facility failed to ensure staff had received abuse training upon hire for four (CNA #1, CNA #2, CNA #3, and housekeeper #1) of five employee files reviewed for abuse training. The administrator identified seven employees hired in the past four months. Findings: The Abuse policy, dated 02/17/22, read in parts, .Training .All new employees will receive in-service training pertaining to all aspects of abuse prohibition before working a shift . 1. CNA #1 was hired on 01/04/24. 2. CNA #2 was hired on 11/11/23. 3. CNA #3 was hired on 11/21/23. 4. Housekeeper #1 was hired on 12/28/23. Review of the employee files did not reveal they had received abuse training upon hire. On 01/29/24 at 2:03 p.m., the DON stated the facility had not provided abuse training upon hire since they switched owners several months ago. On 01/29/24 at 2:28 p.m., the administrator stated they had not provided employee abuse training upon hire since the new company had taken over the facility in September 2023.