

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375505	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/05/2024
NAME OF PROVIDER OR SUPPLIER  Magnolia Creek Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 2610 Cedar Creek Drive Altus, OK 73521	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873</b></p> <p>Based on record review and interview, the facility failed to investigate an incident of alleged resident-to-resident abuse for one (#1) of three sampled residents reviewed for abuse.</p> <p>The administrator identified 72 residents resided in the facility.</p> <p>Findings:</p> <p>A Resident Abuse, Neglect and Misappropriation of Property policy, dated 11/01/22, read in part, The licensed nurse in charge of the unit shall then complete an incident report reflecting any and all findings from the assessment of the resident following the incident. The policy read in part, A member of the administrative staff will then conduct a thorough investigation of the incident/allegation to obtain information about the incident and complete ODH-283. The policy also read in part, Mental abuse is the use of verbal or nonverbal conduct which cause or has the potential to cause the resident to experience humiliation, intimidation, fear, agitation, or degradation.</p> <p>Resident #1 had diagnoses which included cerebral infarction, insomnia, and depressive disorder.</p> <p>A comprehensive assessment, dated 10/05/24, documented Resident #1's cognition was intact, and they required substantial/maximal staff assistance with most activities of daily living.</p> <p>An Incident/Offense report from the [name removed] police department, dated 10/30/24 at 6:30 p.m., documented the officer was dispatched to [address removed] room [ROOM NUMBER] for threats being made. The report documented Resident #1 reported that Resident #2 had been threatening them. The report documented Resident #2 went into Resident #1's room while they were trying to sleep and began shaking the bed. The report documented Resident #1 told Resident #2 to leave the room a total of three times. The report documented Resident #1 reported being afraid. The report documented Resident #1 told Resident #2 that if Resident #2 did not leave the police would be called. The reported documented Resident #2 made a fist and started shaking it at Resident #2. The report documented Resident #2 told Resident #1 they would be sorry while a fist at Resident #1. The report documented the officer spoke with the head nurse about Resident #2 threatening Resident #1. The report also documented the officer advised the administrator and head nurse it would be a good idea to keep both residents separated as much as possible.</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 375505
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Grievance form, dated 10/30/24, documented Resident #2 rolled into Resident #1's room and startled them. The form documented the DON sat at Resident #1's bedside to make sure the resident was okay. The form documented Resident #1's family member called the police and asked the administrator and DON to exit the room. The form documented the police officer reported to the administrator no harm was done and an information report would be completed. The form documented the DON and administrator assured Resident #1 that Resident #2 would be kept from wandering into their room. The form documented staff were educated to put stop signs across Resident #1's door as well as being vigilant if Resident #2 started going down that hallway. The form documented the ombudsman was notified. The form documented to educate staff on Resident #2 roaming on the wrong halls.</p> <p>On 11/04/24 at 12:45 p.m., Resident #1 reported fear of Resident #2. The resident reported this was reported to the DON and the administrator. The resident reported on 10/30/24 Resident #2 came into their room while they were sleeping and shook the end of their bed startling them awake, then started going through their personal belongings. Resident #1 reported Resident #2 was asked to leave the room which they would not do. Resident #1 pushed their call light for assistance and hollered for staff to get the Resident #2 out of their room. Resident #1 reported Resident # 2 came up to the bed and shook a fist at them. Resident #1 reported no staff had come to assist. Resident #1 reported they then told Resident #2 they were going to call the police. They reported Resident #2 told them they would pay for it. Resident #1 reported a staff member finally removed Resident #2 from the room.</p> <p>On 11/05/24 at 10:17 a.m., the DON reported Resident #1 had reported to them on 10/30/24 Resident #2 rolled into the resident's room and grabbed the end of their bed while they were sleeping. The DON reported Resident #1 reported the incident scared them because they were asleep. The DON reported Resident #1 reported Resident #2 had shaken a fist at them. The DON reported not feeling like the incident was an abuse situation.</p> <p>On 11/05/24 at 10:29 a.m., the administrator reported no abuse was reported to them by the police officer. The administrator reported after talking to the resident they did not feel like the incident was an abuse allegation. The administrator reported they conducted a grievance investigation. The administrator reported staff were educated on putting up stop signs on the Resident #1's door to keep Resident #2 from wandering in and educated staff on Resident #2 wandering onto the wrong hallways. The administrator reported no other residents or staff were interviewed related to the incident.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>41873</p> <p>Based on observation, interview, and record review, the facility failed to update a resident's care plan for wandering behavior for one (#2) of three sampled residents reviewed for abuse.</p> <p>The administrator reported 72 residents resided in the facility.</p> <p>Findings:</p> <p>Resident # 2 had diagnoses which included depression.</p> <p>A Behavior note, dated 08/06/24, read in part, Res has had an increase in wandering and exit seeking . Elopement band in place and functioning .Staff continue to redirect.</p> <p>A care plan, dated 09/06/24, documented no care areas related to wandering or elopement behaviors.</p> <p>A comprehensive assessment, dated 09/23/24, documented the resident had severely impaired cognition and no behaviors.</p> <p>A Behavior note, dated 10/30/24, read in part, Resident keeps roaming the halls and entering resident's rooms, resident keeps being redirected to her hallway.</p> <p>On 11/04/24 at 12:30 p.m., Resident #2 was observed in their wheelchair going down the 400 hall looking into other resident's rooms.</p> <p>On 11/04/24 at 12:45 p.m., Resident #1 reported Resident #2 would enter their room uninvited and go through their personal items.</p> <p>On 11/04/24 at 1:30 p.m., Resident #2 was observed sitting behind the nurse's station with the charge nurse.</p> <p>On 11/05/24 at 1:15 p.m., LPN #2 reported wandering and elopement behaviors should be included on a resident's care plan.</p>		