

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375528	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Senior Suites Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 3501 W Washington Street Broken Arrow, OK 74012	

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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>41220</p> <p>Based on record review and interview, the facility failed to deposit resident personal funds in excess of \$50 in an interest bearing account that is separate from the facility's operation accounts for one (# 1) of three residents reviewed for facility funds.</p> <p>The Business office manger identified 15 residents that have money in the trust account and were current residents.</p> <p>Findings:</p> <p>A review of resident accounts balances documented Resident # 1 had a credit balance of \$1,471.00 in the facility's accounts receivable account from 01/19/24 carried through to the current date.</p> <p>Resident # 1 did not have funds in the facility's trust account.</p> <p>On 07/11/24 at 11:22 a.m., the corporate business office manager stated the money was left in the operating system per the family. They then stated the operating system was not an interest bearing account.</p> <p>On 07/11/22 at 3:01 p.m. the corporate regional manager stated resident funds are not to be commingled with operating funds.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0570</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure the security of all personal funds of residents deposited with the facility.</p> <p>41220</p> <p>Based on record review and interview, the facility failed to secure a surety bond with sufficient coverage for the account balance.</p> <p>The Business office manger identified 15 residents that have money in the trust account and were current residents.</p> <p>Findings:</p> <p>A review of the current surety bond for the resident trust account documented the surety bond had coverage of \$10,000</p> <p>The resident trust account monthly bank statement, 07/11/24, documented the account balance was \$18,330.30.</p> <p>On 07/11/24 at 3:01 p.m., the corporate regional manager confirmed the surety bond was only for \$10,000. They stated the previous month they had noticed the surety bond did not cover the trust account balance and had contacted the insurance company, but it had not been corrected.</p>