STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montevista Rehabilitation and Skilled Care	7604 Quanah Parker Trailway Lawton, OK 73505

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 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. 30875 Based on observation, record review, and interview, the facility failed to investigate an allegation of abuse and determine when to report the allegation for one (#3) of three sampled residents reviewed for abuse. The administrator identified 92 residents resided in the facility. The administrator reported six allegations of abuse in the past ninety days. Findings: An Abuse, Neglect and Exploitation and Misappropriation of Resident Property policy, dated 06/23/27, read in part, The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation and misappropriation, and (ii) timely investigation of and reporting to state and local agencies all allegations of abuse, neglect, exploitation and misappropriation of resident property. The policy also read, All residents, family members, visitors, and others are encouraged to report actual or suspected incidents of resident abuse, neglect, exploitation, and/or misappropriation of resident property without fear of retaliation. On 12/09/24 at 6:49 a.m., CNA #2 was observed working the front half of the 500 hall. CNA #2 was asked if there had been a problem on the 600 hall. They reported there was with Resident #3. They reported they were told not to go to the resident's room because they had made a complaint against them. They reported they were told when they made rounds in Resident #3's room they would need to ask for assistance from another staff member. On 12/09/24 at 7:00 a.m., Resident #3 returned from hospital on hospice services. On 12/09/24 at 7:30 a.m., the DON reported a meeting was held with the ombudsman and Resident #3 about the lights shining through their room at night and they discussed darkening curtains. On 12/09/24 at 8:05 a.m., LPN #1 was asked about CNA #2 working on the 600 hall. They reported they heard last week CNA #2 was not allowed on the 600 hall. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montevista Rehabilitation and Skilled Care	7604 Quanah Parker Trailway Lawton, OK 73505

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/09/24 at 9:19 a.m., the ombudsman was asked if they had informed the DON about a complaint regarding rough treatment of Resident #3. They reported they had met with the DON on 11/05/24 and informed them of the complaint of rough and rude treatment. They reported they were informed by the DON they would speak with night shift and investigate. On 12/09/24 at 10:18 a.m., LPN #3 was asked if they were aware CNA #2 was not to provide care for Resident #3. They reported they had heard that from the night shift nurses. They were asked why CNA #2 was not to provide care. They stated because of a family complaint. On 12/09/24 at 11:49 a.m., CNA #1 was asked if they were aware of a staff member that was not allowed to provide care for Resident #3. They identified CNA #2. They were asked if they knew why. They reported Resident #3 had several complaints about CNA #2 being rough and hateful. They were asked who they reported those complaints to. They reported it to several nurses. On 12/09/24 at 12:37 p.m., the administrator was asked how abuse allegations were reported. They reported they typically called them directly or reported to the DON or ADON. They reported they had not received an abuse allegation regarding Resident #3 and CNA #2. On 12/09/24 at 2:28 p.m., the DON reported they had discussed with Resident #3 if anyone had upset them, but they were unaware of an actual allegation. An initial Incident Report Form, dated 12/09/24, read in part, [Resident #3] and [CNA #2]. During a complaint survey it was notified to the facility that there may be an allegation of abuse by the resident &/or family. CNA suspended. Investigation initiated.