STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375541	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chickasha Nursing Center, Inc	2701 South 9th Street Chickasha, OK 73018

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, record review, and interview, the facility failed to:a. implement their abuse policy to protect a resident,b. report within two hours,c. immediately investigate, andd. conduct assessments when an allegation of sexual abuse was received for 1 (#19) of 3 sampled residents reviewed for abuse.On 06/03/26, an IJ situation was determined to exist related to the facility's failure to implement their abuse policy to protect a resident, report within two hours, immediately investigate, and conduct a resident assessment when an allegation of sexual abuse was received.On 06/02/26 at 9:00 a.m., an incident report, dated 06/01/26, was faxed to the OSDH for a sexual abuse allegation. The incident report showed CNA #1 reported an allegation of sexual abuse for CNA #2 toward Resident #19.CNA #1 reported they observed CNA #2 sexually abusing Resident #19 on 06/01/26 around 11:20 p.m. CNA #1 reported the allegation to LPN #1. CNA #1 and LPN #1 failed to intervene and remove CNA #2 from the resident.LPN #1 stated they reported the sexual abuse allegation to the DON and was instructed to write a written statement. LPN#1 did not assess the resident, report the allegation to appropriate entities within 2 hours of an abuse allegation, and conduct an investigation.The DON identified 25 residents resided in the facility. The administrator identified no other sexual abuse allegations since the last survey.On 06/03/25 at 7:42 p.m., the OSHD was notified and verified the existence of the IJ situation.On 06/03/26 at 7:45 p.m., the administrator and DON were notified of the IJ situation.On 06/03/26 at 7:57 p.m., the IJ template was emailed to the administrator.On 06/04/26 at 2:55 p.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part, Plan of Removal for Abuse IJ.Abuse in-service was conducted. It covered the definition of abuse. Then covered the types of abuse to include verbal, sexual, physical, mental, exploitation, seclusion, neglect, and misappropriation. It included training, screening, prevention, identification, the investigation process, protection of the resident, reporting process, and procedures, including the timeline of two hours to report to the state once the incident was immediately reported to the Administrator.The abuse in-service also covered all the entities that had to be notified by the Administrator: Physician, Family, Legal Representative, APS, Law Enforcement, Appropriate Licensing Board, Attorney General, Nurse Aid Registry, and others as required. SIPR (separate, intervene, protect, and report) was covered at length.The Chickasha Nursing Center Abuse Policy was handed out and verbally covered. The need to assess and the process of assessing residents for signs and symptoms of abuse was reviewed as well as the process of conducting an Abuse Questionnaire which is administered to all residents and staff.Abuse reportables will be audited for proper reporting process and procedures, proper prevention taken, proper investigation process and assessment of residents carried out and completed. Audits will be completed on June 4, 2026. Education will be conducted using any error(s) found as training to ensure abuse reports are handled correctly going forward.The staff member alleged to have committed sexual abuse was suspended and has not returned to the building at this time.Medical director was notified as well as Family/Legal Representative, APS, Nurse Aide Registry, and the Ombudsman. Local Law Enforcement was notified. Officer [name withheld] arrived to begin his investigation on June 2, 2026.Interviews were conducted with the CNA who made the allegation, with the LPN who was asked to view the incident in progress, and then the CNA alleged to have committed the allegation.Resident sent out to hospital for SANE (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	[sexual assault nurse examiner] kit test and evaluation.DON concluded his abuse questionnaire with all residents on June 2, 2026.DON completed the abuse questionnaire with all staff on June 2, 2026.All staff will be in-serviced on abuse to include types of abuse, signs and symptoms, and the reporting process by 10:00 a.m. on Thursday, June 4, 2026.Alleged victim and non-verbal residents will be assessed for signs and symptoms of sexual abuse by 8:30 p.m. Thursday, June 3, 2026.Abuse policy has been reviewed and updated according to state guidelines.The facility will ensure the likelihood of serious harm to residents will be removed by noon on June 4, 2026.On 06/05/26, the IJ was lifted, effective 06/04/26, when all components of the plan of removal had been verified as completed. Staff interviews were conducted, and staff were knowledgeable and able to verbalize the facility's abuse policy about types of abuse, protecting the resident by intervening immediately, reporting, investigating, assessing the resident, and preventing abuse. In-services were reviewed and interviews were conducted with staff from all shifts to verify the training. Hospital visit and notifications to appropriate entities were verified.The deficient practice remained isolated with the potential for more than minimal harm that is not immediate jeopardy. Findings:An undated policy titled Abuse Policy provided by the administrator, read in part, Prevention: Identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur .Investigation: Any witness or suspected abuse, neglect, mistreatment, and/or misappropriation of property will be reported immediately to charge nurse. An abuse reporting form will be filled out by employee. Charge nurse will check for injuries and make incident report. Report to OSDH will be sent within two hours. DON and administration will be notified immediately. Employee will be suspended pending investigation. Internal investigation will be started by designated employee appointed by the highest level in chain of command available on day investigation begins. Residents involved will be interviewed, if possible, person accused and witnesses if applicable and will report all findings to administration and DON .Protection: Resident will be protected from harm during an investigation .Reporting: All alleged violations and all substantiated incidents will be reported to the OSDH and to all other agencies as requiredA quarterly assessment for Resident #19, dated 05/21/26, showed the resident's cognition was severely impaired with a BIMS score of 03. The assessment showed Resident #19 was frequently incontinent of bladder and always incontinent of bowel and was dependent on staff for assistance with activities of daily living.Resident #19's medical record did not document any information related to the sexual abuse allegation on 06/01/26.A time sheet record for CNA #2, dated 06/01/26, showed CNA #2 clocked out at 11:34 p.m.An initial incident report form, dated 06/01/26 showed a sexual abuse allegation involving Resident #19 and CNA #2 was faxed to the OSDH on 06/02/26 at 8:59 a.m. The report showed Resident #19 had diagnosis of encephalopathy with anoxic brain damage. On 06/02/26 at 11:19 a.m., the administrator stated they were informed this morning that a sexual abuse allegation was received for an incident on 06/01/26 around 11:45 p.m. The administrator stated CNA #1 reported they saw CNA #2 vaginally penetrating Resident #19. The administrator stated CNA #1 told LPN #1 about their allegation and LPN # 1 went to the resident's room and saw CNA #2 with a washcloth in their hand cleaning the resident. The administrator stated the incident had not been reported to the state or to law enforcement. On 06/02/26 at 11:59 a.m., CNA #1 stated around 11:15 a.m. to 11:20 a.m. on 06/01/26, they heard Resident #19 giggling and saying no stop. CNA #1 stated they opened Resident #19's door and saw CNA #2 kneeled on floor with four fingers of the right hand inside of the resident's vagina up to the knuckles and pulling and twisting on the resident's public hair with their left hand. CNA #1 stated the resident was squirming on the bed and heard CNA #2 tell Resident #19 no, no we have to do this. CNA #1 stated they were shocked and they closed the resident's door to get another employee. CNA #1 stated LPN #1 had walked in the front door to work the next shift and was told what they had witnessed. CNA #1 stated the LPN #1 opened Resident #19's door to observe CNA #2, closed the door, then clocked in for work. CNA #1 stated neither one of them stopped CNA #2 or removed CNA #2 from the resident. CNA #1 stated they called the ADON at 11:32 p.m. to report the incident. CNA #1 stated (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	they should have intervened immediately and removed the CNA #2 from the resident. On 06/02/26 at 1:12 p.m., the ADON stated CNA #1 called them on 06/01/26 at 11:31 p.m. to report what they had witnessed. The ADON stated they would call LPN #1 and instructed CNA #1 to leave a written statement. The ADON immediately called LPN #1 and was told by LPN #1 they had not witnessed sexual abuse. The ADON stated they were unsure what needed to be done since CNA #1 and LPN #1 had seen something different, so LPN #1 was told to call the DON. The ADON stated by the training they had received any allegation of abuse should be investigated. The ADON stated they guessed the abuse coordinator was the administrator.On 06/02/26 at 1:25 p.m., the DON stated LPN #1 called them on 06/01/26 at 11:41 p.m. to report the incident. The DON stated an abuse allegation should be reported to the state within two hours. The DON stated they were the abuse coordinator. The DON stated they would expect LPN #1 to report to state, start the investigation, and assess the resident. The DON stated interviewable residents were questioned about abuse on the morning of 06/02/26 but no skin assessments were done for residents unable to answer questions. The DON stated staff did not follow the abuse policy and did not remove CNA #2 to protect the resident.On 06/02/26 at 1:47 p.m., the administrator stated the DON was probably the abuse coordinator because they were new and the DON stated they had been the one to do abuse training for staff. The administrator stated they were not able to find handouts of what abuse training was covered for staff and the last abuse in-service was 03/11/26.On 06/02/26 at 1:48 p.m., administrator stated CNA #2 exited the facility at 11:34 p.m. on 06/01/26, verified by the time sheet.On 06/02/26 at 1:56 p.m., LPN #1 stated they were walking in the front door of the facility when CNA #1 came up to them and reported CNA #2 was seen trying to pleasure Resident #19 and the resident was moaning. LPN #1 stated they went to Resident #19's room, opened the door, and CNA #2 used one hand to pull back Resident #19's pubic hair, and used one hand to wipe the resident's peritoneal area with a washcloth. LPN #1 stated what they observed was not sexual activity by CNA #2. LPN #1 stated after door was closed to Resident #19's room they went and clocked in. LPN #1 stated the ADON called the facility and told them to call the DON. LPN #1 stated they told the DON what CNA #1 had seen and what they had seen. LPN #1 stated they told the DON they had not seen any abuse. LPN #1 stated the DON told them to write a statement, and the DON would take care of it. LPN #1 stated the DON was responsible for reporting abuse. LPN #1 stated they had not been in-serviced on reporting abuse as a charge nurse and had not received abuse training for 2026. On 06/02/26 at 4:10 p.m., CNA #2 stated they were providing incontinent care for Resident #19 before finishing up their shift and had heard someone open and close the resident's door. CNA #2 stated Resident #19 had bowel movement that was dried on them and hard to remove. CNA #2 stated they had to pick bowel movement from the resident's pubic hair, and it was hard to get the resident clean. CNA #2 stated CNA #1 was supposed to be helping with resident care but was never around to help. CNA #2 stated the resident was known to holler out a lot during care. CNA #2 stated they had to kneel down to keep the resident from rolling off of the bed and it was normal that they did that. CNA #2 stated they did not get along with CNA #1.On 06/02/26 at 4:28 p.m., the administrator stated the abuse protocol, and policy was not followed by staff for the allegation of sexual abuse. The administrator stated the staff should have removed CNA #2 from the facility, the resident should have been assessed, the incident should have been reported within two hours, the incident should have been immediately investigated, and the administrator should have been notified.On 06/03/26 at 2:45 p.m., LPN #1 stated they were not aware when CNA #2 left the facility. LPN #1 stated after they spoke with the ADON and DON, CNA #2 was gone from the facility. LPN #1 stated now they were aware of a lot of things they should have done differently. LPN #1 stated they should have separated CNA #2 from the resident since another staff member made an allegation. LPN #1 stated they did not do an assessment on Resident #19 after the allegation was reported to them, but no CNA staff had reported any redness or pain from the resident. LPN stated they did not do an assessment on the resident but no staff working their shift had reported any redness or pain for the resident.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report and investigate a reasonable suspicion of illegal drug use by an employee providing care for residents while on shift.On 06/04/26, an IJ situation was determined to exist related to the facility's failure to report and investigate reasonable suspicion of a crime, resulting in employees suspected of using or being under the influence of illegal drugs being allowed to continue to provide care to residents.On 03/30/26 around 2:00 a.m., RN #1 found a purse was found in an employee restroom that contained suspected illegal drugs and drug paraphernalia. RN #1 locked the suspected illegal substance in the DON's office, questioned CNA #3 and CNA #4 about the purse belonging to one of them, watched the two CNAs for any sign of being under the influence of an illegal drug, and allowed both CNAs to continue working their shift. The incident was not reported to police, and drug screens were not requested by RN #1. RN #1 did not immediately notify the DON and did not investigate the incident or report it to OSDH. RN #1 stated they addressed the purse being found with the DON around 5:00 a.m. when the DON entered the facility. The DON identified the purse with the potential illegal drug substance and paraphernalia belonged to CNA #3. The DON returned it to CNA #3 and transported CNA #3 home. The DON did not contact the police or request a drug screen. The DON identified 25 residents resided in the facility.On 06/04/25 at 8:09 p.m., the OSDH was notified and verified the existence of the IJ situation.On 06/04/26 at 8:11 p.m., the administrator was notified of the IJ situation.On 06/04/26 at 8:29 p.m., the IJ template was emailed to the administrator.On 06/05/26 at 2:13 p.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part, Plan of Removal - F609.On 06/04/26, all department heads were in-serviced as to what to do if a crime is discovered or witnessed. This included taking action immediately, calling the police regardless, administering a drug test to the offender, not leaving the property or allowing the offender to leave. It was reiterated that we were not the one to make the determination if it is something illegal. That confirmation will be done by those trained to do so. We are to act upon suspicion.On 06/04/26, law enforcement was notified. Officer [name withheld] came and educated us as to the importance of timely reporting and notification, as well as not for us to determine if in fact there is any illegal. We are to report if suspicious.A Criminal Activity Policy and Procedure has been written to include the procedure upon discovering suspected illegal activity, reporting procedures and time frames, the investigation process, corrective actions that will be taken, prevention methods, and non-retaliation expectations.A mandatory in-service was held to review this new policy. All in attendance were given the policy. The Administrator verbally read all sections of the policy to them and asked if there were any questions. Special attention was given to the fact that it is not up to them to determine if it is illegal; if it is suspicious, they report it. Further, they report immediately keeping in mind the facility will have only 2 hours to get the state report sent in. Everyone signed the policy, and it will be placed in employee files. Any employee not in attendance will be in-serviced before they are allowed to work. The in-service also included the emphatic reminder that everyone is an obligated reporter. Anyone suspicious of anything that is or might be illegal is obligated to call the police and then notify the Administrator.The Physician (if applicable), Medical Director, Family (if applicable), APS (if applicable), Law Enforcement, and the Attorney General (again if applicable) will be notified, as will the Nursing Licensing Board and Nurse Aid Registry. Any other agencies will be notified if needed and identified.On 06/05/26, both residents and staff were interviewed as asked if they had ever seen a crime being committed at the facility; and if they had, what they did.A State Reportable was sent on 06/04/26, which also shows the Law Enforcement case #. The original investigation was started on March 30. In light of that investigation not being completed and done correctly, the investigation was reinstated and will be completed on 06/05/26.The staff member who was suspected of criminal activity was terminated the same day [they] admitted the items in question were theirs. Going forward, it is mandatory for an employee (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	found to be involved in criminal activity to be terminated according to the new policy.The Chickasha Nursing Center has ensured that, going forward, in the event of unforeseen criminal activity, the likelihood of improper reporting and response to such activity has been removed as of noon on 06/05/26.On 06/05/26, the IJ was lifted, when all components of the plan of removal had been verified as completed. Staff interviews were conducted. Staff were knowledgeable and able to verbalize the facility's criminal activity policy, who was responsible for reporting, who was responsible for investigating, when to report and investigate, and who to report to. In-services were reviewed and interviews were conducted with staff from all shifts to verify the training.The deficient practice remained isolated with the potential for more than minimal harm that is not immediate jeopardy. Findings: A dismissal report, dated 03/30/26, showed CNA #3 was terminated for suspected drug use. The report showed CNA #3 left a syringe, tourniquet, and four items wrapped in aluminum foil in the employee restroom. The report showed the reason for termination was suspected drug use. On 06/04/26 at 11:32 a.m., the DON stated CNA #3 was terminated immediately after the CNA admitted the purse belonged to them. The DON stated the police was not called or a report sent into the OSDH because they were not sure what the substance was in the wristlet. On 06/04/26 at 2:00 p.m., the administrator stated they could not locate a facility policy on criminal activity. They stated the police should be called and a report sent to the OSDH, and other required entities. On 06/04/26 at 5:04 p.m., RN #1 stated they found a wristlet purse in the employee restroom by the nurses' station during their shift on 03/30/26 at 2:00 a.m. RN #1 stated the purse contained a needle and syringe with a red liquid substance, a tourniquet, and foil packets with a white powdery substance inside. RN #1 stated the purse was placed and locked in the DON's office. RN #1 stated they contacted the DON and ADON at 2:03 a.m. by text. RN #1 stated CNA #3 and CNA #4 were asked if they left something in the restroom and both answered no. RN #1 stated they kept an eye on both CNAs for the rest of the shift to ensure they did not appear impaired. RN #1 stated the suspected drug paraphernalia was discussed with the DON around 5:00 a.m. when the DON arrived at the facility. RN #1 stated they worked part time and was not aware of the facility procedure for reporting and investigating illegal substance use. RN #1 stated they were not aware that the police should have been called. On 06/04/26 at 5:21 p.m., CNA #4 stated CNA #3 spent a lot of time in the bathroom then went to their vehicle. CNA #4 described CNA #3 as having bloodshot eyes, slurred words, and wore long sleeves every time they worked together. On 06/04/26 at 5:34 p.m., the DON stated they were made aware around 5:00 a.m. on 03/30/26 of a possible illegal substance being found in the employee restroom. The DON stated the incident was not reported to the police or the OSDH since they were not sure what the purse contained. The DON stated they watched video footage to see what employee was in the restroom before the purse was found by RN #1. The DON stated CNA #3 was questioned and admitted the purse belonged to them but would not admit was inside the purse. The DON stated the purse was returned to CNA #3 and CNA #3 was transported home by the DON. The DON stated they did not have a policy for illegal drug use or criminal activity. The DON stated RN #1 should have called the police, conducted a drug test, and a report made to the OSDH. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/04/26 at 7:40 p.m., the administrator stated they or the DON was responsible for investigating suspected criminal activity.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility failed to maintain clean and sanitary equipment during 3 of 3 dining observations. The dietary manager identified 25 residents utilized the ice machine daily. Findings: On 06/01/26 at 9:45 a.m., the following observations were made for the ice machine in the dining room: a. there was a black slimy substance on the inside walls of the ice dispenser area, and b. a rectangular type, damp piece of wood that replaced the ice grate, had a black substance on the bottom side. On 06/02/26 at 11:45 a.m., the ice dispenser on the ice machine remained with a black slimy substance visible. An undated facility cleaning schedule for kitchen and dining room showed the ice machine was wiped down on Saturdays. On 06/01/26 at 10:00 a.m., the dietary manager stated they wiped down the outside of the ice machine on Saturday, 05/31/26. On 06/05/26 at 1:30 p.m., the administrator agreed the ice dispenser was unsanitary. On 06/06/26 at 1:32 p.m., the maintenance director stated a new ice dispenser has been ordered.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interview, the facility failed to have an administrator to ensure: a. a facility assessment was updated annually, b. a PBJ report was sent quarterly, c. criminal activity was investigated and reported to the OSDH, and other required entities. d. in-service training was done monthly, and e. QAPI meetings were conducted quarterly. The DON identified 25 residents resided in the facility. Findings: Refer to tags F607, F609, F838, F851, F868, F940, and F944 for additional evidence. On 06/04/26 at 2:10 p.m., the administrator stated the incident which involved suspected drug use was not thoroughly investigated or reported to the OSDH. The administrator stated suspected illicit drug and criminal activity should have been reported to the police, the OSDH, and the nurse aide registry. They stated all in services should have an explanation summarizing the content of the meetings and CNAs should receive two hours of training each month on various topics. On 06/10/26 at 4:15 p.m., the administrator stated a new medical director was employed to start attending quarterly QAPI meetings. The administrator stated there should have been a meeting in May 2026. The administrator stated the PBJ reports were not completed as required.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on record review and interview, the facility failed to have a licensed administrator. The DON identified 25 residents resided in the facility. Findings: An Oklahoma Employment Security Commission Employee Response Statement showed the last date of employment for the previous administrator was 04/17/25. The facility staff list showed the current administrator was hired 05/08/26. The facility was without an administrator for over 365 days. Refer to tags F607, F609, F838, F851, F868, F940, and F944 for additional evidence. On 06/10/26 at 3:30 p.m., the administrator was unable to locate a governing body policy for the facility.