

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375554	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/24/2025
NAME OF PROVIDER OR SUPPLIER  Saint Simeons Episcopal Home		STREET ADDRESS, CITY, STATE, ZIP CODE  3701 Martin Luther King Jr Blvd Tulsa, OK 74106	

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 - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>41220</p> <p>Based on record review, and interview, the facility failed to ensure residents were free from abuse for two (#3 and #4) of three residents sampled for abuse. On 10/05/24 Res #3 was left soiled in bed and stuck between the bed and the wall. On 10/14/24 LPN #4 did not provide hydration, medication, or dressing changes for Res #4. The facility was in past noncompliance after having put the final measures in place to correct the deficiency on 12/13/24.</p> <p>The administrator identified 75 residents who resided in the facility.</p> <p>Findings:</p> <p>1. Res #3 had diagnoses which included Parkinson's and immobility.</p> <p>A state reportable incident form, dated 10/05/24, documented on 10/05/24 CNA #4 left Resident #3 soiled and wedged in the bed while covering for another aide who was on break. The form documented CNA #4 was removed from patient care immediately and suspended. The form documented the administrator contacted the family, resident's legal representative, Adult Protective Services, and the appropriate licensing board. The form documented all residents residing in the facility were questioned on abuse and neglect by the administrator.</p> <p>Record review revealed CNA #4 was immediately removed from patient care and terminated after the incident was investigated. The record review documented CNA #4 was terminated and reported to the nurse aide registry.</p> <p>2. Resident #4 had diagnoses which included Alzheimer's disease and osteoporosis.</p> <p>A state reportable incident form, dated 10/14/24, documented the facility discovered LPN #4 had inaccurately documented care for Resident #4. The care included hydration, dressing changes, and medication.</p> <p>Record review revealed LPN #4 was immediately suspended from the facility and terminated after the investigation was completed. The record review documented the LPN was terminated and reported to the appropriate licensing board.</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
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The in-service book documented multiple in-services on abuse and neglect. The initial in-service was conducted on 10/05/24 and another was conducted on 12/13/24 for all staff members. Staff members were interviewed and could voice information related to the inservice they attended.</p> <p>Residents were interviewed and denied abuse by staff.</p> <p>On 01/23/25 at 3:30 p.m., the administrator stated they reported the allegations of abuse to OSDH immediately. They stated they conducted a thorough investigation for both incidents by talking with all residents and staff members in the facility. The administrator stated to prevent recurrence they held abuse education services to educate all staff on abuse and neglect. The administrator stated CNA #4 and LPN #4 were terminated and reported to the appropriate registries. The administrator stated monitoring had been put into place to ensure these events did not reoccur and the QA committee had reviewed the incident and interventions.</p>		