

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/17/2024
NAME OF PROVIDER OR SUPPLIER  Boyce Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1600 East Highway Holdenville, OK 74848	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>46582</p> <p>On 12/16/24 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect Res #1's right to be free from abuse. Res #1 was assaulted by Res #2 resulting in stab wounds which required sutures.</p> <p>On 12/16/24 at 11:24 a.m., the Oklahoma State Department of Health verified the existence of an IJ situation.</p> <p>On 12/16/24 at 12:48 p.m., the administrator was notified of the immediate jeopardy situation.</p> <p>On 12/16/24 at 4:00 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility plan of removal documented:</p> <p>a. all staff education - abuse and neglect policy and procedures and resident to resident conflicts. All staff will be educated with a sign in sheet that are currently working in the facility. Any remaining staff will be called and educated over the telephone. Employee names and time of call will be documented;</p> <p>b. behavior monitoring - currently in progress. All residents' charts will be reviewed for active behavior issues. Physician will be notified if any resident is displaying current behaviors. Interventions will be implemented and care plans updated as needed. Any resident assessed to be under the influence of alcohol will be monitored one on one until the physician is notified for further instructions. All residents with a diagnosis of alcoholism will be assessed and their care plan will be updated; and</p> <p>c. upon completion of the immediate corrections, audit and observations will continue by the administrator and director of nursing for 90 days.</p> <p>The IJ was lifted, effective 12/17/24 at 12:50 p.m., when all components of the plan of removal had been completed. The deficient practice remained as isolated with potential for harm to the residents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were free from abuse for two (#1 and #2) of six sampled residents reviewed for abuse. Res #1 was assaulted by Res #2 resulting in stab wounds which required sutures.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The DON identified 48 residents who resided in the facility.</p> <p>Findings:</p> <p>An undated Resident Code of Conduct policy, read in part, The following code of conduct is effective in order to protect the rights and safety of all residents that reside here at [name withheld]. Violation of any of following acts could/will constitute cause for discharge from the facility: Under the influence/possession of alcohol, drugs, non-prescribed narcotics, or in any physical condition making it unsafe for residents or staff within the facility; any form of physical violence including throwing objects toward other residents or staff; unauthorized possession of firearms or other weapons on nursing home property; and any violation of residents/staff rights, including threats of any nature.</p> <p>An Abuse - Reportable Events policy, revised January 2018, read in part, It is the responsibility of all facility staff to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person .When an employee becomes aware of an allegation or suspicion of abuse .the charge nurse will: asses the resident or resident(s) .notify the administrator .begin taking written statements from the person reporting the allegation or suspicion and any witnesses including staff, family, and/or residents .After investigation, administration will analyze the occurrence to determine what changes, if any, are needed to the policies and procedures to prevent further occurrences.</p> <p>1. Res #1 was admitted with diagnoses which included anxiety and paranoid schizophrenia.</p> <p>An annual assessment, dated 05/10/24, documented Res #1 was cognitively intact, had minimal depression, and had not exhibited behaviors.</p> <p>2. Res #2 was admitted with diagnoses which included alcohol abuse and major depressive disorder.</p> <p>A care plan, dated 12/06/21, documented Res #2 often had verbal outbursts towards staff. The care plan documented a goal was the resident would not exhibit behaviors harmful to self or others.</p> <p>An annual assessment, dated 01/15/24, documented the Res #2 was cognitively intact, had mild depression, and had not exhibited behaviors.</p> <p>A nurse note, dated 03/24/24, documented Res #2 was witnessed as intoxicated by staff. The note documented empty alcohol bottles were observed in the resident's room.</p> <p>A nurse note, dated 06/07/24, documented Res #2 verbally threatening physical harm to another resident.</p> <p>A nurse note, dated 10/27/24, documented Res #2 was in another unnamed resident's room yelling and cussing. The note documented Res #2 was removed from the other resident's room, but continued to yell/cuss and attempted to fight the other resident. The note documented Res #2 smelled of alcohol and an empty alcohol bottle was found outside in the courtyard trash can after the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>There was no documentation of an incident report or investigation regarding the above incidents. There was no documentation of Res #2's behaviors documented in the care plan.</p> <p>An OSDH initial incident report form, dated 11/09/24, documented Res #1 stated Res #2 had entered their room while they were asleep and attacked them with a weapon. The report documented Res #1 appeared beaten with a bruised and bleeding face, blood running out of their right arm, and a puncture wound with moderate bleeding on their right foot.</p> <p>A staff witness statement, dated 11/09/24, documented Res #2's room was searched after the incident. The statement documented two small trash cans full of vodka and mouthwash bottles were observed.</p> <p>A hospital emergency room report, dated 11/09/24, documented Res #1 presented to the hospital with stab wounds to the right heel and right forearm, bruising to the left eye, and other various scratches/lacerations. The report documented Res #1 required sutures to close the wounds to the right heel and right forearm.</p> <p>An OSDH final incident report, dated 11/11/24, documented Res #2 was presently in jail and had been charged with first degree assault and battery.</p> <p>On 11/25/24 at 10:50 a.m., the DON stated Res #2 had a history of occasional alcohol abuse while residing in the facility. The DON stated they thought family members or other residents had provided Res #2 with the alcohol. They stated the resident had been counseled regarding the prohibition of alcohol within the facility in the past. The DON stated Res #2 was intoxicated on the day the assault on Res #1 occurred. They stated a pocket knife had been found that was used in the attack. The DON stated the facility was unable to determine which resident had the pocket knife prior to the assault.</p> <p>On 11/25/24 at 12:00 p.m., Res #1 was observed in their room. Res #1 stated they were assaulted with a pocket knife by Res #2 a few weeks ago. Res #1 stated they had a history of not getting along with Res #2. They stated they had never been physically attacked prior to the incident. Res #1 stated they received two wounds that required sutures and feared for their life on the day of the assault.</p> <p>On 11/27/24 at 9:00 a.m., the DON stated no interventions had been initiated or documented in Res #2's care plan to prohibit abusive behavior related to alcohol use. They stated Res #2's past incidents of abusive behavior should have been reported and investigated by the facility.</p> <p>It was documented Res #2 no longer resided in the facility.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46582</p> <p>Based on record review and interview, the facility failed to report an allegation of abuse to OSDH within two hours and failed to report an allegation of resident-to-resident abuse for two (#1 and #2) of six sampled residents reviewed for abuse.</p> <p>The DON identified 48 residents who resided in the facility.</p> <p>Findings:</p> <p>An Abuse - Reportable Events policy, revised January 2018, read in part, It is the responsibility of all facility staff to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person .Abuse-2 hour limit .If the events that cause reasonable suspicion result in serious bodily injury, the report must be made immediately after forming the suspicion (but no later than two (2) hours after forming the suspicion) .All alleged allegations of abuse will be reported to the appropriate state agency and to all other agencies as required by regulation.</p> <p>1. Res #1 was admitted with diagnoses which included anxiety and paranoid schizophrenia.</p> <p>An annual assessment, dated 05/10/24, documented the resident was cognitively intact, had minimal depression, and had not exhibited behaviors.</p> <p>An OSDH initial incident report form, dated 11/09/24, documented Res #1 stated Res #2 had entered their room while they were asleep and attacked them with a weapon. The report documented Res #1 appeared beaten with a bruised and bleeding face, blood running out of their right arm, and a puncture wound with moderate bleeding on their right foot.</p> <p>A fax transmission report documented the incident report was submitted to OSDH on 11/10/24.</p> <p>On 11/27/24 at 8:45 a.m., the DON stated the altercation between Res #1 and Res #2 occurred around lunch time on 11/09/24. They stated the initial OSDH report was not submitted within the required two hour timeframe.</p> <p>2. Res #2 was admitted with diagnoses which included alcohol abuse and major depressive disorder.</p> <p>An annual assessment, dated 01/15/24, documented the resident was cognitively intact, had mild depression, and had not exhibited behaviors.</p> <p>A nurse note, dated 10/27/24, documented Res #2 was in another unnamed resident's room yelling and cussing. The note documented Res #2 was removed from the other resident's room, but continued to yell/cuss and attempted to fight the other resident. The note documented Res #2 smelled of alcohol and an empty alcohol bottle was found outside in the courtyard trash can after the incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no report to OSDH regarding the incident located.</p> <p>On 11/27/24 at 8:30 a.m., the DON stated an allegation of abuse regarding Res #2 on 10/27/24 was not reported to OSDH. The DON stated allegations involving physical abuse were supposed to be reported, but they were not aware verbal allegations should be reported also.</p>		