STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375557	A. Building B. Wing	05/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boyce Manor Nursing Home	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. On 04/29/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents were free from abuse. On 04/29/25 at 4:35 p.m., the Oklahoma State Department of Health verified the existence of an IJ situation. On 04/29/25 at 4:37 p.m., the administrator was notified of the immediate jeopardy situation. An immediate jeopardy template was provided to the administrator. On 05/02/25 at 9:40 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility plan of removal showed: All staff will immediately be educated by facility Administrator on the facility updated policy regarding resident to resident altercations. They will be educated on ensuring the safety and well-being of all residents by preventing, identifying, and managing resident-to-resident altercations. When a resident poses a risk to others, immediate action will be taken, including 1:1 supervision and, if necessary, removal or transfer to a more appropriate setting. Education will be verified using a sign in sheet. Employee names and time of call will be documented. All residents will be reassessed for active behavior issues to determine the risks for future altercations. Physician will be notified if any resident is displaying current behaviors. Interventions will be implemented and care plans updated as needed. A resident safe survey will be conducted on all verbal residents to determine if residents feel safe within the facility. Counseling services will be offered and provided as needed. Non-verbal communication tools such as an emotions picture card will be used to determine if non-verbal residents feel safe. Staff will be trained to recognize signs of discomfort, fear, or distress, and respond in calm, and respectful ways. A QAPI meeting led by the Administrator will be completed immediately to address safety concerns in the facility, abuse prevention, and prevention of resident-to-resident altercations. (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ was lifted, effective 05/02/25 at 1:00 p.m., when all components of the plan of removal had been completed. Resident interviews and staff interviews were completed regarding abuse. A review of the 'Abuse-Reportable Events' updated policy, resident assessments, and staff education regarding abuse was completed. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on observation, record review, and interview, the facility failed to ensure residents were free from abuse for 1 (#2) of 5 sampled residents reviewed for abuse. The administrator identified 44 residents resided in the facility. Findings: An undated facility policy titled RESIDENT CODE OF CONDUCT, 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 THE FOLLOWING ACTS COULD/WILL CONSTITUTE CAUSE FOR DISCHARGE FROM THE FACILITY: .Disorderly, immoral, or indecent conduct, inappropriate language.Any form of physical violence including throwing objects toward other residents or staff.Willful or careless disregard of name calling/racial slurs toward a resident with the intent to cause emotional distress.Any violation of resident/staff rights, including threats of any nature A facility policy titled Abuse-Reportable Events, revised January 2018, read in part, Mental and Verbal Abuse: (as stated in guidance to Surveyor in CMS SOM Section PP F600) Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse is a type of mental abuse and includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend or disability.Physical abuse: (as stated in guidance to Surveyor in CMS SOM Section PP F600) Physical action within the definition of abuse, including, but not limited to, hitting, slapping, punching, and kicking. It also includes controlling behavior through corporal punishment. 1. An undated face sheet showed Res #1 had diagnoses which included paranoid schizophrenia, mood disorder, post-traumatic stress disorder, brief psychotic disorder, and depression. An incident report, dated 09/26/24, showed an allegation of abuse. The report showed Res #1 kicked another resident in the face because they were cussing at them. The report showed local law enforcement escorted Res #1 to the hospital for a psychological evaluation. A progress note, dated 09/26/24, showed the resident returned to the facility from the hospital. The note showed the resident was evaluated by mental health, medications were adjusted, and was not a harm to themselves or anyone else. A quarterly assessment, dated 10/24/24, showed Res #1 had a BIMS of 11 and was moderately impaired cognitively. The assessment showed Res #1 had verbal behaviors toward others. An incident report, dated 10/26/24, showed an allegation of abuse for Res #1. The report showed Res #1 was yelling at another resident, hit them in the head twice, and started kicking them. The report showed Res #1 was placed on observation and was pending admission into an inpatient facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 11/15/24 at 2:37 p.m., showed Res #1 was walking to their room saying, Go ahead and call the police and I'll kill you, you B***h. The note showed the resident was then on the couch mumbling about killing people. A progress note, dated 11/15/24 at 3:30 p.m., showed Res #1 entered a facility office and reported, Im ready to go to the hospital or jail, I keep f****** having these sexual hallucinations and Im sick of it, I'll kill everyone in here!! A progress note, dated 11/15/24 at 8:45 p.m., showed the resident returned to the facility from the emergency room with no new orders. The note showed the resident continued to mumble about killing people and calling staff b*****s and prostitutes. An incident report, dated 01/10/25, showed an allegation of abuse for Res #1. The report showed Res #1 was cussing at another resident. The report showed Res #1 was transferred to inpatient for psychological treatment. A quarterly assessment, dated 01/13/25, showed Res #1 had a BIMS of 13 and was cognitively intact. The assessment showed Res #1 had no physical behaviors and had verbal behaviors that occurred one to three days. An incident report, dated 04/16/25, showed an allegation of abuse for Res #1. The report showed Res #1 punched Res #2 in the face several times. The report showed Res #1 was verbally abusive to Res #2 and proceeded to hit Res #2 after yelling at them unprovoked. The report showed the resident was sent to behavioral health inpatient for a psychological evaluation. A care plan, with updated intervention through 04/17/25, showed interventions put in place after the 01/10/25 incident were relisted interventions from the 10/26/24 incident. The care plan showed interventions listed after the 04/16/25 incident was every 15 minute checks after episodes of physical violence until evaluated by physician and send for mental health evaluation as ordered. On 04/28/25 at 12:20 p.m., the administrator stated when the incident occurred the residents were separated. The administrator stated Res #1 was placed on every 15 minute observations until leaving the facility. On 04/28/25 at 4:05 p.m., the care plan coordinator reviewed Res #1's care plan. The care plan coordinator stated the care plan relisted interventions that had already been implemented regarding the problem identified of agitation and aggressive behavior. The coordinator stated there was no new interventions for the incident occurring on 01/10/25. The coordinator stated new interventions should be put in place if agitation and aggressive behaviors continue. On 04/29/25 at 9:20 a.m., CNA #1 stated Res #1 had behaviors since admission. The CNA stated Res #1 cussed at staff and stated they were going to kill staff. The CNA stated they were aware of Res #1 pushing Res #2 on three different occasions, the last time resulting in Res #1 hitting Res #2 on the head. CNA #1 stated there was no way to know when the resident would have aggressive behaviors, it would just happen. CNA #1 stated they would separate Res #1 from other residents and ask for staff assistance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/29/25 at 3:23 p.m., the DON stated Res #1 was last seen by the psychiatrist was June 2024. The DON stated the physician's office reported Res #1 did not have any scheduled appointments. 2. An undated face sheet showed Res #2 had diagnoses which included paranoid schizophrenia, pseudobulbar affect, and major depressive disorder. The annual assessment, dated 04/03/25, showed Res #2 had a BIMS of 8 and was moderately impaired cognitively. The assessment showed Res #2 did not have verbal or physical behaviors toward others. A progress note, dated 04/16/25, showed Res #2 reported to staff Res #1 was verbally abusing them unprovoked. The note showed Res #2 reported Res #1 hit them in the face and right ear multiple times. The note showed the local police department was called and staff assisted with Res #1 being taken out of the facility for evaluation of aggressive behaviors. The care plan, updated 04/16/25, showed Res #2 was hit by another resident and she may be at risk for fear. The interventions showed to allow the resident to verbalize her feelings and to reassure the resident they were safe. On 04/29/25 at 9:00 a.m., Res #2 was sitting on the side of their bed wearing a jacket and watching television. On 04/29/25 at 9:02 a.m., Res #2 stated they were currently not afraid. The resident stated they were afraid of Res #1 and hoped they did not return to the facility. The resident stated in a tearful voice Res #1 might kill them.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facilty failed to review and revise the care plan for 1 (#1) of 5 sampled residents whose care plans were reviewed. The administrator identified 44 residents resided in the facility. Findings: An undated face sheet showed Res #1 had diagnoses which included paranoid schizophrenia, mood disorder, post-traumatic stress disorder, brief psychotic disorder, and depression. An incident report, dated 09/26/24, showed an allegation of abuse. The report showed Res #1 kicked another resident in the face because they were cussing at them. The report showed local law enforcement escorted Res#1 to the hospital for a psychological evaluation. An incident report, dated 10/26/24, showed an allegation of abuse for Res #1. The report showed Res #1 was yelling at another resident, hit them in the head twice, and started kicking them. The report showed Res #1 was placed on observation and was pending admission into an inpatient facility. An incident report, dated 01/10/25, showed an allegation of abuse for Res #1. The report showed Res #1 was cussing at another resident. The report showed Res #1 was transferred for inpatient treatment. A care plan, with updated intervention through 04/17/25, showed interventions put in place after the 01/10/25 incident were relisted interventions from the 10/26/24 incident. The care plan showed interventions listed after the 04/16/25 incident was every 15 minute checks after episodes of physical violence until evaluated by physician and send for mental health evaluation as ordered. On 04/28/25 at 4:05 p.m., the care plan coordinator reviewed Res #1's care plan. The coordinator stated the care plan relisted interventions that had already been implemented regarding the problem identified of agitation and aggressive behavior. The coordinator stated there was no new interventions for the incident occurring on 01/10/25. The coordinator stated new intervention should be put in place if agitation and aggressive behavior continue.