STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37E624	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Callaway Nursing Home	1300 West Lindsey Sulphur, OK 73086

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 34333 Based on record review and interview, the facility failed to ensure a refund was completed within 30 days from the resident's date of discharge for one (#8) of one sampled resident reviewed for timely refunds. The administrator identified one resident in the past six months who required a refund. Findings: A Resident Funds policy, not dated, documented in part, Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days of the resident's funds, and a final accounting of those funds, to the resident .in accordance with State law. A physician's order, dated 01/29/24, documented Resident #8 was to be discharged to another long term care facility. A progress note, dated 01/29/24 at 1:00 p.m., documented Resident #8 was transferred to another long term care facility via private car with their family member. Refund check #5426 in the amount of $328.00, dated 03/25/24, documented a refund for Resident #8 was made to the facility where the resident was transferred. Refund check #5422 in the amount of $1,024.00, dated 03/26/24, documented a refund for Resident #8 was made to the Social Security Administration. On 11/15/24 at 10:00 a.m., the administrator reported the business office manager no longer worked in the facility. The administrator reported they did not know why there was a delay in completing the refund for Resident #8.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34333 Based on record review and interview, the facility failed to report allegations of abuse to the State Agency (OSDH) and other officials as required for two (#1 and #5) of two sampled residents reviewed for abuse. The administrator identified two allegations of abuse in the past 120 days. Findings: An undated Allegations of Abuse, Neglect, Exploitation or Mistreatment policy, read in part, Purpose: Ensure alleged violations related to mistreatment, exploitation, neglect, or abuse .the results of all investigations are thoroughly investigated and reported to the proper authorities within required time frames .reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. Resident #1 had diagnoses which included Huntington's disease, depression, vascular dementia, mood disorder, and anxiety. A care plan for Resident #1, dated 07/22/24, documented the resident had a diagnosis of psychosis with physical aggression. The care plan documented the resident required assistance with activities of daily living. An MDS assessment for Resident #1, dated 09/18/24, documented the resident was severely impaired with cognition. A handwritten statement signed by CNA #1, dated 10/30/24, documented an incident in which the CNA entered Resident #1's room during routine rounds. The statement documented the resident had a bowel movement and became aggressive with the CNA while they were trying to clean and change the resident. The statement documented the nurse on duty witnessed the resident trying to kick the CNA and did not offer assistance. The statement documented Resident #1 put themselves on the floor while the CNA was changing their linens. The statement documented the CNA eventually got the resident back in bed, covered the resident, and continued their rounds. A typed statement by the previous BOM, dated 11/07/24, documented the BOM had notified the receiver on 10/31/24 of an allegation of abuse involving Resident #1 and CNA #1. The statement documented CNA #3 had reported the incident to the BOM due to feeling the incident was not being investigated. The statement documented the receiver requested the administrator speak to CNA #3 the following day. On 11/13/24 at 12:45 p.m., Resident #1 was observed lying in bed in their room with a blanket pulled over their head. The resident responded only with one word responses. The resident stated, yes, when asked if they were doing okay and stated, yes, when asked if staff treated them well. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 4:28 p.m., the ADON reported the night nurse reported an incident involving Resident #1 and CNA #1, in which the resident was found with scratches to their chest and neck area after the CNA had provided care. The ADON reported they assessed the resident and the administrator accompanied them to interview the resident. The ADON reported Resident #1 denied anyone had hurt them and it appeared the resident might have scratched themselves. The ADON reported they interviewed other residents, and none voiced complaints related to CNA #1, but there was no documentation of the interviews. The ADON stated they pulled the camera footage and did not see anything concerning with CNA #1's appearance or behavior following care provided to Resident #1. The ADON stated the charge nurse would normally initiate an incident report and if it was an abuse allegation, it would be reported to the State Agency, but they were not aware of an incident report being completed. On 11/14/24 at 5:30 a.m., CNA #3 reported they had observed scratch marks on Resident #1 after CNA #1 came out of the resident's room the morning of 10/31/24. The CNA stated they reported their concerns to the charge nurse on duty, an unnamed agency nurse. On 11/14/24 at 5:45 a.m., CNA #1 reported on the morning of the alleged incident with Resident #1, they had checked the resident and found them incontinent of a large bowel movement. The CNA stated the resident was being very combative and ended up putting themselves on the floor. The CNA reported they finally got the resident cleaned up and settled in bed, but received no assistance from other staff. The CNA reported staff made the allegation against them, but never offered to help the CNA with Resident #1. The CNA reported the incident happened on a Friday night shift and they were off until the following Wednesday. The CNA reported they gave their statement and talked with the administrator. A typed summary of the incident, without a date or signature, was provided by the administrator. The summary documented following the allegation of abuse, Resident #1 had been assessed for injuries and CNA #1 had been interviewed. The summary documented there were no witnesses to the incident and other residents were interviewed, but there was no documentation related to resident interviews. The summary documented a statement was never received from CNA #3. An incident report was not completed and the alleged allegation of abuse was not reported to OSDH or other required officials. 2. Resident #5 was admitted with diagnoses which included schizophrenia, peripheral vascular disease, Type 2 diabetes, bipolar disease, depression, and pain. A MDS assessment, dated 04/12/24, documented the resident was moderately impaired with cognition. A Grievance/Complaint Form, with a complaint date of 11/03/24, documented no resident's name, but was reported to be for Resident #5. The form documented the previous BOM took the complaint on 11/04/24, when the resident reported a CMA had cursed at the resident and almost hit them with the break room door. The form documented the administrator talked with the CMA and called the receiver for a phone interview with the CMA. The form documented the CMA was suspended for two days while an investigation was completed. A typed summary, signed by the administrator and dated 11/05/24, documented the administrator had received a complaint from a resident stating a CMA called them a derogatory term. The summary documented the administrator spoke with the CMA, reviewed cameras, and reviewed statements received from other employees. The summary documented the claim was unsubstantiated. There was no incident report and the allegation of abuse was not reported to OSDH or other required officials. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 1:30 p.m., Resident #5 reported CMA #1 was suspended for two days after the resident complained to the administrator the CMA had cursed at them. The resident was asked if they felt safe and they stated, Yes. On 11/15/24 at 11:20 a.m., the administrator reported they did not complete an incident report for the allegations of abuse. The administrator stated the incidents were not reported to OSDH or other required officials, as the administrator determined the allegations were unsubstantiated.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34333 Based on record review and interview, the facility failed to thoroughly investigate allegations of abuse and report the results of the investigations for two (#1 and #5) of two residents reviewed for abuse. The administrator identified two allegations of abuse in the past 120 days. Findings: An undated Allegations of Abuse, Neglect, Exploitation or Mistreatment policy, read in part, Purpose: Ensure alleged violations related to mistreatment, exploitation, neglect, or abuse .the results of all investigations are thoroughly investigated and reported to the proper authorities within required time frames .reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. Resident #1 had diagnoses which included Huntington's disease, depression, vascular dementia, mood disorder, and anxiety. A care plan for Resident #1, dated 07/22/24, documented the resident had a diagnosis of psychosis with physical aggression. The care plan documented the resident required assistance with activities of daily living. A MDS assessment for Resident #1, dated 09/18/24, documented the resident was severely impaired with cognition. A handwritten statement signed by CNA #1, dated 10/30/24, documented an incident in which the CNA entered Resident #1's room during routine rounds. The statement documented the resident had a bowel movement and became aggressive with the CNA while they were trying to clean and change the resident. The statement documented the nurse on duty witnessed the resident trying to kick the CNA and did not offer assistance. The statement documented Resident #1 put themselves on the floor while the CNA was changing the their linens. The statement documented the CNA eventually got the resident back in bed, covered the resident, and continued their rounds. A typed statement by the previous BOM, dated 11/07/24, documented the BOM had notified the receiver on 10/31/24 of an allegation of abuse involving Resident #1 and CNA #1. The statement documented CNA #3 had reported the incident to the BOM due to feeling the incident was not being investigated. The statement documented the receiver requested the administrator speak to CNA #3 the following day. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 4:28 p.m., the ADON reported the night nurse reported an incident involving Resident #1 and CNA #1, in which the resident was found with scratches to their chest and neck area after the CNA had provided care. The ADON reported they assessed the resident and the administrator accompanied them to interview the resident. The ADON reported Resident #1 denied anyone had hurt them and it appeared the resident might have scratched themselves. The ADON reported they interviewed other residents, and none voiced complaints related to CNA #1, but there was no documentation of the interviews. On 11/14/24 at 5:30 a.m., CNA #3 reported they had observed scratch marks on Resident #1 after CNA #1 came out of the resident's room the morning of 10/31/24. The CNA stated they reported their concerns to the charge nurse on duty, an unnamed agency nurse. On 11/14/24 at 5:45 a.m., CNA #1 reported on the morning of the alleged incident with Resident #1, they had checked the resident and found them incontinent of a large bowel movement. The CNA stated the resident was being very combative and ended up putting themselves on the floor. The CNA reported they finally got the resident cleaned up and settled in bed, but received no assistance from other staff. The CNA reported staff made the allegation against them, but never offered to help the CNA with Resident #1. The CNA reported the incident happened on a Friday night shift and they were off until the following Wednesday. The CNA reported they gave their statement and talked with the administrator. A typed summary of the incident, without a date or signature, was provided by the administrator. The summary documented that following the allegation of abuse, Resident #1 had been assessed for injuries and CNA #1 had been interviewed. The summary documented there were no witnesses to the incident and other residents were interviewed, but there was no documentation related to resident interviews. The summary documented a statement was never received from CNA #3. 2. Resident #5 was admitted with diagnoses which included schizophrenia, peripheral vascular disease, Type 2 diabetes, bipolar disease, depression, and pain. A MDS assessment, dated 04/12/24, documented the resident was moderately impaired with cognition. A Grievance/Complaint Form, with a complaint date of 11/03/24, documented no resident's name, but was reported to be for Resident #5. The form documented the previous BOM took the complaint on 11/04/24, when the resident reported a CMA had cursed at the resident and almost hit them with the break room door. The form documented the administrator talked with the CMA and called the receiver for a phone interview with the CMA. The form documented the CMA was suspended for two days while an investigation was completed. A typed summary, signed by the administrator and dated 11/05/24, documented the administrator had received a complaint from a resident stating a CMA called them a derogatory term. The summary documented the administrator spoke with the CMA, reviewed cameras, and reviewed statements received from other employees. There was no documentation related to interviews with other residents. The summary documented the claim was unsubstantiated. On 11/15/24 at 11:20 a.m., the administrator reported they did not complete an incident report or document all of their findings related to a thorough investigation of the allegations of abuse.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 34333 Based on record review and interview, the facility failed to electronically transmit completed MDS data to the CMS system within 14 days of completion. The administrator identifed 47 residents resided in the facility. Findings: An undated MDS policy, read in part, Policy Objectives .Maintain compliance with quality reporting requirements .Submit MDS data to the CMS database as required .Monitor submission compliance and address issues proactively .Submit MDS data to CMS via the Quality Improvement and Evaluation System within the required timeframes. On 11/13/24 at 4:00 p.m., review of MDS data documented MDS assessments were not submitted from 05/01/24 to 07/08/24. On 11/13/24 at 4:11 p.m., a phone interview was conducted with LPN #1. The LPN reported they had started working for the facility in July 2024 as the MDS coordinator. The LPN reported the facility was having difficulty transmitting MDS data and the issues had just recently been resolved. The LPN reported they were able to transmit a batch of approximately 200 MDS assessments on 10/08/24.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34333 Based on record review and interview, the facility failed to have a registered nurse on duty for at least eight consecutive hours a day, seven days a week, and failed to have a director of nursing on a full time basis. The administrator identified 47 residents resided in the facility. Findings: An undated Registered Nurse policy, read in part, .Ensure that a Registered Nurse is available for supervision in the facility .Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week .Except when waived, the facility must designate a registered nurse to serve as the director of nursing on a full-time basis. A review of staff time cards and schedules for August 2024 documented no RN or DON coverage on 08/01/24, 08/02, 08/05, 08/06, 08/07, 08/08, and 08/09/24. A review of staff time cards and schedules for September 2024 documented the DON worked 09/23/24, 09/24, 09/25, 09/26, 09/27, and 09/30/24. No other RN coverage was documented. A review of staff time cards and schedules for October 2024 documented the last day the DON worked was 10/09/24. There was no documentation of RN coverage for 10/11/24, 10/14, 10/15, 10/18, 10/21, 10/22, 10/23, 10/24, 10/25, 10/28, and 10/30/24. On 11/14/24 at 11:05 a.m., the ADON reported the facility had RN coverage on most weekends. The ADON was asked if the RN covered any of the DON responsibilities. They stated they did not think so. The ADON reported they were not aware of any staffing waivers. On 11/14/24 at 12:30 p.m., the administrator provided time card reports which documented the previous DON had last worked on 10/09/24. The administrator reported RN #1 worked most weekends and occasionally worked a night shift. The administrator reported RN #1 did not cover any DON responsibilities. The administrator reported they expected the new DON to start the following week.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34333 Based on observation and interview, the facility failed to grant access to the EMR for the survey team. The administrator identified 47 residents resided in the facility. Findings: On 11/13/24 at 12:15 p.m., surveyors entered the facility to conduct complaint investigations. The administrator reported the facility utilized an EMR and staff members were observed to utilize the EMR. The administrator was informed surveyors would require access to the EMR for record review during the investigations. On 11/13/24 at 3:50 p.m., the administrator reported they were informed by the receiver their company did not provide access of the EMR to surveyors. The administrator was informed they were required to grant access to surveyors to avoid impeding the survey process. On 11/13/24 at 4:00 p.m., the receiver reported they did not grant access of the EMR to surveyors, but would print off any requested documentation. The receiver was informed they were required to grant access of the EMR to surveyors, but the receiver refused to comply.