OKLAHOMA
State Department
of Health

Delivery Via Email: lburrell@thecommons-umrc.com; MBrinker@thecommons-umrc.com

July 21, 2021

CCN: 375488
Cycle Start Date: July 1, 2021
Survey Event ID: C7JI11

Ms. Ladeana Burrell, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

Dear Ms. Burrell:

On **July 1, 2021,** agents from our office concluded a Covid-19 Focused survey in conjunction with a complaint investigation at The Commons to determine if your facility was in compliance with the Federal requirements for nursing home participation in the Medicare and/or Medicaid programs. This inspection found the most serious deficiency(ies) in your facility to be:

- Deficiency level "K"; a pattern of deficiencies that constitutes **immediate jeopardy** to resident health and safety, as evidenced by the CMS-2567, whereby significant corrections are required.

Although the survey team has determined that your facility **removed the immediate jeopardy** to resident health and safety, your facility has **not yet achieved substantial compliance** with the federal participation requirements for nursing facilities in the Medicare and Medicaid programs.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Determination of Substandard Quality of Care

The following deficiencies have been determined to constitute substandard quality of care.

F0600 -- S/S: K -- 483.12(a)(1) -- Free from Abuse And Neglect;
F0607 -- S/S: K -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies;
F0609 -- S/S: K -- 483.12(c)(1)(4) -- Reporting of Alleged Violations;
F0610 -- S/S: K -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation

In accordance with sections 1819(f) and/ or 1919(f) of the Social Security Act and regulations at 42 CFR Part 498, the Oklahoma State Department of Health is providing

notice as authorized by the Dallas Regional Office that the Centers for Medicare and Medicaid Services (CMS) has made a determination of Substandard Quality of Care which led to an extended or partial extended survey. This will result in the State withdrawing your Nurse Aide Training and Certification program (NATCEP) for two years.

Statutory provisions at 1819(g)(5)(c) and/or 1919(g)(5)(c) of the Social Security Act and the federal regulation at 42CFR488.325(h), require the Oklahoma State Department of Health to issue notice to the attending physician of each resident who was identified as having been subject to substandard quality of care.

You are required to provide the following information to the Oklahoma State Department of Health within ten (10) working days of your receipt of this letter:

> The name and address of the attending physician of each resident found to have been subject to substandard quality of care. A list of the affected residents is attached.

Pursuant to §488.325(g), your failure to provide to the Oklahoma State Department of Health within ten (10) working days the name and address of the attending physician for each of the listed residents will result in termination of participation or imposition of alternative remedies

In addition, 1819(g)(5)(c) and/or 1919(g)(5)(c) of the Social Security Act and the federal regulations at 42CFR488.325(h) require the Oklahoma State Department of Health to issue notice of the substandard quality of care to the Oklahoma State Board of Examiners of Long Term Care Administrators (OSBELTCA). The Oklahoma State Department of Health is issuing notice of the substandard quality of care to OSBELTCA and including a copy of this letter and the enclosed CMS 2567. If you need more information about OSBELTCA's handling of this notice, please contact OSBELTCA directly.

Plan of Correction (PoC)

You must submit an acceptable plan of correction within ten calendar days of receipt of the complete CMS-2567. An acceptable PoC shows a provider's willingness and ability to achieve and maintain compliance and to provide residents the care and services they need. An acceptable PoC demonstrates correction has been, or will be achieved and makes the provider's allegation of compliance credible. An acceptable PoC is required before a revisit (to verify correction) will be made. To be considered acceptable, your PoC must contain the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. This is part of your quality assurance plan. At the revisit, the quality assurance plan shall be reviewed to determine the earliest date of compliance. If there is no finding of continuing non-compliance, **evidence of quality assurance being implemented will be required to establish a correction date earlier than the date of the revisit.**

- An acceptable completion date for correction of each deficiency. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

In addition, the PoC must contain only a Plan of Correction OR evidence refuting each deficient practice in a deficiency citation. It must be specific and realistic, stating exactly how the deficiency will be or was corrected.

Please submit your plan of correction under the second column on the Form CMS-2567. Address each deficiency, and include the month, day, and year of the expected completion date in the third column. Sign, date, and indicate your title in the appropriate blocks on page 1 of the form. Return the CMS-2567 with the PoCs to:

LTCEnforcement@health.ok.gov

OR

Long Term Care Enforcement Division
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave., Ste. 1702
Oklahoma City, OK 73102-6406

If you fail to submit an acceptable PoC by the due date, we may recommend (to the CMS Regional Office) termination of your provider agreement [42CFR488.456(b)(1)(ii)].

OKLAHOMA
State Department
of Health

Optional Denial of Payment for New Admissions (ODPNA)

Based on deficiencies cited during this survey, and as authorized by Centers for Medicare & Medicaid Services (CMS) Dallas Regional Office, **this is formal notification of Optional Denial of Payment for New Admissions (ODPNA). ODPNA will start August 5, 2021.** Your State Medicaid Agency will be notified by copy of this letter. The CMS Regional Office will notify your Medicare payer. The Medicare and Medicaid programs will make no payment for residents admitted on or after the ODPNA effective date. ODPNA will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.]

PROPOSED Remedies

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, we will provide you with a separate formal notification of that determination.

Based on the findings of noncompliance the Oklahoma State Department of Health is recommending that the following penalties be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office:

- **DENIAL OF PAYMENT FOR NEW MEDICARE/MEDICAID ADMISSIONS**: **We are recommending a discretionary Denial of Payment for New Admissions (DPNA) effective August 5, 2021** in accordance with the statutory provisions at 1819(h) and/or 1919(h) and the federal regulation at 42 CFR 488.417(b).

- **TERMINATION OF PROVIDER AGREEMENT** if the facility is not in substantial compliance within six months after this inspection.

- **Civil Money Penalty:** In accordance with CMS enforcement policies, a Civil Money Penalty (CMP) is recommended for the deficiencies cited during the **July 1, 2021** survey. The CMS will notify you if a CMP is imposed, the amount of the CMP, and the dates the CMP is in effect. The CMS will notify you of your rights for all remedies that are imposed.

Filing An Appeal

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of Nurse Aide Training and Competency Evaluation program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U. S. Department of Health and Human Services,

Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, *et seq.* You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). **A written request for a hearing must be filed no later than September 18, 2021 (60 days from the date of receipt of this letter).** Such written request should be made directly to:

U. S. Department of Health and Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

If you prefer, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System (DAB E-File) website: *https:/dab.efile.hhs.gov*. When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The email address and password given during registration must be entered on the login screen at: *https:/dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59 p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at *https://dab.efile.hhs.gov/appeals/to_crd_instructions*.

In addition, please forward a copy of your request to:

OKLAHOMA
State Department
of Health

CMS Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Survey and Certification
ATTN: Leena Volmer
1301 Young Street; Room 827
Dallas, Texas 75202

Additional Triggers for Loss of Approval of Nurse Aide Training and Competency Evaluation Program (NATCEP) and Competency Evaluation Program (CEP)

Please note that §1919(f)(2)(B) also prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) and Competency Evaluation Programs (CEP) offered by or in any facility which within the previous two years:

42 CFR §483.151(b)

(2) The State may not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years—

(i) In the case of a skilled nursing facility, has operated under a waiver under section 1819(b)(4)(C)(ii)(II) of the Act;

(ii) In the case of a nursing facility, has operated under a waiver under section 1919(b)(4)(C)(ii) of the Act that was granted on the basis of a demonstration that the facility is unable to provide nursing care required under section 1919(b)(4)(C)(i) of the Act for a period in excess of 48 hours per week;

(iii) Has been subject to an extended (or partial extended) survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act;

(iv) Has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) of 1919(h)(2)(A)(ii) of the Act of not less than $10,697 as adjusted annually under 45 CFR part 102; or

(v) Has been subject to a remedy described in sections 1819(h)(2)(B) (i) or (iii), 1819(h)(4), 1919(h)(1)(B)(i), or 1919(h)(2)(A) (i), (iii) or (iv) of the Act.

Informal Dispute Resolution

In accordance with 42 CFR §488.331 and §7212 of the State Operations Manual (SOM), you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire

a copy of the ODH Form 833 and the Oklahoma IDR Process for Medicare/Medicaid Certified Facilities.

The IDR request must be submitted within ten calendar days from receipt of the Statement of Deficiencies (CMS-2567). This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request Form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave., Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Scope and severity assessments of deficiencies with the exception of scope and severity assessments that constitute substandard quality of care (SQC) or immediate jeopardy (IJ);
- Remedy (ies) imposed by the Department;
- Alleged failure of the survey team to comply with a requirement of the survey process;
- Alleged inconsistency of the survey team in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process.

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, telephone at (405) 426-8200.

If you have any questions, please contact me at (405) 426-8200.

OKLAHOMA
State Department
of Health

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
Date: 2021.07.21 08:30:18 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

C: Executive Director, Oklahoma State Board of Examiners for Long Term Care Administrators

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **The Commons**
Address: **301 South Oakwood Road**
City, State, Zip: **Enid, OK, 73607**
Provider #: **375488**
Complaint #: **OK00056619**
Investigation Date(s): **06/21-06/25/21 and 06/28-07/01/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure medications were administered according to physicians' orders.	**S**
2. The facility failed to notify resident's representative or interested family with a significant change in condition.	**US**
3. The facility failed to assess and monitor residents with fractures/with a sling to prevent skin breakdown.	**US**

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 06/21/2021 at 5:10 p.m.

A sample of five residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 684 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to notify the residents' legal representative or interested family with a significant change in condition was conducted.

A review of records documented residents' legal representatives had been notified when a resident had a change in condition.

Residents were asked if staff notified their families when they had a change in condition. They all stated they did. Staff members were asked when they would notify a residents' family member. They stated they would notify them with any changes.

At the time of the investigation, there was no deficient practice related to notifying the residents' legal representative or interested family with a significant change in condition.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to assess and monitor residents with fractures/with a sling to prevent skin breakdown was conducted.

A review of records documented skin assessments had been conducted routinely. They documented no wounds had developed as a result of slings.

Residents were asked if staff assessed their skin. They all stated they did.

Staff members were asked how they ensured residents with a sling did not get skin breakdown. They stated resident skin assessments were conducted daily and as needed.

At the time of the investigation, there was no deficient practice related to the facility failing to assess and monitor residents with fractures/with a sling to prevent skin breakdown.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation #2 and #3. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

R. Belt RN

Rae Belt, RN, CHFS

Date report completed: 07/01/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **The Commons**
Address: **301 South Oakwood Road**
City, State, Zip: **Enid, Ok, 73706**
Provider #: **375488**
Complaint #: **OK00056688**
Investigation Date(s): **06/21-06/25/21 through 06/28-07/01/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to provide care as ordered by the physician.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 06/21/2021 at 5:10 p.m.

A sample of three residents including any identified residen, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag F684 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

R Belt RN

Rae Belt, RN, CHFS

Date report completed: 07/01/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **The Commons**
Address: **301 South Oakwood Road**
City, State, Zip: **Enid, OK, 73706**
Provider #: **375488**
Complaint #: **OK00057230**
Investigation Date(s): **06/21-06/25/21 and 06/28-07/01/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to protect residents' right to privacy.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 06/21/2021 at 5:10 p.m.

A sample of six residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag F583 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Other Concerns:

Investigations were conducted related to abuse. See the Statement of Deficiencies, Form 2567, Tag F600, F607, F609, F610 and F835 for details.

Thank you for bringing these concerns to our attention.

Rae Belt By E&Rn.

Rae Belt, RN, CHFS

Date report completed: 07/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375488	A. BUILDING _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On June 21st, 2021 through June 25th, 2021 and June 28th, 2021 through July 1st, 2021, the Oklahoma State Department of Health conducted a complaint investigation for complaints #OK00056688, OK00057230 and #OK00056691 and a COVID-19 Focused Survey to determine if the facility was in compliance with Federal requirements related to the complaint and implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375488	A. BUILDING _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1	F 580		

is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, it was determined the facility failed to notify the physician of a change in the resident's condition for one (#7) of four sampled residents reviewed for notification.

The facility identified 95 residents resided in the facility.

Findings:

Resident #7 admitted with diagnoses which included convulsions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375488	A. BUILDING _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 The resident's care plan, dated 11/11/19, documented, "...is at risk for injury d/t [due to] seizures/convulsions ...Monitor/record time and duration, type of movement. Report to physician..." Nurses' progress notes, dated 02/06/21, documented the resident had a seizure at 4:00 a.m. and again at 6:06 a.m. There was no documentation the physician had been notified of either seizure. On 06/28/21 at 2:45 p.m., the administrator was asked if the physician was notified of the seizure activities. She stated it didn't look like it according to documentation. At 3:28 p.m., the assistant director of nursing stated the physician had not been notified.	F 580		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken),	F 583		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375488	A. BUILDING _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 3	F 583		

written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, it was determined the facility failed to ensure the resident's privacy was protected for one (#1) of one sampled resident who was reviewed for privacy.

The facility identified 95 residents resided in the facility.

Findings:

Resident #1 was admitted with diagnoses which included Parkinson's disease.

A quarterly assessment, dated 06/12/21, documented the resident's cognition was severely impaired.

A state incident report, dated 06/12/21,

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F 583	Continued From page 4 documented, "...Allegation of a staff member posting a video of a resident on the staff members personal social media. Investigation started [and] in process..." A document, titled "Final State Report," dated 06/12/21, documented, "...an incident was reported...staff member recorded [resident] tying her shoe for her and she posted the video on her personal Snap Chat story..." On 06/29/21 at 11:12 a.m., the director of nurses was asked how the facility protects the resident's privacy. She stated by not giving any information to anyone that doesn't have a right to see it. She was asked if the resident's privacy was protected when a video was taken of him. She stated, "No."	F 583		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		

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On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents (#5,6,7,8, and #9) were free from abuse.

A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse.

An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured. The residents were not protected as the staff member was allowed to work.

The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse.

Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made.

Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going.

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At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 11:28 a.m., the Administrator (ADM) was notified of the IJ.

An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

"Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21...

An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying,

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Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed."

On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect.

The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern.

Based on observation, record review, interviews, it was determined the facility failed to ensure residents were free from abuse and neglect for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse and neglect. The facility also failed to have an environement that ensured staff were free to report allegations of abuse and negelct without fear of retaliation.

The facility identified 95 residents resided in the facility.

Findings:

An employee handbook, dated 03/2020, documented, "...The Company actively works to prevent...abuse by...Protecting employees...from adverse action when they do the right thing and report any genuine concern

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regarding...abuse...The Company strictly prohibits retaliation, in any form, against any individual making a report, complaint, or inquiry in good faith...Abuse & Neglect Policy...NO FORM OF ABUSE OR NEGLECT IS TOLERATED AND MUST BE REPORTED IMMEDIATELY...FAILURE TO REPORT ABUSE OR NEGLECT, EVEN SUSPECTED ABUSE OR NEGLECT, LEAVES YOU RESPONSIBLE FOR THE SITUATION...Bullying & Harassment...The Commons will not, in ay instance, tolerate bullying or harassing behavior. Employees found in violation of this policy will be disciplined, up to and including termination...examples of bullying and/or harassment: Verbal...ridiculing...humiliating...Shouting, raising voice at in individual in public...Telephone Calls & Cell Phones...Cell phone use is limited to break time only...Code of Conduct ...Disciplinary Procedures...Violations of any of these rules...may result in corrective action being taken, up to and including discharge...Physical or mental abuse of the residents or failure to report physical or mental abuse by others...Social Media...Employees must not post confidential...about...clients...Employees should not disparage any person...based on...disability..."

An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The

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Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route

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every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally everyday, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurances, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family

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called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications.

The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

The employee continued to work during the investigaion of the alleged negelct.

The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld.

On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the

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conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader.

At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that witheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me cause when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

2. Resident #7 was admitted to the facility with

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diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The allegation of abuse was not reported to the admininistraor until the next day after it occured.

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair

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outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

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A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

An Oklahoma Board of Nursing complaint form,

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submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred.

The facility failed to protect residents from further abuse during the investigation.

The facilty failed to report the allegation timely to the administrator and a through investigation was not completed.

On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my

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hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were inserviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employeed by the faciltiy.

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3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I

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yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA

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#2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."

CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

The facility had documented the allegation was unsubstantited even through there was a witness, and failed to complete a thourgh investigation by interviewing other staff members and residents.

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On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of

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the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved.

4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.

A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.

A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.

A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..."

On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."

At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy

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lady who says she was raped and I didn't send the two ladies home."

An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached...

A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..."

A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She can not really describe them...Staff has been going in her room with 2 people and then after

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being told by Administration we have been going in with 2 Licensed nurses..."

A statement from CNA #5, dated 06/28/21 ay 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..."

A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..."

A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..."

On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us."

The ADM was asked how many staff had worked with the resident last night. She stated, "Two."

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She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN.

The ADM was asked how she proteceted the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."

On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.

Reviewed with the ADM her interview from 06/28/21, where she reported the charge nurse texted herthat the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated, "Yes", reffering to the discrepances in information. She was asked if she was concerned about the

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discrepancies. She stated, "What does the report say." Reviewed her interview from yesterday that she stated the nurse reported to her the description the resident stated "looks like us" and the report documented the resident was unable to describe the perpetrator. There was no response given.

The two employees remained working at the facility all night after the allegation of rape and the resident identifying the RN and CNA as the ones who raped her.

The facility failed to have an accurate a through investigation into the allegations.

5. Resident #6 had diagnoses which included Huntington's disease.

A resident assessment, dated 02/15/21, documented the resident's cognition was intact.

A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m.

A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..."

An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet,

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documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.

There was no documentation in the resident's clinical record of the alleged abuse against the resident.

The facility did not report the allegation of abuse to the Oklahoma State Department of Health within the required two hours.

A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m.

A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the following...For 5 day and final reports, please include a summary of the investigation...Face Sheet attached, investigation attached..."

Safe surveys were conducted with three residents on 03/23/21. The following questions were asked:
1. Do you feel like when you turn on your call light, you get everything you need taken care of?
2. Have you heard staff using inappropriate language?
3. Has staff ever yelled or spoken harsh to you?
4. If you feel like your needs aren't met, do you know who to talk to?
No negative answers were documented.

LPN #1 reamained working after the allegation of verbal abuse had been made and throughout the invesitigation.

There were no written staff statements from the reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The

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administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur.

On 06/24/21 at 1:35 p.m., the DON was asked when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation had been completed. She stated the investigation was completed, but the documentation was not. She stated there was conflict between the activity aide and LPN #1. She was asked if LPN #1 had worked during the investigation. The DON stated, "Yes." She was asked what was put in place to prevent reoccurrence and to protect the residents. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. She stated the complainant was re-interviewed and had a discussion about how the allegation could not have occurred. She was asked if was reported timely. She stated she was not notified until the next day.

On 06/25/21 at 3:09 a.m., the activity aide was asked if she recalled the incident on 03/21/21. She stated she did. She stated LPN #1 had cursed at the resident when she reported to her that he had fallen. She stated, LPN #1 said, "Jesus F*** Christ, [Resident]. Really." She was asked who she had reported the incident to. She stated she reported it to her supervisor that day and that her supervisor was going to call the

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administrator.

The facility failed to protect residents during an investigation of abuse, thourghly invesitgate an allegation of abuse and failed to report the allegation to the administrator and approriate agencies timely.

6. Resident #1 was admitted to the facility with diagnoses which included Parkinson's disease.

A quarterly resident assessment, dated 06/12/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 06/12/21, documented, "...Resident...Involved...[resident #1]...Incident Type...Allegations of Abuse/Mistreatment..."

A notification of nurse aide report, dated 06/12/21, documented, "...CNA #1...was employee terminated...Yes...termination date 06/12/2021...ALLEGATIONS/FACTS OF ABUSE...On June 12, 2021 at approximately 11:00 am a incident was reported by a staff member in which a Resident [resident #1] was involved. CNA #1 recorded [resident #1] tying her shoe for her and she posted the video on her personal SnapChat story with the caption "But does your resident ever tie your shoes for no reason??" The caption was followed by a laughing face emoji and heart emoji. [CNA #1] was terminated for mistreatment of a resident and violation of our facility Social Media Policy..."

On 06/23/21 at 8:59 a.m., the DON was asked when were the staff inserviced related to cell phone use and social media. She stated they are

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inserviced when they are hired during orientation. She was asked what the cell phone and social media restrictions were. She stated not to post anything about residents, the facility and no pictures. She stated staff were only to have their cell phones in break room and not to have a cell phone in resident areas. The DON was asked if the staff were inserviced related to the incident. She stated they planned on inservicing staff in July. She stated they were going to in June but they had to wait for their board's approval of the updated policy. She was asked if any corrective measures were put in place to protect the residents from further occurrence. She stated they weren't.

On 06/24/21 at 2:00 p.m., the DON was asked what staff were interviewed as part as their investigation. She stated CMA #1. She stated they did not interview other staff who were working that same shift. She was asked if other staff members were not interviewed, was a thorough investigation completed. She stated, "Guess not." She was asked how residents were protected from further occurrence. She stated they did not initiate any new interventions.

A thorough investigation had not been completed related to this incident. As a result, it is unknown if any other staff or residents had been involved.

7. A grievance concern form, dated 07/24/20, documented, "...Person Filing Complaint...[CMA #4]...Nature of the Concern...Weekend staff would yell at [Resident] when she came out of her room to go back, would walk her back, close her door after she went in [and] hold the door so she couldn't open it. She eventually came out again, the Med [medication] aide grabbed her walker,

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yanked it around [and] said "I'm tired of this shit. When [CMA #4] said anything, she was bullied [and] retaliated against...

Staff Assigned to Investigate...ADON]..Investigation...Watched the 2-10 shift for 7/19/20 on camera and saw nothing to confirm the above complain. I talked to the nurse and she stated no issues were reported to her and when [resident] comes out of her room, they put a mask on her and let her go...Resolution...[CMA#4] was called in to discuss her allegations. Was informed the video didn't back those allegations up. She received an employee warning for 1) dishonesty, misrepresentation 2) conducting one self in a manner contrary to recognized standards of morality [and] decency...[On the back of the concern form]When [CMA #4] told the nurse, she refused to do anything [and] just said a bunch of F words. Would throw things off the desk [and] make [CMA #4] pick them up...This happened every weekend she has worked...This specific incident happened on 7/19/20...Wants to remain anonymous...wants to be notified of resolutions..."

An employee warning notice, dated 07/27/20, documented, "...EMPLOYEE [CMA#4]...Date of event...07/24/2020...PROBLEM/EVENT/INCIDENT...Dishonesty [and] misrepresentation about material information-suspension of one day...ACTION TAKEN:...WRITTEN WARNING #1...SUSPENSION..."

CMA #4 was disciplined and written up for misrepresentation and dishonesty as a direct result of reporting an allegation of verbal abuse against her co-workers.

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On 06/23/21 at 8:30 a.m., LPN #3 was asked who staff reported suspected abuse to. She stated they reported it to the DON because that was their chain of command. She stated, about three months ago, a resident had reported verbal abuse to her and another nurse. She stated the DON was busy testing staff, the ADM was in a meeting so they went to the admin's assistant. She stated they were told they had to go to their chain of command. She was asked who they reported to if the DON was not in the facility. She stated they can always reach her on her the cell phone.

On 06/24/21 at 11:10 a.m., CMA # 3 was asked if she witnessed abuse. She stated she did a month or two ago and she reported it to the ADM. She was asked when and who did she report to. She stated staff typically report through the chain of command but the person who had done the abuse was her chain of command. She went on to state the incident was "traumatizing to me." She was asked if she was afraid to report abuse. She stated she was worried that someone would hold it against her.

On 06/25/21 at 9:50 a.m., LPN #1 was asked if she had ever felt like she could not report incidents of allegations of abuse. She stated, "Yeah." She stated, "Sometimes things don't get done." She stated, "We feel like people should be more in trouble for certain things."

At 3:09 p.m., the activity aide was asked if she had ever felt like she could not report allegations of abuse. She stated, "Honestly, yes." She stated, "Last time I reported to her [ADM], she blew me off."

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F 600	Continued From page 33 On 06/28/21 at 3:20 p.m., the Social Services[SS] #1 and ADM were asked to describe the investigation related to the grievance form dated 07/24/20. SS#1 stated she took the statement from CMA #4. The ADM stated the ADON and herself looked at the cameras for the 07/19/20. She was asked if it was for one shift. She stated they looked at the whole day. She was asked if the incident was thoroughly investigated. The ADM stated, "No." They were asked if CMA #4 received disciplinary action. The ADM stated, "Yes." She was asked why. SS #1 stated the DON and ADON had decided. The ADM stated in her opinion, they [DON and ADON] thought CMA #4 was lying. SS#1 stated, from what she remembered, they [DON and ADON] thought it was a fraudulent report. SS#1 stated she argued with them [DON and ADON] because, in her opinion, it was retaliation against the staff member. She stated CMA #4 wanted to remain anonymous. On 06/29/21 at 7:02 p.m., CMA #3 was asked if she was fearful of reporting allegations of abuse. She stated, "Yes and No." She stated if LPN #3 was aware, I'd be afraid she'd come back at me."	F 600		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		

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misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to develope and implement an abuse policy and procedure that promoted an environement where allegations of abuse could be made without fear of retailiation, residents were protected/free of abuse and neglect, allegations were reported timely to the administrator and other agencies, allegations were throughly investigated and corrective measuers were taken to prevent further abuse.

A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse.

An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured. The residents were not protected as the staff member was allowed to work.

The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and

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implement corrected measures to prevent further abuse.

Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made.

Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going.

At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 11:28 a.m., the Administrator (ADM) was notified of the IJ.

An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

"Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the

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outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21...

An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed."

On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect.

The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern.

Based on observation, record review and resident and staff interviews, it was determined the facility failed to develop and implement a policy and

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F 607	Continued From page 37 procedure for abuse by not: ~ reporting abuse allegations timely, ~ conducting thorough investigations, ~ protecting the residents, ~ implementing corrective measures and ~ ensuring staff were held accountable for their actions for six [#1, 5, 6, 7, 8 and #9] of six sampled residents reviewed for abuse. The facility identified 95 residents resided in the facility. Findings: An employee handbook, dated 03/2020, documented, "...The Company actively works to prevent...abuse by...Protecting employees...from adverse action when they do the right thing and report any genuine concern regarding...abuse...The Company strictly prohibits retaliation, in any form, against any individual making a report, complaint, or inquiry in good faith...Abuse & Neglect Policy...NO FORM OF ABUSE OR NEGLECT IS TOLERATED AND MUST BE REPORTED IMMEDIATELY...FAILURE TO REPORT ABUSE OR NEGLECT, EVEN SUSPECTED ABUSE OR NEGLECT, LEAVES YOU RESPONSIBLE FOR THE SITUATION...Bullying & Harassment...The Commons will not, in ay instance, tolerate bullying or harassing behavior. Employees found in violation of this policy will be disciplined, up to and including termination...examples of bullying and/or harassment:	F 607		

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Verbal...ridiculing...humiliating...Shouting, raising voice at in individual in public...Telephone Calls & Cell Phones...Cell phone use is limited to break time only...Code of Conduct ...Disciplinary Procedures...Violations of any of these rules...may result in corrective action being taken, up to and including discharge...Physical or mental abuse of the residents or failure to report physical or mental abuse by others...Social Media...Employees must not post confidential...about...clients...Employees should not disparage any person...based on...disability..."

An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON,

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ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/2021, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally everyday, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or

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butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurances, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications. The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

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On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader.

At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was once. He stated he turned it in and now he gets it. He was asked who the staff member was who withheld the medication. He

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stated he was not going to tell.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me cause when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse and negeclt.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary

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of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The allegation of abuse was not reported to the administrator until the next day after it occurred.

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21,

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documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented,

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"...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred.

The facility failed to protect residents from further

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abuse during the investigation.

The facilty failed to report the allegation timely to the administrator and a through investigation was not completed.

On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were in serviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with

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residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employed by the facility.

The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[resident #5]...Incident Type...Allegations of

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Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

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A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are

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delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."

CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

The facility had documented the allegation was unsubstantiated even through there was a witness, and failed to complete a thorough investigation by interviewing other staff members and residents.

On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she

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considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been

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involved.

The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse.

4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.

A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.

A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.

A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..."

On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."

At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home."

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An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached...

A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..."

A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She cannot really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..."

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A statement from CNA #5, dated 06/28/21 at 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..."

A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..."

A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..."

On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us."

The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the

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resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN.

The ADM was asked how she protected the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."

On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.

Reviewed with the ADM her interview from 06/28/21, where she reported the charge nurse texted her that the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated, "Yes", referring to the discrepancies in information. She was asked if she was concerned about the discrepancies. She stated, "What does the report say." Reviewed her

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interview from yesterday that she stated the nurse reported to her the description the resident stated "looks like us" and the report documented the resident was unable to describe the perpetrator. There was no response given.

The two employees remained working at the facility all night after the allegation of rape and the resident identifying the RN and CNA as the ones who raped her.

The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse.

5. Resident #6 had diagnoses which included Huntington's disease.

A resident assessment, dated 02/15/21, documented the resident's cognition was intact.

A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m.

A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..."

An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today.

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The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.

There was no documentation in the resident's clinical record of the alleged abuse against the resident.

The facility did not report the allegation of abuse to the Oklahoma State Department of Health within the required two hours.

A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m.

A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the following...For 5 day and final reports, please include a summary of the investigation...Face Sheet attached, investigation attached..."

Safe surveys were conducted with three residents on 03/23/21. The following questions were asked:
1. Do you feel like when you turn on your call light, you get everything you need taken care of?
2. Have you heard staff using inappropriate language?
3. Has staff ever yelled or spoken harsh to you?
4. If you feel like your needs aren't met, do you know who to talk to?
No negative answers were documented.

LPN #1 reamained working after the allegation of verbal abuse had been made and throughout the invesitigation.

There were no written staff statements from the

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reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur.

On 06/24/21 at 1:35 p.m., the DON was asked when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation had been completed. She stated the investigation was completed, but the documentation was not. She stated there was conflict between the activity aide and LPN #1. She was asked if LPN #1 had worked during the investigation. The DON stated, "Yes." She was asked what was put in place to prevent reoccurrence and to protect the residents. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. She stated the complainant was re-interviewed and had a discussion about how the allegation could not have occurred. She was asked if was reported timely. She stated she was not notified until the next day.

On 06/25/21 at 3:09 a.m., the activity aide was asked if she recalled the incident on 03/21/21. She stated she did. She stated LPN #1 had cursed at the resident when she reported to her that he had fallen. She stated, LPN #1 said, "Jesus F*** Christ, [Resident]. Really." She was asked who she had reported the incident to. She

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stated she reported it to her supervisor that day and that her supervisor was going to call the administrator.

The facility failed to develope and implement an abuse policy and procedure for reporting allegations timely to the administrator and approrpaite agencies, that protected residents during an investigation, and thoroughly investigate an allegation of abuse. .

6. Resident #1 was admitted to the facility with diagnoses which included Parkinson's disease.

A quarterly resident assessment, dated 06/12/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 06/12/21, documented, "...Resident...Involved...[resident #1]...Incident Type...Allegations of Abuse/Mistreatment..."

A notification of nurse aide report, dated 06/12/21, documented, "...CNA #1...was employee terminated...Yes...termination date 06/12/2021...ALLEGATIONS/FACTS OF ABUSE...On June 12, 2021 at approximately 11:00 am a incident was reported by a staff member in which a Resident [resident #1] was involved. CNA #1 recorded [resident #1] tying her shoe for her and she posted the video on her personal SnapChat story with the caption "But does your resident ever tie your shoes for no reason??" The caption was followed by a laughing face emoji and heart emoji. [CNA #1] was terminated for mistreatment of a resident and violation of our facility Social Media Policy..."

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On 06/23/21 at 8:59 a.m., the DON was asked when were the staff inserviced related to cell phone use and social media. She stated they are inserviced when they are hired during orientation. She was asked what the cell phone and social media restrictions were. She stated not to post anything about residents, the facility and no pictures. She stated staff were only to have their cell phones in break room and not to have a cell phone in resident areas. The DON was asked if the staff were inserviced related to the incident. She stated they planned on inservicing staff in July. She stated they were going to in June but they had to wait for their board's approval of the updated policy. She was asked if any corrective measures were put in place to protect the residents from further occurrence. She stated they weren't.

On 06/24/21 at 2:00 p.m., the DON was asked what staff were interviewed as part as their investigation. She stated CMA #1. She stated they did not interview other staff who were working that same shift. She was asked if other staff members were not interviewed, was a thorough investigation completed. She stated, "Guess not." She was asked how residents were protected from further occurrence. She stated they did not initiate any new interventions.

The facility failed to develope and implement an abuse policy and procedure for completing a thorough investigation .

7. A grievance concern form, dated 07/24/20, documented, "...Person Filing Complaint...[CMA #4]...Nature of the Concern...Weekend staff would yell at [Resident] when she came out of her room to go back, would walk her back, close her

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door after she went in [and] hold the door so she couldn't open it. She eventually came out again, the Med [medication] aide grabbed her walker, yanked it around [and] said "I'm tired of this shit. When [CMA #4] said anything, she was bullied [and] retaliated against...

Staff Assigned to Investigate...ADON]..Investigation...Watched the 2-10 shift for 7/19/20 on camera and saw nothing to confirm the above complain. I talked to the nurse and she stated no issues were reported to her and when [resident] comes out of her room, they put a mask on her and let her go...Resolution...[CMA#4] was called in to discuss her allegations. Was informed the video didn't back those allegations up. She received an employee warning for 1) dishonesty, misrepresentation 2) conducting one self in a manner contrary to recognized standards of morality [and] decency...[On the back of the concern form]When [CMA #4] told the nurse, she refused to do anything [and] just said a bunch of F words. Would throw things off the desk [and] make [CMA #4] pick them up...This happened every weekend she has worked...This specific incident happened on 7/19/20...Wants to remain anonymous...wants to be notified of resolutions..."

An employee warning notice, dated 07/27/20, documented, "...EMPLOYEE [CMA#4]...Date of event...07/24/2020...PROBLEM/EVENT/INCIDENT...Dishonesty [and] misrepresentation about material information-suspension of one day...ACTION TAKEN:...WRITTEN WARNING #1...SUSPENSION..."

CMA #4 was disciplined and written up for misrepresentation and dishonesty as a direct

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result of reporting an allegation of verbal abuse against her co-workers.

On 06/23/21 at 8:30 a.m., LPN #3 was asked who staff reported suspected abuse to. She stated they reported it to the DON because that was their chain of command. She stated, about three months ago, a resident had reported verbal abuse to her and another nurse. She stated the DON was busy testing staff, the ADM was in a meeting so they went to the admin's assistant. She stated they were told they had to go to their chain of command. She was asked who they reported to if the DON was not in the facility. She stated they can always reach her on her the cell phone.

On 06/24/21 at 11:10 a.m., CMA # 3 was asked if she witnessed abuse. She stated she did a month or two ago and she reported it to the ADM. She was asked when and who did she report to. She stated staff typically report through the chain of command but the person who had done the abuse was her chain of command. She went on to state the incident was "traumatizing to me." She was asked if she was afraid to report abuse. She stated she was worried that someone would hold it against her.

On 06/25/21 at 9:50 a.m., LPN #1 was asked if she had ever felt like she could not report incidents of allegations of abuse. She stated, "Yeah." She stated, "Sometimes things don't get done." She stated, "We feel like people should be more in trouble for certain things."

At 3:09 p.m., the activity aide was asked if she had ever felt like she could not report allegations of abuse. She stated, "Honestly, yes." She

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stated, "Last time I reported to her [ADM], she blew me off."

On 06/28/21 at 3:20 p.m., the Social Services[SS] #1 and ADM were asked to describe the investigation related to the grievance form dated 07/24/20. SS#1 stated she took the statement from CMA #4.

The ADM stated the ADON and herself looked at the cameras for the 07/19/20. She was asked if it was for one shift. She stated they looked at the whole day. She was asked if the incident was thoroughly investigated. The ADM stated, "No."

They were asked if CMA #4 received disciplinary action. The ADM stated, "Yes." She was asked why.

SS #1 stated the DON and ADON had decided. The ADM stated in her opinion, they [DON and ADON] thought CMA #4 was lying. SS#1 stated, from what she remembered, they [DON and ADON] thought it was a fraudulent report. SS#1 stated she argued with them [DON and ADON] because, in her opinion, it was retaliation against the staff member. She stated CMA #4 wanted to remain anonymous.

On 06/29/21 at 7:02 p.m., CMA #3 was asked if she was fearful of reporting allegations of abuse. She stated, "Yes and No." She stated if LPN #3 was aware, I'd be afraid she'd come back at me."

The facility failed to develope an abuse policy and procedure that ensured allegations could be reported with retribution.

On 06/28/21 at 2:42 p.m., the administrator

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F 609 SS=K	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are 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, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		

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On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure staff reported allegations of abuse immediately after identifying suspected and/or actual abuse had occurred.

A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator for investigation.

An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured.

The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse.

Staff witnessed verbal abuse to Resident #6, by an employee and reported it to the charge nurse. The charge nurse did not report the allegation to the administrator timely.

At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 11:28 a.m., the Administrator (ADM) was notified of the IJ.

An acceptable plan of removal was provided by the administrator on 06/25/21 at 9:55 p.m. It documented the following:

"All residents will be interviewed 06/25/2021. All

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staff on shift will be educated on updated policy immediately, and if not currently working will be inserviced by phone call by midnight on 06/25/2021. (see attached) (amended to be 9 am on 06/26/2021)
** if unable to be contacted, we will document date and time, and the staff member will be taken off the schedule until completed**
The following texts will be sent to all staff immediately...Surveyors have identified serious deficiencies in Abuse reporting. All staff are required to complete in-service. Someone from The Commons will be calling you before midnight tonight...If you have been not contacted to complete an in-service by midnight, call [director of nursing] or will be removed from the schedule...Beginning IMMEDIATELY-reporting of ANY abuse allegations will be need to be texted or called to [administrator]...[assistant administrator]...This is any time- DAY or NIGHT! If no response to a text, then CALL...All staff that have been identified as not timely reporting abuse will be given a 1 day suspension. [Resident #5] -Staff member with physical abuse allegation will be terminated immediately. At every allegation of abuse, a text will be sent to all staff to remind staff that we take abuse very seriously...An allegation has been reported, this is a reminder NO forms of abuse will be tolerated Administrator, Asst Administrator and DON have learned that a thorough investigation includes resident safe surveys on all halls that the alleged abuser has worked. Handwritten statements from those questioned should be included in an investigation. We have reviewed the different types and examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the witness is the person that has

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reported the incident during the investigation. We learned that to properly assess the resident we must conduct medical, psychosocial, and mental status assessment at the time, and an assessment each shift for 3 days for 9 occurrences"

On 06/28/21, six nurse aides (CNA), seven certified medication aides (CMA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse.

At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of her administrator forums online. She was asked if she shared that information with her administrative staff. She stated they looked up information themselves. She was asked if there was anything specific they educated the administrative staff on. She stated, "No, nothing specific."

At 3:30 p.m., the administrator was made aware that an amended plan of removal was needed due to ongoing abuse and neglect allegations not being reported timley, not rotecting residents and conducting thorough investigations.

An acceptable plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

"Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th,

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	375488	A. BUILDING _____ B. WING _____	C 07/01/2021

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F 609	Continued From page 68 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21... An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed." On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect.	F 609		

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The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern.

Based on record review, resident and staff interviews, it was determined the facility failed to ensure staff reported allegations of abuse immediately after identifying abuse/suspected abuse had occurred for four (#5, 6, 7 and #9) of six sampled residents reviewed for abuse.

The facility identified 95 residents resided in the facility.

Findings:

An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must

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also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at

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12:35 a.m., documented, "Generally every day, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

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Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications.

The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

The employee continued to work during the investigaion of the alleged negelct.

The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld.

On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader.

At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the

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surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that withheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me because when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of

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Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The allegation of abuse was not reported to the administrator until the next day after it occurred.

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to

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talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A investigative summary, undated, documented, "...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

On 06/23/21 at 2:24 p.m., the admin was asked who the staff could report suspected abuse to.

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She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were inserviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[Resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated

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06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

An investigative summary, undated, documented, "...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

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On 06/24/21 at 12:48 p.m., the DON acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours.

4. Resident #6 had diagnoses which included Huntington's disease.

A resident assessment, dated 02/15/21, documented the resident's cognition was intact.

A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..."

An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.

On 06/24/21 at 1:35 p.m., the DON was asked if was reported timely. She stated she was not notified until the next day.

On 06/25/21 at 3:09 a.m., the activity aide was asked who she had reported the incident to. She stated she reported it to her supervisor that day

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F 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a thorough investigation had been conducted and appropriate corrective actions were taken for allegation of abuse. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse.	F 610		

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An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work.

The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse.

Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made.

Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going.

At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 11:28 a.m., the Administrator (ADM) was notified of the IJ.

An acceptable plan of removal was provided by the administrator on 06/25/21 at 9:55 p.m. It documented the following:

"All residents will be interviewed 06/25/2021. All

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THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

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staff on shift will be educated on updated policy immediately, and if not currently working will be inserviced by phone call by midnight on 06/25/2021. (see attached) (amended to be 9 am on 06/26/2021)
** if unable to be contacted, we will document date and time, and the staff member will be taken off the schedule until completed**
The following texts will be sent to all staff immediately...Surveyors have identified serious deficiencies in Abuse reporting. All staff are required to complete in-service. Someone from The Commons will be calling you before midnight tonight...If you have been not contacted to complete an in-service by midnight, call [director of nursing] or will be removed from the schedule...Beginning IMMEDIATELY-reporting of ANY abuse allegations will be need to be texted or called to [administrator]...[assistant administrator]...This is any time- DAY or NIGHT! If no response to a text, then CALL...All staff that have been identified as not timely reporting abuse will be given a 1 day suspension. [Resident #5] -Staff member with physical abuse allegation will be terminated immediately. At every allegation of abuse, a text will be sent to all staff to remind staff that we take abuse very seriously...An allegation has been reported, this is a reminder NO forms of abuse will be tolerated Administrator, Asst Administrator and DON have learned that a thorough investigation includes resident safe surveys on all halls that the alleged abuser has worked. Handwritten statements from those questioned should be included in an investigation. We have reviewed the different types and examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the witness is the person that has

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reported the incident during the investigation. We learned that to properly assess the resident we must conduct medical, psychosocial, and mental status assessment at the time, and an assessment each shift for 3 days for 9 occurrences"

On 06/28/21, six nurse aides (CNA), seven certified medication aides (CMA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse.

At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of her administrator forums online. She was asked if she shared that information with her administrative staff. She stated they looked up information themselves. She was asked if there was anything specific they educated the administrative staff on. She stated, "No, nothing specific."

The facility reported resident #8 made an allegation of rape by staff on 06/28/21 and the staff contnued to work over six hours after the allegation. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted.

At 3:30 p.m., the administrator was made aware that an amended plan of removal was needed due to ongoing abuse and neglect allegations

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without protecting residents and conducting thorough investigations.

An acceptable plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

"Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21...

An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and

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respond to allegations to ensure all thorough investigation has been completed."

On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect.

The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern.

Based on record review, resident and staff interviews, it was determined the facility failed to:

~ ensure a thorough investigation had been completed and

~ implement appropriate corrective actions when abuse had been idenitified for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse.

The facility identified 95 residents resided in the facility.

Findings:

An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent

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further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

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Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally every day, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurrences, [Resident] won't receive pain meds until sometimes 10 a.m. or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of

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Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications.

The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

The employee continued to work during the investigation of the alleged neglect.

The facility did not complete a thorough investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld.

On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think

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you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader.

At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that withheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me because when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN

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#3 would have her administer Tylenol or Ultram instead of the Norco.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's

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station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said

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Im sick of him acting like this..."

A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

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An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred.

The facility failed to protect residents from further abuse during the investigation.

The facility failed to report the allegation timely to the administrator and a thorough investigation was not completed.

On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero

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tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were in serviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employed by the facility.

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The facility failed to complete a through and accurate investigation into the allegation of verbal abuse.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[Resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told

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me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again.

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until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."

CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

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The facility had documented the allegation was unsubstantiated even through there was a witness, and failed to complete a thorough investigation by interviewing other staff members and residents.

On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in

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place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved.

4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.

A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.

A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.

A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..."

On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received

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a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."

At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home."

An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached...

A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..."

A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no

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sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She cannot really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..."

A statement from CNA #5, dated 06/28/21 at 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..."

A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..."

A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..."

On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a

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female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us."

The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN.

The ADM was asked how she protected the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."

On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.

Reviewed, with the ADM, her interview from 06/28/21, where she reported the charge nurse

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texted her that the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated, "Yes", referring to the discrepancies in information. She was asked if she was concerned about the discrepancies. She stated, "What does the report say." Reviewed her interview from yesterday that she stated the nurse reported to her the description the resident stated "looks like us" and the report documented the resident was unable to describe the perpetrator. There was no response given.

The two employees remained working at the facility all night after the allegation of rape and the resident identifying the RN and CNA as the ones who raped her.

The facility failed to have an accurate a thorough investigation into the allegations.

5. Resident #6 had diagnoses which included Huntington's disease.

A resident assessment, dated 02/15/21, documented the resident's cognition was intact.

A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m.

A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..."

An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity

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director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.

There was no documentation in the resident's clinical record of the alleged abuse against the resident.

The facility did not report the allegation of abuse to the Oklahoma State Department of Health within the required two hours.

A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m.

A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the following...For 5 day and final reports, please include a summary of the investigation...Face Sheet attached, investigation attached..."

Safe surveys were conducted with three residents on 03/23/21. The following questions were asked:
1. Do you feel like when you turn on your call light, you get everything you need taken care of?
2. Have you heard staff using inappropriate language?
3. Has staff ever yelled or spoken harsh to you?
4. If you feel like your needs aren't met, do you know who to talk to?
No negative answers were documented.

LPN #1 remained working after the allegation of

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verbal abuse had been made and throughout the investigation.

There were no written staff statements from the reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur.

On 06/24/21 at 1:35 p.m., the DON was asked when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation had been completed. She stated the investigation was completed, but the documentation was not. She stated there was conflict between the activity aide and LPN #1. She was asked if LPN #1 had worked during the investigation. The DON stated, "Yes." She was asked what was put in place to prevent reoccurrence and to protect the residents. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. She stated the complainant was re-interviewed and had a discussion about how the allegation could not have occurred. She was asked if was reported timely. She stated she was not notified until the next day.

On 06/25/21 at 3:09 a.m., the activity aide was asked if she recalled the incident on 03/21/21. She stated she did. She stated LPN #1 had

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cursed at the resident when she reported to her that he had fallen. She stated, LPN #1 said, "Jesus F*** Christ, [Resident]. Really." She was asked who she had reported the incident to. She stated she reported it to her supervisor that day and that her supervisor was going to call the administrator.

The facility failed to protect residents during an investigation of abuse, thoroughly investigate an allegation of abuse and failed to report the allegation to the administrator and appropriate agencies timely.

6. Resident #1 was admitted to the facility with diagnoses which included Parkinson's disease.

A quarterly resident assessment, dated 06/12/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 06/12/21, documented, "...Resident...Involved...[resident #1]...Incident Type...Allegations of Abuse/Mistreatment..."

A notification of nurse aide report, dated 06/12/21, documented, "...CNA #1...was employee terminated...Yes...termination date 6/12/2021...ALLEGATIONS/FACTS OF ABUSE...On June 12, 2021 at approximately 11:00 am a incident was reported by a staff member in which a Resident [resident #1] was involved. CNA #1 recorded [resident #1] tying her shoe for her and she posted the video on her personal SnapChat story with the caption "But does your resident ever tie your shoes for no reason??" The caption was followed by a laughing face emoji and heart emoji. [CNA #1]

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F 610	Continued From page 106 was terminated for mistreatment of a resident and violation of our facility Social Media Policy..." On 06/23/21 at 8:59 a.m., the DON was asked when the staff were in serviced related to cell phone use and social media. She stated they are in serviced when they are hired during orientation. She was asked what the cell phone and social media restrictions were. She stated not to post anything about residents, the facility and no pictures. She stated staff were only to have their cell phones in break room and not to have a cell phone in resident areas. The DON was asked if the staff were in serviced related to the incident. She stated they planned on in servicing staff in July. She stated they were going to in June but they had to wait for their board's approval of the updated policy. She was asked if any corrective measures were put in place to protect the residents from further occurrence. She stated they weren't. On 06/24/21 at 2:00 p.m., the DON was asked what staff were interviewed as part as their investigation. She stated CMA #1. She stated they did not interview other staff who were working that same shift. She was asked if other staff members were not interviewed, was a thorough investigation completed. She stated, "Guess not." She was asked how residents were protected from further occurrence. She stated they did not initiate any new interventions. A thorough investigation had not been completed related to this incident. As a result, it is unknown if any other staff or residents had been involved.	F 610		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		

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§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure physician's orders were followed for one (#3) of three sampled residents reviewed for following physician's orders.

The facility identified 95 residents resided in the facility.

Findings:

Resident #3 had diagnoses which included fractured left humerus.

On emergency department final report, dated 02/05/21, documented, " ...Shoulder pain-swelling ...Follow up with: [physician name deleted] ...Within 1-2 days ..."

A progress note, dated 02/05/21 at 9:54 p.m., documented the resident returned to the facility with no new orders.

A progress note, dated 02/12/21 at 9:14 a.m., documented a virtual visit with the resident's physician had been conducted. This was the first visit since the emergency department visit.

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F 684	Continued From page 108 On 06/30/21 at 1:50 p.m., the director of nursing was shown the emergency department final report and the progress note of the virtual visit. She was asked if physician's orders had been followed for the follow-up appointment. She stated, "No, not specifically."	F 684		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: On 06/28/21, an Immediate Jeopardy (IJ) situation was determined to exist related to facility failed to have an effective administration to implement an abuse program for ~thoroughly investigating allegations of abuse and neglect; ~ protecting residents during investigations of abuse and neglect; ~ ensure residents were free from abuse and neglect; and ~ staff could report allegations without fear of reprisal. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn	F 835		

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against the nurse.

An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work.

The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse.

Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made.

Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigation was on going.

At 3:03 p.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 3:30 p.m., the Administrator (ADM) was notified of the IJ.

An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

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An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to the Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/2021 with advanced training on ABUSE. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure a thorough investigation has been completed.

On 07/01/21, the administrative staff were interviewed and were able to state the seven components of abuse.

The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern.

Based on observation, record review and staff interview it was determined the facility failed to have an effective administration to implement an abuse program for:

~ thoroughly investigating allegations of abuse and neglect;

~protecting residents during investigations of abuse and neglect;

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~ensuring residents were free from abuse for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse; and

~ have an envrironement were staff could report allegations of abuse/negelect without fear of reprisal.

The facility Censeus was

Findings:

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally every day,

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on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents.

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The questions asked to the residents were not related to receiving pain medications.

The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

The employee continued to work during the investigaion of the alleged negelct.

The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld.

On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader.

At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff

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members respect your requests and allow you to make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that witheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me because when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of

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Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The allegation of abuse was not reported to the administrator until the next day after it occurred.

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence,

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[resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also

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told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

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A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred.

The facility failed to protect residents from further abuse during the investigation.

The facilty failed to report the allegation timely to the administrator and a through investigation was not completed.

On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were in serviced about reporting timely. She stated,

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"Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employed by the facility.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[resident #5]...Incident Type...Allegations of

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Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

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A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are

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delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."

CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

The facility had documented the allegation was unsubstantiated even through there was a witness, and failed to complete a thorough investigation by interviewing other staff members and residents.

On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she

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considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been

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involved.

4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.

A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.

A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.

A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..."

On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."

At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home."

An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her

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when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached...

A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..."

A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She cannot really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..."

A statement from CNA #5, dated 06/28/21 at 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..."

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A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..."

A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..."

On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us."

The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN.

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The ADM was asked how she protected the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."

On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.

Reviewed with the ADM her interview from 06/28/21, where she reported the charge nurse texted her that the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated, "Yes", referring to the discrepancies in information. She was asked if she was concerned about the discrepancies. She stated, "What does the report say." Reviewed her interview from yesterday that she stated the nurse reported to her the description the resident stated "looks like us" and the report documented the resident was unable to describe the perpetrator. There was no response given.

The two employees remained working at the

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facility all night after the allegation of rape and the resident identifying the RN and CNA as the ones who raped her.

The facility failed to have an accurate a thorough investigation into the allegations.

5. Resident #6 had diagnoses which included Huntington's disease.

A resident assessment, dated 02/15/21, documented the resident's cognition was intact.

A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m.

A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..."

An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.

There was no documentation in the resident's clinical record of the alleged abuse against the resident.

The facility did not report the allegation of abuse to the Oklahoma State Department of Health

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within the required two hours.

A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m.

A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the following...For 5 day and final reports, please include a summary of the investigation...Face Sheet attached, investigation attached..."

Safe surveys were conducted with three residents on 03/23/21. The following questions were asked:
1. Do you feel like when you turn on your call light, you get everything you need taken care of?
2. Have you heard staff using inappropriate language?
3. Has staff ever yelled or spoken harsh to you?
4. If you feel like your needs aren't met, do you know who to talk to?
No negative answers were documented.

LPN #1 reamained working after the allegation of verbal abuse had been made and throughout the invesitigation.

There were no written staff statements from the reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur.

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On 06/24/21 at 1:35 p.m., the DON was asked when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation had been completed. She stated the investigation was completed, but the documentation was not. She stated there was conflict between the activity aide and LPN #1. She was asked if LPN #1 had worked during the investigation. The DON stated, "Yes." She was asked what was put in place to prevent reoccurrence and to protect the residents. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. She stated the complainant was re-interviewed and had a discussion about how the allegation could not have occurred. She was asked if was reported timely. She stated she was not notified until the next day.

On 06/25/21 at 3:09 a.m., the activity aide was asked if she recalled the incident on 03/21/21. She stated she did. She stated LPN #1 had cursed at the resident when she reported to her that he had fallen. She stated, LPN #1 said, "Jesus F*** Christ, [Resident]. Really." She was asked who she had reported the incident to. She stated she reported it to her supervisor that day and that her supervisor was going to call the administrator.

The facility failed to protect residents during an investigation of abuse, thoroughly investigate an allegation of abuse and failed to report the allegation to the administrator and appropriate agencies timely.

6. Resident #1 was admitted to the facility with

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diagnoses which included Parkinson's disease.

A quarterly resident assessment, dated 06/12/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 06/12/21, documented, "...Resident...Involved...[resident #1]...Incident Type...Allegations of Abuse/Mistreatment..."

A notification of nurse aide report, dated 06/12/21, documented, "...CNA #1...was employee terminated...Yes...termination date 06/12/2021...ALLEGATIONS/FACTS OF ABUSE...On June 12, 2021 at approximately 11:00 am a incident was reported by a staff member in which a Resident [resident #1] was involved. CNA #1 recorded [resident #1] tying her shoe for her and she posted the video on her personal SnapChat story with the caption "But does your resident ever tie your shoes for no reason??" The caption was followed by a laughing face emoji and heart emoji. [CNA #1] was terminated for mistreatment of a resident and violation of our facility Social Media Policy..."

On 06/23/21 at 8:59 a.m., the DON was asked when were the staff inserviced related to cell phone use and social media. She stated they are inserviced when they are hired during orientation. She was asked what the cell phone and social media restrictions were. She stated not to post anything about residents, the facility and no pictures. She stated staff were only to have their cell phones in break room and not to have a cell phone in resident areas. The DON was asked if the staff were inserviced related to the incident. She stated they planned on inservicing staff in

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July. She stated they were going to in June but they had to wait for their board's approval of the updated policy. She was asked if any corrective measures were put in place to protect the residents from further occurrence. She stated they weren't.

On 06/24/21 at 2:00 p.m., the DON was asked what staff were interviewed as part as their investigation. She stated CMA #1. She stated they did not interview other staff who were working that same shift. She was asked if other staff members were not interviewed, was a thorough investigation completed. She stated, "Guess not." She was asked how residents were protected from further occurrence. She stated they did not initiate any new interventions.

A thorough investigation had not been completed related to this incident. As a result, it is unknown if any other staff or residents had been involved.

7. A grievance concern form, dated 07/24/20, documented, "...Person Filing Complaint...[CMA #4]...Nature of the Concern...Weekend staff would yell at [Resident] when she came out of her room to go back, would walk her back, close her door after she went in [and] hold the door so she couldn't open it. She eventually came out again, the Med [medication] aide grabbed her walker, yanked it around [and] said "I'm tired of this shit. When [CMA #4] said anything, she was bullied [and] retaliated against...

Staff Assigned to Investigate...ADON]..Investigation...Watched the 2-10 shift for 7/19/20 on camera and saw nothing to confirm the above complain. I talked to the nurse and she stated no issues were reported to

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her and when [resident] comes out of her room, they put a mask on her and let her go...Resolution...[CMA#4] was called in to discuss her allegations. Was informed the video didn't back those allegations up. She received an employee warning for 1) dishonesty, misrepresentation 2) conducting one self in a manner contrary to recognized standards of morality [and] decency...[On the back of the concern form]When [CMA #4] told the nurse, she refused to do anything [and] just said a bunch of F words. Would throw things off the desk [and] make [CMA #4] pick them up...This happened every weekend she has worked...This specific incident happened on 7/19/20...Wants to remain anonymous...wants to be notified of resolutions..."

An employee warning notice, dated 07/27/20, documented, "...EMPLOYEE [CMA#4]...Date of event...07/24/2020...PROBLEM/EVENT/INCIDENT...Dishonesty [and] misrepresentation about material information-suspension of one day...ACTION TAKEN:...WRITTEN WARNING #1...SUSPENSION..."

CMA #4 was disciplined and written up for misrepresentation and dishonesty as a direct result of reporting an allegation of verbal abuse against her co-workers.

On 06/23/21 at 8:30 a.m., LPN #3 was asked who staff reported suspected abuse to. She stated they reported it to the DON because that was their chain of command. She stated, about three months ago, a resident had reported verbal abuse to her and another nurse. She stated the DON was busy testing staff, the ADM was in a meeting so they went to the admin's assistant. She stated they were told they had to go to their

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chain of command. She was asked who they reported to if the DON was not in the facility. She stated they can always reach her on her the cell phone.

On 06/24/21 at 11:10 a.m., CMA # 3 was asked if she witnessed abuse. She stated she did a month or two ago and she reported it to the ADM. She was asked when and who did she report to. She stated staff typically report through the chain of command but the person who had done the abuse was her chain of command. She went on to state the incident was "traumatizing to me." She was asked if she was afraid to report abuse. She stated she was worried that someone would hold it against her.

On 06/25/21 at 9:50 a.m., LPN #1 was asked if she had ever felt like she could not report incidents of allegations of abuse. She stated, "Yeah." She stated, "Sometimes things don't get done." She stated, "We feel like people should be more in trouble for certain things."

At 3:09 p.m., the activity aide was asked if she had ever felt like she could not report allegations of abuse. She stated, "Honestly, yes." She stated, "Last time I reported to her [ADM], she blew me off."

On 06/28/21 at 3:20 p.m., the Social Services[SS] #1 and ADM were asked to describe the investigation related to the grievance form dated 07/24/20. SS#1 stated she took the statement from CMA #4.

The ADM stated the ADON and herself looked at the cameras for the 07/19/20. She was asked if it was for one shift. She stated they looked at the

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whole day. She was asked if the incident was thoroughly investigated. The ADM stated, "No."

They were asked if CMA #4 received disciplinary action. The ADM stated, "Yes." She was asked why.

SS #1 stated the DON and ADON had decided. The ADM stated in her opinion, they [DON and ADON] thought CMA #4 was lying. SS#1 stated, from what she remembered, they [DON and ADON] thought it was a fraudulent report. SS#1 stated she argued with them [DON and ADON] because, in her opinion, it was retaliation against the staff member. She stated CMA #4 wanted to remain anonymous.

On 06/29/21 at 7:02 p.m., CMA #3 was asked if she was fearful of reporting allegations of abuse. She stated, "Yes and No." She stated if LPN #3 was aware, I'd be afraid she'd come back at me."

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LL000	Initial Comments On 06/21/21 through 06/25/21 and 06/28/21 through 07/01/21, the Oklahoma State Department of Health completed a COVID-19 Focused Survey to determine if the facility was in compliance with implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. Complaints #OK00056688, OK00057230 and #OK00056691 were investigated in conjunction with the survey.	LL000		
LL067	O.S. 63, 1-1939(H) Liability to residents A facility employee or agent who becomes aware of abuse, neglect or exploitation of a resident prohibited by the Nursing Home Care Act shall immediately report the matter to the facility administrator. A facility administrator who becomes aware of abuse, neglect, or exploitation of a resident shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department. This Rule is not met as evidenced by: On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to develope and implement an abuse policy and procedure that promoted an environement where allegations of abuse could be made without fear of retailiation, residents were protected/free of abuse and neglect, allegations were reported timely to the administrator and other agencies, allegations were throughly investigated and corrective measuers were taken to prevent further abuse.	LL067		

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LL067	Continued From page 1 A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse. An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured. The residents were not protected as the staff member was allowed to work. The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse. Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made. Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going. At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation. At 11:28 a.m., the Administrator (ADM) was notified of the IJ.	LL067		

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LL067	Continued From page 2 An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following: "Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21... An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed."	LL067		

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LL067	Continued From page 3 On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect. The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern. Based on observation, record review and resident and staff interviews, it was determined the facility failed to develop and implement a policy and procedure for abuse by not: ~ reporting abuse allegations timely, ~ conducting thorough investigations, ~ protecting the residents, ~ implementing corrective measures and ~ ensuring staff were held accountable for their actions for six [#1, 5, 6, 7, 8 and #9] of six sampled residents reviewed for abuse. The facility identified 95 residents resided in the facility. Findings: An employee handbook, dated 03/2020, documented, "...The Company actively works to prevent...abuse by...Protecting employees...from adverse action when they do the right thing and report any genuine concern	LL067		

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regarding...abuse...The Company strictly prohibits retaliation, in any form, against any individual making a report, complaint, or inquiry in good faith...Abuse & Neglect Policy...NO FORM OF ABUSE OR NEGLECT IS TOLERATED AND MUST BE REPORTED IMMEDIATELY...FAILURE TO REPORT ABUSE OR NEGLECT, EVEN SUSPECTED ABUSE OR NEGLECT, LEAVES YOU RESPONSIBLE FOR THE SITUATION...Bullying & Harassment...The Commons will not, in ay instance, tolerate bullying or harassing behavior. Employees found in violation of this policy will be disciplined, up to and including termination...examples of bullying and/or harassment: Verbal...ridiculing...humiliating...Shouting, raising voice at in individual in public...Telephone Calls & Cell Phones...Cell phone use is limited to break time only...Code of Conduct ...Disciplinary Procedures...Violations of any of these rules...may result in corrective action being taken, up to and including discharge...Physical or mental abuse of the residents or failure to report physical or mental abuse by others...Social Media...Employees must not post confidential...about...clients...Employees should not disparage any person...based on...disability..."

An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from

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abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/2021, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

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LL067	Continued From page 6 Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain... Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..." A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally everyday, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurances, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..." An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..." A statement from LPN #3, dated 06/27/21 at	LL067		

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12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications. The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader.

At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that.

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LL067	Continued From page 8 On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was once. He stated he turned it in and now he gets it. He was asked who the staff member was who withheld the medication. He stated he was not going to tell. At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me cause when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco. The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse and negeclt. 2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder. A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.	LL067		

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A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The allegation of abuse was not reported to the administrator until the next day after it occurred.

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him

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again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per

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[admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

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LL067	Continued From page 12 A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred. The facility failed to protect residents from further abuse during the investigation. The facilty failed to report the allegation timely to the administrator and a through investigation was not completed. On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were in serviced about reporting timely. She stated, "Nothing in writing."	LL067		

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LL067	Continued From page 13 On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No." The ADM was asked if the resident was assessed after the incident. She stated, "No." The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes. The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employed by the facility. The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse. 3. Resident #5 was admitted to the facility with diagnoses which included dementia. A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for	LL067		

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LL067	Continued From page 14 daily decision making was severely impaired. An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..." A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..." A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what	LL067		

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happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the

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DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."

CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

The facility had documented the allegation was unsubstantiated even through there was a witness, and failed to complete a thorough investigation by interviewing other staff members and residents.

On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She

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was asked if staff worked the same hall. She stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result,

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LL067	Continued From page 18 it is unknown if other residents had been involved. The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse. 4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain. A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m. A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m. A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..." On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago." At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home."	LL067		

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LL067	Continued From page 19 An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached... A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..." A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She cannot really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..."	LL067		

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LL067	Continued From page 20 A statement from CNA #5, dated 06/28/21 at 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..." A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..." A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..." On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us." The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the	LL067		

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nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN.

The ADM was asked how she protected the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two,

On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to develope and implement an abuse policy and procedure that promoted an environement where allegations of abuse could be made without fear of retailiation, residents were protected/free of abuse and neglect, allegations were reported timely to the administrator and other agencies, allegations were throughly investigated and corrective measuers were taken to prevent further abuse.

A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse.

An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured. The residents were not protected as the staff member was allowed to work.

The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the

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resident, complete a thorough investigation and implement corrected measures to prevent further abuse.

Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made.

Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going.

At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 11:28 a.m., the Administrator (ADM) was notified of the IJ.

An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

"Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the

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outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21...

An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed."

On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect.

The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern.

Based on observation, record review and resident and staff interviews, it was determined the facility failed to develop and implement a policy and procedure for abuse by not:

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LL067	Continued From page 24 ~ reporting abuse allegations timely, ~ conducting thorough investigations, ~ protecting the residents, ~ implementing corrective measures and ~ ensuring staff were held accountable for their actions for six [#1, 5, 6, 7, 8 and #9] of six sampled residents reviewed for abuse. The facility identified 95 residents resided in the facility. Findings: An employee handbook, dated 03/2020, documented, "...The Company actively works to prevent...abuse by...Protecting employees...from adverse action when they do the right thing and report any genuine concern regarding...abuse...The Company strictly prohibits retaliation, in any form, against any individual making a report, complaint, or inquiry in good faith...Abuse & Neglect Policy...NO FORM OF ABUSE OR NEGLECT IS TOLERATED AND MUST BE REPORTED IMMEDIATELY...FAILURE TO REPORT ABUSE OR NEGLECT, EVEN SUSPECTED ABUSE OR NEGLECT, LEAVES YOU RESPONSIBLE FOR THE SITUATION...Bullying & Harassment...The Commons will not, in ay instance, tolerate bullying or harassing behavior. Employees found in violation of this policy will be disciplined, up to and including termination...examples of bullying and/or harassment: Verbal...ridiculing...humiliating...Shouting, raising voice at in individual in public...Telephone Calls &	LL067		

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Cell Phones...Cell phone use is limited to break time only...Code of Conduct ...Disciplinary Procedures...Violations of any of these rules...may result in corrective action being taken, up to and including discharge...Physical or mental abuse of the residents or failure to report physical or mental abuse by others...Social Media...Employees must not post confidential...about...clients...Employees should not disparage any person...based on...disability..."

An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the

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resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/2021, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally everyday, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to

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administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurances, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications. The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol

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versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader.

At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was once. He stated he turned it in and now he gets it. He was asked who the staff member was who withheld the medication. He stated he was not going to tell.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me cause

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when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse and negeclt.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

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The allegation of abuse was not reported to the administrator until the next day after it occurred.

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She

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screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The

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resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred.

The facility failed to protect residents from further abuse during the investigation.

The facilty failed to report the allegation timely to the administrator and a through investigation was not completed.

On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she

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didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were in serviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3

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worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employed by the facility.

The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling

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on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help

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him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled

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Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."

CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

The facility had documented the allegation was unsubstantiated even through there was a witness, and failed to complete a thorough investigation by interviewing other staff members and residents.

On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was

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suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved.

The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse.

4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.

A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.

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LL067	Continued From page 39 A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m. A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..." On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago." At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home." An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached... A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed	LL067		

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bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..."

A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She cannot really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..."

A statement from CNA #5, dated 06/28/21 at 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..."

A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..."

A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..."

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LL067	Continued From page 41 On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us." The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN. The ADM was asked how she protected the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them.	LL067		

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She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."

On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.

Reviewed with the ADM her interview from 06/28/21, where she reported the charge nurse texted her that the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated, "Yes", referring to the discrepancies in information. She was asked if she was concerned about the discrepancies. She stated, "What does the report say." Reviewed her interview from yesterday that she stated the nurse reported to her the description the resident stated "looks like us" and the report documented the resident was unable to describe the perpetrator. There was no response given.

The two employees remained working at the facility all night after the allegation of rape and the resident identifying the RN and CNA as the ones who raped her.

The facility failed to develope and implement and abuse policy and procedure that allowed fo an accurate a thorough investigation into the allegations abuse. The facility further failed to develope and implement an abuse policy for protecting residents from abuse.

5. Resident #6 had diagnoses which included Huntington's disease.

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LL067	Continued From page 43 A resident assessment, dated 02/15/21, documented the resident's cognition was intact. A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m. A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..." An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m. There was no documentation in the resident's clinical record of the alleged abuse against the resident. The facility did not report the allegation of abuse to the Oklahoma State Department of Health within the required two hours. A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m. A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the following...For 5 day and final reports, please include a summary of the investigation...Face Sheet attached, investigation attached..."	LL067		

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LL067	Continued From page 44 Safe surveys were conducted with three residents on 03/23/21. The following questions were asked: 1. Do you feel like when you turn on your call light, you get everything you need taken care of? 2. Have you heard staff using inappropriate language? 3. Has staff ever yelled or spoken harsh to you? 4. If you feel like your needs aren't met, do you know who to talk to? No negative answers were documented. LPN #1 reamained working after the allegation of verbal abuse had been made and throughout the invesitigation. There were no written staff statements from the reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur. On 06/24/21 at 1:35 p.m., the DON was asked when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation had been completed. She stated the investigation was completed, but the documentation was not. She stated there was conflict between the activity aide and LPN #1. She was asked if LPN #1 had worked during the investigation. The DON stated, "Yes." She was asked what was put in	LL067		

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place to prevent reoccurrence and to protect the residents. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. She stated the complainant was re-interviewed and had a discussion about how the allegation could not have occurred. She was asked if was reported timely. She stated she was not notified until the next day.

On 06/25/21 at 3:09 a.m., the activity aide was asked if she recalled the incident on 03/21/21. She stated she did. She stated LPN #1 had cursed at the resident when she reported to her that he had fallen. She stated, LPN #1 said, "Jesus F*** Christ, [Resident]. Really." She was asked who she had reported the incident to. She stated she reported it to her supervisor that day and that her supervisor was going to call the administrator.

The facility failed to develope and implement an abuse policy and procedure for reporting allegations timely to the administrator and approrpaite agencies, that protected residents during an investigation, and thoroughly investigate an allegation of abuse. .

6. Resident #1 was admitted to the facility with diagnoses which included Parkinson's disease.

A quarterly resident assessment, dated 06/12/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 06/12/21, documented, "...Resident...Involved...[resident #1]...Incident Type...Allegations of Abuse/Mistreatment..."

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A notification of nurse aide report, dated 06/12/21, documented, "...CNA #1...was employee terminated...Yes...termination date 06/12/2021...ALLEGATIONS/FACTS OF ABUSE...On June 12, 2021 at approximately 11:00 am a incident was reported by a staff member in which a Resident [resident #1] was involved. CNA #1 recorded [resident #1] tying her shoe for her and she posted the video on her personal SnapChat story with the caption "But does your resident ever tie your shoes for no reason??" The caption was followed by a laughing face emoji and heart emoji. [CNA #1] was terminated for mistreatment of a resident and violation of our facility Social Media Policy..."

On 06/23/21 at 8:59 a.m., the DON was asked when were the staff inserviced related to cell phone use and social media. She stated they are inserviced when they are hired during orientation. She was asked what the cell phone and social media restrictions were. She stated not to post anything about residents, the facility and no pictures. She stated staff were only to have their cell phones in break room and not to have a cell phone in resident areas. The DON was asked if the staff were inserviced related to the incident. She stated they planned on inservicing staff in July. She stated they were going to in June but they had to wait for their board's approval of the updated policy. She was asked if any corrective measures were put in place to protect the residents from further occurrence. She stated they weren't.

On 06/24/21 at 2:00 p.m., the DON was asked what staff were interviewed as part as their investigation. She stated CMA #1. She stated they did not interview other staff who were working that same shift. She was asked if other

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staff members were not interviewed, was a thorough investigation completed. She stated, "Guess not." She was asked how residents were protected from further occurrence. She stated they did not initiate any new interventions.

The facility failed to develope and implement an abuse policy and procedure for completing a thorough investigation .

7. A grievance concern form, dated 07/24/20, documented, "...Person Filing Complaint...[CMA #4]...Nature of the Concern...Weekend staff would yell at [Resident] when she came out of her room to go back, would walk her back, close her door after she went in [and] hold the door so she couldn't open it. She eventually came out again, the Med [medication] aide grabbed her walker, yanked it around [and] said "I'm tired of this shit. When [CMA #4] said anything, she was bullied [and] retaliated against...

Staff Assigned to Investigate...ADON]..Investigation...Watched the 2-10 shift for 7/19/20 on camera and saw nothing to confirm the above complain. I talked to the nurse and she stated no issues were reported to her and when [resident] comes out of her room, they put a mask on her and let her go...Resolution...[CMA#4] was called in to discuss her allegations. Was informed the video didn't back those allegations up. She received an employee warning for 1) dishonesty, misrepresentation 2) conducting one self in a manner contrary to recognized standards of morality [and] decency...[On the back of the concern form]When [CMA #4] told the nurse, she refused to do anything [and] just said a bunch of F words. Would throw things off the desk [and] make [CMA #4] pick them up...This happened

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LL067	Continued From page 48	LL067		

every weekend she has worked...This specific incident happened on 7/19/20...Wants to remain anonymous...wants to be notified of resolutions..."

An employee warning notice, dated 07/27/20, documented, "...EMPLOYEE [CMA#4]...Date of event...07/24/2020...PROBLEM/EVENT/INCIDENT...Dishonesty [and] misrepresentation about material information-suspension of one day...ACTION TAKEN:...WRITTEN WARNING #1...SUSPENSION..."

CMA #4 was disciplined and written up for misrepresentation and dishonesty as a direct result of reporting an allegation of verbal abuse against her co-workers.

On 06/23/21 at 8:30 a.m., LPN #3 was asked who staff reported suspected abuse to. She stated they reported it to the DON because that was their chain of command. She stated, about three months ago, a resident had reported verbal abuse to her and another nurse. She stated the DON was busy testing staff, the ADM was in a meeting so they went to the admin's assistant. She stated they were told they had to go to their chain of command. She was asked who they reported to if the DON was not in the facility. She stated they can always reach her on her the cell phone.

On 06/24/21 at 11:10 a.m., CMA # 3 was asked if she witnessed abuse. She stated she did a month or two ago and she reported it to the ADM. She was asked when and who did she report to. She stated staff typically report through the chain of command but the person who had done the abuse was her chain of command. She went on to state the incident was "traumatizing to me." She was asked if she was afraid to report abuse.

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LL067	Continued From page 49 She stated she was worried that someone would hold it against her. On 06/25/21 at 9:50 a.m., LPN #1 was asked if she had ever felt like she could not report incidents of allegations of abuse. She stated, "Yeah." She stated, "Sometimes things don't get done." She stated, "We feel like people should be more in trouble for certain things." At 3:09 p.m., the activity aide was asked if she had ever felt like she could not report allegations of abuse. She stated, "Honestly, yes." She stated, "Last time I reported to her [ADM], she blew me off." On 06/28/21 at 3:20 p.m., the Social Services[SS] #1 and ADM were asked to describe the investigation related to the grievance form dated 07/24/20. SS#1 stated she took the statement from CMA #4. The ADM stated the ADON and herself looked at the cameras for the 07/19/20. She was asked if it was for one shift. She stated they looked at the whole day. She was asked if the incident was thoroughly investigated. The ADM stated, "No." They were asked if CMA #4 received disciplinary action. The ADM stated, "Yes." She was asked why. SS #1 stated the DON and ADON had decided. The ADM stated in her opinion, they [DON and ADON] thought CMA #4 was lying. SS#1 stated, from what she remembered, they [DON and ADON] thought it was a fraudulent report. SS#1 stated she argued with them [DON and ADON] because, in her opinion, it was retaliation against the staff member. She stated CMA #4 wanted to	LL067		

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LL067	Continued From page 50 remain anonymous. On 06/29/21 at 7:02 p.m., CMA #3 was asked if she was fearful of reporting allegations of abuse. She stated, "Yes and No." She stated if LPN #3 was aware, I'd be afraid she'd come back at me." The facility failed to develope an abuse policy and procedure that ensured allegations could be reported with retribution. On 06/28/21 at 2:42 p.m., the administrator acknowledged the facility policy and procedure was not fully developed and implemented for abuse.	LL067		
LL242	1-O.S.63, 1-1918(B)5 RESIDENT RIGHTS Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated;	LL242		

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LL242	Continued From page 51	LL242		

This Rule is not met as evidenced by:
Based on record review and staff interviews, it was determined the facility failed to notify the physician of a change in the resident's condition for one (#7) of four sampled residents reviewed for notification.

The facility identified 95 residents resided in the facility.

Findings:

Resident #7 admitted with diagnoses which included convulsions.

The resident's care plan, dated 11/11/19, documented, "...is at risk for injury d/t [due to] seizures/convulsions ...Monitor/record time and duration, type of movement. Report to physician..."

Nurses' progress notes, dated 02/06/21, documented the resident had a seizure at 4:00

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LL242	Continued From page 52 a.m. and again at 6:06 a.m. There was no documentation the physician had been notified of either seizure. On 06/28/21 at 2:45 p.m., the administrator was asked if the physician was notified of the seizure activities. She stated it didn't look like it according to documentation. At 3:28 p.m., the assistant director of nursing stated the physician had not been notified. Based on record review and staff interviews, it was determined the facility failed to notify the physician of a change in the resident's condition for one (#7) of four sampled residents reviewed for notification. The facility identified 95 residents resided in the facility. Findings: Resident #7 admitted with diagnoses which included convulsions. The resident's care plan, dated 11/11/19, documented, "...is at risk for injury d/t [due to] seizures/convulsions ...Monitor/record time and duration, type of movement. Report to physician..." Nurses' progress notes, dated 02/06/21, documented the resident had a seizure at 4:00 a.m. and again at 6:06 a.m. There was no documentation the physician had been notified of either seizure.	LL242		

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LL242	Continued From page 53 On 06/28/21 at 2:45 p.m., the administrator was asked if the physician was notified of the seizure activities. She stated it didn't look like it according to documentation. At 3:28 p.m., the assistant director of nursing stated the physician had not been notified.	LL242		
LL244	1-O.S. 63-1-1918(B)(12) Rights and Responsibilities - Violations Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;	LL244		

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LL244	Continued From page 54	LL244		

This REQUIREMENT is not met as evidenced by:
On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents (#5,6,7,8, and #9) were free from abuse.

A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse.

An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured. The residents were not protected as the staff member was allowed to work.

The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse.

Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made.

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LL244	Continued From page 55 Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going. At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation. At 11:28 a.m., the Administrator (ADM) was notified of the IJ. An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following: "Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21... An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant	LL244		

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LL244	Continued From page 56 Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed." On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect. The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern. Based on observation, record review, interviews, it was determined the facility failed to ensure residents were free from abuse and neglect for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse and neglect. The facility also failed to have an environement that ensured staff were free to report allegations of abuse and negelct without fear of retaliation. The facility identified 95 residents resided in the facility.	LL244		

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LL244	Continued From page 57 Findings: An employee handbook, dated 03/2020, documented, "...The Company actively works to prevent...abuse by...Protecting employees...from adverse action when they do the right thing and report any genuine concern regarding...abuse...The Company strictly prohibits retaliation, in any form, against any individual making a report, complaint, or inquiry in good faith...Abuse & Neglect Policy...NO FORM OF ABUSE OR NEGLECT IS TOLERATED AND MUST BE REPORTED IMMEDIATELY...FAILURE TO REPORT ABUSE OR NEGLECT, EVEN SUSPECTED ABUSE OR NEGLECT, LEAVES YOU RESPONSIBLE FOR THE SITUATION...Bullying & Harassment...The Commons will not, in ay instance, tolerate bullying or harassing behavior. Employees found in violation of this policy will be disciplined, up to and including termination...examples of bullying and/or harassment: Verbal...ridiculing...humiliating...Shouting, raising voice at in individual in public...Telephone Calls & Cell Phones...Cell phone use is limited to break time only...Code of Conduct ...Disciplinary Procedures...Violations of any of these rules...may result in corrective action being taken, up to and including discharge...Physical or mental abuse of the residents or failure to report physical or mental abuse by others...Social Media...Employees must not post confidential...about...clients...Employees should not disparage any person...based on...disability..." An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be	LL244		

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reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer

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LL244	Continued From page 59 medications as prescribed..." Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN... Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain... Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..." A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally everyday, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurances, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..." An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of	LL244		

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LL244	Continued From page 60	LL244		

Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications.

The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

The employee continued to work during the investigaion of the alleged negelct.

The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld.

On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was

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LL244	Continued From page 61 asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader. At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that. On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that witheld the medication. At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me cause when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.	LL244		

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LL244	Continued From page 62 2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder. A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired. A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..." The allegation of abuse was not reported to the admininistraor until the next day after it occured. The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH). A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's	LL244		

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station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

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LL244	Continued From page 64 A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..." A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..." An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's	LL244		

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LL244	Continued From page 65 Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..." A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred. The facility failed to protect residents from further abuse during the investigation. The facilty failed to report the allegation timely to the administrator and a through investigation was not completed. On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening	LL244		

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to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were inserviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employeed by the faciltiy.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

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LL244	Continued From page 67 A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired. An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..." A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..." A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat	LL244		

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at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the

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nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."

CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

The facility had documented the allegation was unsubstantited even through there was a witness, and failed to complete a thourgh investigation by interviewing other staff members and residents.

On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on

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the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not

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interviewing other staff and residents. As a result, it is unknown if other residents had been involved.

4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.

A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.

A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.

A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..."

On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."

At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home."

An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She

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was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached...

A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..."

A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She can not really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..."

A statement from CNA #5, dated 06/28/21 ay 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..."

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LL244	Continued From page 73 A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..." A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..." On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us." The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN. The ADM was asked how she proteceted the	LL244		

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residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."

On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.

Reviewed with the ADM her interview from 06/28/21, where she reported the charge nurse texted herthat the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated

On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents (#5,6,7,8, and #9) were free from abuse.

A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn

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against the nurse.

An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured. The residents were not protected as the staff member was allowed to work.

The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse.

Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made.

Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going.

At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 11:28 a.m., the Administrator (ADM) was notified of the IJ.

An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

"Plan of AMENDED Removal for IJ's - ALL

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LL244	Continued From page 76 THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21... An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed." On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect.	LL244		

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LL244	Continued From page 77 The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern. Based on observation, record review, interviews, it was determined the facility failed to ensure residents were free from abuse and neglect for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse and neglect. The facility also failed to have an environement that ensured staff were free to report allegations of abuse and negelct without fear of retaliation. The facility identified 95 residents resided in the facility. Findings: An employee handbook, dated 03/2020, documented, "...The Company actively works to prevent...abuse by...Protecting employees...from adverse action when they do the right thing and report any genuine concern regarding...abuse...The Company strictly prohibits retaliation, in any form, against any individual making a report, complaint, or inquiry in good faith...Abuse & Neglect Policy...NO FORM OF ABUSE OR NEGLECT IS TOLERATED AND MUST BE REPORTED IMMEDIATELY...FAILURE TO REPORT ABUSE OR NEGLECT, EVEN SUSPECTED ABUSE OR NEGLECT, LEAVES YOU RESPONSIBLE FOR THE SITUATION...Bullying & Harassment...The Commons will not, in ay instance, tolerate bullying or harassing behavior. Employees found in violation of this policy will be disciplined, up to and including termination...examples of bullying	LL244		

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and/or harassment:
Verbal...ridiculing...humiliating...Shouting, raising voice at in individual in public...Telephone Calls & Cell Phones...Cell phone use is limited to break time only...Code of Conduct ...Disciplinary Procedures...Violations of any of these rules...may result in corrective action being taken, up to and including discharge...Physical or mental abuse of the residents or failure to report physical or mental abuse by others...Social Media...Employees must not post confidential...about...clients...Employees should not disparage any person...based on...disability..."

An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON,

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ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally everyday, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the

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request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurances, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications.

The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

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LL244	Continued From page 81 The employee continued to work during the investigaion of the alleged negelct. The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld. On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader. At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that. On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually	LL244		

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a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that witheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me cause when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See

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attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The allegation of abuse was not reported to the admininistraor until the next day after it occured.

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident

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came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What

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happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred.

The facility failed to protect residents from further abuse during the investigation.

The facilty failed to report the allegation timely to the administrator and a through investigation was not completed.

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THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
LL244	Continued From page 86 On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were inserviced about reporting timely. She stated, "Nothing in writing." On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."	LL244		

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The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employeed by the faciltiy.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that

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way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he

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was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on

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LL244	Continued From page 90 06/08/2021..." CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m. The facility had documented the allegation was unsubstantited even through there was a witness, and failed to complete a thourgh investigation by interviewing other staff members and residents. On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No." She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch	LL244		

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Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved.

4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.

A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.

A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.

A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration

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LL244	Continued From page 92 per policy..." On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago." At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home." An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached... A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..."	LL244		

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LL244	Continued From page 93 A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She can not really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..." A statement from CNA #5, dated 06/28/21 ay 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..." A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..." A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..." On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she	LL244		

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told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us."

The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN.

The ADM was asked how she proteceted the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."

On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.

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LL244	Continued From page 95 Reviewed with the ADM her interview from 06/28/21, where she reported the charge nurse texted her that the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated, "Yes", reffering to the discrepances in information. She was asked if she was concerned about the discrepancies. She stated, "What does the report say." Reviewed her interview from yesterday that she stated the nurse reported to her the description the resident stated "looks like us" and the report documented the resident was unable to describe the perpetrator. There was no response given. The two employees remained working at the facility all night after the allegation of rape and the resident identifying the RN and CNA as the ones who raped her. The facility failed to have an accurate a through investigation into the allegations. 5. Resident #6 had diagnoses which included Huntington's disease. A resident assessment, dated 02/15/21, documented the resident's cognition was intact. A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m. A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..." An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of	LL244		

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Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.

There was no documentation in the resident's clinical record of the alleged abuse against the resident.

The facility did not report the allegation of abuse to the Oklahoma State Department of Health within the required two hours.

A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m.

A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the following...For 5 day and final reports, please include a summary of the investigation...Face Sheet attached, investigation attached..."

Safe surveys were conducted with three residents on 03/23/21. The following questions were asked:
1. Do you feel like when you turn on your call light, you get everything you need taken care of?
2. Have you heard staff using inappropriate language?
3. Has staff ever yelled or spoken harsh to you?
4. If you feel like your needs aren't met, do you know who to talk to?
No negative answers were documented.

LPN #1 reamained working after the allegation of

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verbal abuse had been made and throughout the invesitigation.

There were no written staff statements from the reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur.

On 06/24/21 at 1:35 p.m., the DON was asked when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation had been completed. She stated the investigation was completed, but the documentation was not. She stated there was conflict between the activity aide and LPN #1. She was asked if LPN #1 had worked during the investigation. The DON stated, "Yes." She was asked what was put in place to prevent reoccurrence and to protect the residents. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. She stated the complainant was re-interviewed and had a discussion about how the allegation could not have occurred. She was asked if was reported timely. She stated she was not notified until the next day.

On 06/25/21 at 3:09 a.m., the activity aide was asked if she recalled the incident on 03/21/21. She stated she did. She stated LPN #1 had cursed at the resident when she reported to her

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that he had fallen. She stated, LPN #1 said, "Jesus F*** Christ, [Resident]. Really." She was asked who she had reported the incident to. She stated she reported it to her supervisor that day and that her supervisor was going to call the administrator.

The facility failed to protect residents during an investigation of abuse, thourghly invesitgate an allegation of abuse and failed to report the allegation to the administrator and approriate agencies timely.

6. Resident #1 was admitted to the facility with diagnoses which included Parkinson's disease.

A quarterly resident assessment, dated 06/12/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 06/12/21, documented, "...Resident...Involved...[resident #1]...Incident Type...Allegations of Abuse/Mistreatment..."

A notification of nurse aide report, dated 06/12/21, documented, "...CNA #1...was employee terminated...Yes...termination date 06/12/2021...ALLEGATIONS/FACTS OF ABUSE...On June 12, 2021 at approximately 11:00 am a incident was reported by a staff member in which a Resident [resident #1] was involved. CNA #1 recorded [resident #1] tying her shoe for her and she posted the video on her personal SnapChat story with the caption "But does your resident ever tie your shoes for no reason??" The caption was followed by a laughing face emoji and heart emoji. [CNA #1] was terminated for mistreatment of a resident and violation of our facility Social Media Policy..."

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LL244	Continued From page 99 On 06/23/21 at 8:59 a.m., the DON was asked when were the staff inserviced related to cell phone use and social media. She stated they are inserviced when they are hired during orientation. She was asked what the cell phone and social media restrictions were. She stated not to post anything about residents, the facility and no pictures. She stated staff were only to have their cell phones in break room and not to have a cell phone in resident areas. The DON was asked if the staff were inserviced related to the incident. She stated they planned on inservicing staff in July. She stated they were going to in June but they had to wait for their board's approval of the updated policy. She was asked if any corrective measures were put in place to protect the residents from further occurrence. She stated they weren't. On 06/24/21 at 2:00 p.m., the DON was asked what staff were interviewed as part as their investigation. She stated CMA #1. She stated they did not interview other staff who were working that same shift. She was asked if other staff members were not interviewed, was a thorough investigation completed. She stated, "Guess not." She was asked how residents were protected from further occurrence. She stated they did not initiate any new interventions. A thorough investigation had not been completed related to this incident. As a result, it is unknown if any other staff or residents had been involved. 7. A grievance concern form, dated 07/24/20, documented, "...Person Filing Complaint...[CMA #4]...Nature of the Concern...Weekend staff would yell at [Resident] when she came out of her room to go back, would walk her back, close her	LL244		

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door after she went in [and] hold the door so she couldn't open it. She eventually came out again, the Med [medication] aide grabbed her walker, yanked it around [and] said "I'm tired of this shit. When [CMA #4] said anything, she was bullied [and] retaliated against...

Staff Assigned to Investigate...ADON]..Investigation...Watched the 2-10 shift for 7/19/20 on camera and saw nothing to confirm the above complain. I talked to the nurse and she stated no issues were reported to her and when [resident] comes out of her room, they put a mask on her and let her go...Resolution...[CMA#4] was called in to discuss her allegations. Was informed the video didn't back those allegations up. She received an employee warning for 1) dishonesty, misrepresentation 2) conducting one self in a manner contrary to recognized standards of morality [and] decency...[On the back of the concern form]When [CMA #4] told the nurse, she refused to do anything [and] just said a bunch of F words. Would throw things off the desk [and] make [CMA #4] pick them up...This happened every weekend she has worked...This specific incident happened on 7/19/20...Wants to remain anonymous...wants to be notified of resolutions..."

An employee warning notice, dated 07/27/20, documented, "...EMPLOYEE [CMA#4]...Date of event...07/24/2020...PROBLEM/EVENT/INCIDENT...Dishonesty [and] misrepresentation about material information-suspension of one day...ACTION TAKEN:...WRITTEN WARNING #1...SUSPENSION..."

CMA #4 was disciplined and written up for misrepresentation and dishonesty as a direct result of reporting an allegation of verbal abuse

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against her co-workers.

On 06/23/21 at 8:30 a.m., LPN #3 was asked who staff reported suspected abuse to. She stated they reported it to the DON because that was their chain of command. She stated, about three months ago, a resident had reported verbal abuse to her and another nurse. She stated the DON was busy testing staff, the ADM was in a meeting so they went to the admin's assistant. She stated they were told they had to go to their chain of command. She was asked who they reported to if the DON was not in the facility. She stated they can always reach her on her the cell phone.

On 06/24/21 at 11:10 a.m., CMA # 3 was asked if she witnessed abuse. She stated she did a month or two ago and she reported it to the ADM. She was asked when and who did she report to. She stated staff typically report through the chain of command but the person who had done the abuse was her chain of command. She went on to state the incident was "traumatizing to me." She was asked if she was afraid to report abuse. She stated she was worried that someone would hold it against her.

On 06/25/21 at 9:50 a.m., LPN #1 was asked if she had ever felt like she could not report incidents of allegations of abuse. She stated, "Yeah." She stated, "Sometimes things don't get done." She stated, "We feel like people should be more in trouble for certain things."

At 3:09 p.m., the activity aide was asked if she had ever felt like she could not report allegations of abuse. She stated, "Honestly, yes." She stated, "Last time I reported to her [ADM], she blew me off."

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LL244	Continued From page 102 On 06/28/21 at 3:20 p.m., the Social Services[SS] #1 and ADM were asked to describe the investigation related to the grievance form dated 07/24/20. SS#1 stated she took the statement from CMA #4. The ADM stated the ADON and herself looked at the cameras for the 07/19/20. She was asked if it was for one shift. She stated they looked at the whole day. She was asked if the incident was thoroughly investigated. The ADM stated, "No." They were asked if CMA #4 received disciplinary action. The ADM stated, "Yes." She was asked why. SS #1 stated the DON and ADON had decided. The ADM stated in her opinion, they [DON and ADON] thought CMA #4 was lying. SS#1 stated, from what she remembered, they [DON and ADON] thought it was a fraudulent report. SS#1 stated she argued with them [DON and ADON] because, in her opinion, it was retaliation against the staff member. She stated CMA #4 wanted to remain anonymous. On 06/29/21 at 7:02 p.m., CMA #3 was asked if she was fearful of reporting allegations of abuse. She stated, "Yes and No." She stated if LPN #3 was aware, I'd be afraid she'd come back at me."	LL244		
LL610	310:675-7-5.1(b) Reporting abuse, neglect or misappropriation The facility shall report to the Department allegations and incidents of resident abuse, neglect or misappropriation of residents' property [63 O.S. §1-1939(I)(1)(e)]. This requirement does	LL610		

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LL610	Continued From page 103 not supersede reporting requirements in Title 43A of the Oklahoma Statutes (relating to the Protective Services for the Elderly and for Incapacitated Adults Act). This Rule is not met as evidenced by: On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure staff reported allegations of abuse immediately after identifying suspected and/or actual abuse had occurred. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator for investigation. An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured. The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse. Staff witnessed verbal abuse to Resident #6, by an employee and reported it to the charge nurse. The charge nurse did not report the allegation to the administrator timely. At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation. At 11:28 a.m., the Administrator (ADM) was notified of the IJ.	LL610		

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LL610	Continued From page 104 An acceptable plan of removal was provided by the administrator on 06/25/21 at 9:55 p.m. It documented the following: "All residents will be interviewed 06/25/2021. All staff on shift will be educated on updated policy immediately, and if not currently working will be inserviced by phone call by midnight on 06/25/2021. (see attached) (amended to be 9 am on 06/26/2021) ** if unable to be contacted, we will document date and time, and the staff member will be taken off the schedule until completed** The following texts will be sent to all staff immediately...Surveyors have identified serious deficiencies in Abuse reporting. All staff are required to complete in-service. Someone from The Commons will be calling you before midnight tonight...If you have been not contacted to complete an in-service by midnight, call [director of nursing] or will be removed from the schedule...Beginning IMMEDIATELY-reporting of ANY abuse allegations will be need to be texted or called to [administrator]...[assistant administrator]...This is any time- DAY or NIGHT! If no response to a text, then CALL...All staff that have been identified as not timely reporting abuse will be given a 1 day suspension. [Resident #5] -Staff member with physical abuse allegation will be terminated immediately. At every allegation of abuse, a text will be sent to all staff to remind staff that we take abuse very seriously...An allegation has been reported, this is a reminder NO forms of abuse will be tolerated Administrator, Asst Administrator and DON have learned that a thorough investigation includes resident safe surveys on all halls that the alleged abuser has worked. Handwritten statements from those questioned should be included in an investigation. We have reviewed the different types and	LL610		

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examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the witness is the person that has reported the incident during the investigation. We learned that to properly assess the resident we must conduct medical, psychosocial, and mental status assessment at the time, and an assessment each shift for 3 days for 9 occurrences"

On 06/28/21, six nurse aides (CNA), seven certified medication aides (CMA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse.

At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of her administrator forums online. She was asked if she shared that information with her administrative staff. She stated they looked up information themselves. She was asked if there was anything specific they educated the administrative staff on. She stated, "No, nothing specific."

At 3:30 p.m., the administrator was made aware that an amended plan of removal was needed due to ongoing abuse and neglect allegations not being reported timley, not rotecting residents and conducting thorough investigations.

An acceptable plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

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LL610	Continued From page 106 "Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21... An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed." On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were	LL610		

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able to state accurate information related to abuse and neglect.

The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern.

Based on record review, resident and staff interviews, it was determined the facility failed to ensure staff reported allegations of abuse immediately after identifying abuse/suspected abuse had occurred for four (#5, 6, 7 and #9) of six sampled residents reviewed for abuse.

The facility identified 95 residents resided in the facility.

Findings:

An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the

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DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at

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12:35 a.m., documented, "Generally every day, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents.

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LL610	Continued From page 110 The questions asked to the residents were not related to receiving pain medications. The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m. The employee continued to work during the investigaion of the alleged negelct. The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld. On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader. At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to	LL610		

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make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that withheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me because when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21

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from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The allegation of abuse was not reported to the administrator until the next day after it occurred.

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was

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sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A investigative summary, undated, documented, "...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

On 06/23/21 at 2:24 p.m., the admin was asked who the staff could report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were inserviced about reporting timely. She stated, "Nothing in

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writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[Resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling

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on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

An investigative summary, undated, documented, "...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

On 06/24/21 at 12:48 p.m., the DON acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one

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LL610	Continued From page 116 and a half to two and a half hours. 4. Resident #6 had diagnoses which included Huntington's disease. A resident assessment, dated 02/15/21, documented the resident's cognition was intact. A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..." An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m. On 06/24/21 at 1:35 p.m., the DON was asked if was reported timely. She stated she was not notified until the next day. On 06/25/21 at 3:09 a.m., the activity aide was asked who she had reported the incident to. She stated she reported it to her supervisor that day and that her supervisor was going to call the administrator.	LL610		

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On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure staff reported allegations of abuse immediately after identifying suspected and/or actual abuse had occurred.

A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator for investigation.

An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occured.

The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse.

Staff witnessed verbal abuse to Resident #6, by an employee and reported it to the charge nurse.

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LL610	Continued From page 118 The charge nurse did not report the allegation to the administrator timely. At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation. At 11:28 a.m., the Administrator (ADM) was notified of the IJ. An acceptable plan of removal was provided by the administrator on 06/25/21 at 9:55 p.m. It documented the following: "All residents will be interviewed 06/25/2021. All staff on shift will be educated on updated policy immediately, and if not currently working will be inserviced by phone call by midnight on 06/25/2021. (see attached) (amended to be 9 am on 06/26/2021) ** if unable to be contacted, we will document date and time, and the staff member will be taken off the schedule until completed** The following texts will be sent to all staff immediately...Surveyors have identified serious deficiencies in Abuse reporting. All staff are required to complete in-service. Someone from The Commons will be calling you before midnight tonight...If you have been not contacted to complete an in-service by midnight, call [director of nursing] or will be removed from the schedule...Beginning IMMEDIATELY-reporting of ANY abuse allegations will be need to be texted or called to [administrator]...[assistant administrator]...This is any time- DAY or NIGHT! If no response to a text, then CALL...All staff that have been identified as not timely reporting abuse will be given a 1 day suspension. [Resident #5] -Staff member with physical abuse allegation will be terminated immediately. At every allegation of	LL610		

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abuse, a text will be sent to all staff to remind staff that we take abuse very seriously...An allegation has been reported, this is a reminder NO forms of abuse will be tolerated Administrator, Asst Administrator and DON have learned that a thorough investigation includes resident safe surveys on all halls that the alleged abuser has worked. Handwritten statements from those questioned should be included in an investigation. We have reviewed the different types and examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the witness is the person that has reported the incident during the investigation. We learned that to properly assess the resident we must conduct medical, psychosocial, and mental status assessment at the time, and an assessment each shift for 3 days for 9 occurrences"

On 06/28/21, six nurse aides (CNA), seven certified medication aides (CMA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse.

At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of her administrator forums online. She was asked if she shared that information with her administrative staff. She stated they looked up information themselves. She was asked if there was anything specific they educated the administrative staff on. She stated, "No, nothing specific."

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LL610	Continued From page 120 At 3:30 p.m., the administrator was made aware that an amended plan of removal was needed due to ongoing abuse and neglect allegations not being reported timley, not rotecting residents and conducting thorough investigations. An acceptable plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following: "Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21... An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response	LL610		

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on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed."

On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect.

The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern.

Based on record review, resident and staff interviews, it was determined the facility failed to ensure staff reported allegations of abuse immediately after identifying abuse/suspected abuse had occurred for four (#5, 6, 7 and #9) of six sampled residents reviewed for abuse.

The facility identified 95 residents resided in the facility.

Findings:

An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken

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including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen

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LL610	Continued From page 123 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN... Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain... Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..." A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally every day, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..." An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family	LL610		

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LL610	Continued From page 124 called..." A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..." Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications. The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m. The employee continued to work during the investigaion of the alleged negelct. The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld. On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated.	LL610		

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LL610	Continued From page 125 She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader. At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that. On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that withheld the medication. At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me because when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco. 2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.	LL610		

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LL610	Continued From page 126 A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired. A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..." The allegation of abuse was not reported to the administrator until the next day after it occurred. The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH). A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of	LL610		

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here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A investigative summary, undated, documented, "...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility

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supervisory/management staff first contacted about the incident...On Feb 23rd..."

On 06/23/21 at 2:24 p.m., the admin was asked who the staff could report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were inserviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[Resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse

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towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

An investigative summary, undated, documented, "...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility

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supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

On 06/24/21 at 12:48 p.m., the DON acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours.

4. Resident #6 had diagnoses which included Huntington's disease.

A resident assessment, dated 02/15/21, documented the resident's cognition was intact.

A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..."

An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.

On 06/24/21 at 1:35 p.m., the DON was asked if was reported timely. She stated she was not notified until the next day.

On 06/25/21 at 3:09 a.m., the activity aide was

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LL610	Continued From page 131 asked who she had reported the incident to. She stated she reported it to her supervisor that day and that her supervisor was going to call the administrator.	LL610		
LL815	310:675-9-1.1(a) NURSING AND PERSONAL CARE SERVICES The facility shall ensure that resident rights are respected in the provision of care. This LEVEL A is not met as evidenced by: On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a thorough investigation had been conducted and appropriate corrective actions were taken for allegation of abuse. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse. An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until	LL815		

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LL815	Continued From page 132 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work. The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse. Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made. Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going. At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation. At 11:28 a.m., the Administrator (ADM) was notified of the IJ. An acceptable plan of removal was provided by the administrator on 06/25/21 at 9:55 p.m. It documented the following: "All residents will be interviewed 06/25/2021. All staff on shift will be educated on updated policy immediately, and if not currently working will be inserviced by phone call by midnight on 06/25/2021. (see attached) (amended to be 9 am	LL815		

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LL815	Continued From page 133 on 06/26/2021) ** if unable to be contacted, we will document date and time, and the staff member will be taken off the schedule until completed** The following texts will be sent to all staff immediately...Surveyors have identified serious deficiencies in Abuse reporting. All staff are required to complete in-service. Someone from The Commons will be calling you before midnight tonight...If you have been not contacted to complete an in-service by midnight, call [director of nursing] or will be removed from the schedule...Beginning IMMEDIATELY-reporting of ANY abuse allegations will be need to be texted or called to [administrator]...[assistant administrator]...This is any time- DAY or NIGHT! If no response to a text, then CALL...All staff that have been identified as not timely reporting abuse will be given a 1 day suspension. [Resident #5] -Staff member with physical abuse allegation will be terminated immediately. At every allegation of abuse, a text will be sent to all staff to remind staff that we take abuse very seriously...An allegation has been reported, this is a reminder NO forms of abuse will be tolerated Administrator, Asst Administrator and DON have learned that a thorough investigation includes resident safe surveys on all halls that the alleged abuser has worked. Handwritten statements from those questioned should be included in an investigation. We have reviewed the different types and examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the witness is the person that has reported the incident during the investigation. We learned that to properly assess the resident we must conduct medical, psychosocial, and mental status assessment at the time, and an assessment each shift for 3 days for 9	LL815		

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LL815	Continued From page 134 occurrences" On 06/28/21, six nurse aides (CNA), seven certified medication aides (CMA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse. At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of her administrator forums online. She was asked if she shared that information with her administrative staff. She stated they looked up information themselves. She was asked if there was anything specific they educated the administrative staff on. She stated, "No, nothing specific." The facility reported resident #8 made an allegation of rape by staff on 06/28/21 and the staff contnued to work over six hours after the allegation. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. At 3:30 p.m., the administrator was made aware that an amended plan of removal was needed due to ongoing abuse and neglect allegations without protecting residents and conducting thorough investigations. An acceptable plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:	LL815		

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LL815	Continued From page 135 "Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21... An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed." On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were	LL815		

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LL815	Continued From page 136 able to state accurate information related to abuse and neglect. The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern. Based on record review, resident and staff interviews, it was determined the facility failed to: ~ ensure a thorough investigation had been completed and ~ implement appropriate corrective actions when abuse had been idenitified for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse. The facility identified 95 residents resided in the facility. Findings: An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or	LL815		

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abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

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LL815	Continued From page 138 Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..." A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally every day, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurrences, [Resident] won't receive pain meds until sometimes 10 a.m. or as late a 2 p.m. as reflected on the MAR [medication administration record]..." An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..." A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med	LL815		

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LL815	Continued From page 139 is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..." Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications. The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m. The employee continued to work during the investigation of the alleged neglect. The facility did not complete a thorough investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld. On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader. At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents	LL815		

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related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that withheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me because when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21,

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documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards

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his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as

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it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately

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LL815	Continued From page 144 4 hours and 48 minutes after the abuse occurred. The facility failed to protect residents from further abuse during the investigation. The facility failed to report the allegation timely to the administrator and a thorough investigation was not completed. On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were in serviced about reporting timely. She stated, "Nothing in writing." On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3	LL815		

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continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employed by the facility.

The facility failed to complete a through and accurate investigation into the allegation of verbal abuse.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[Resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse

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towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready

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then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

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LL815	Continued From page 148 A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..." CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m. The facility had documented the allegation was unsubstantiated even through there was a witness, and failed to complete a thorough investigation by interviewing other staff members and residents. On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked	LL815		

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when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved.

4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.

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A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.

A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.

A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..."

On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."

At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home."

An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached...

A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented,

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"...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..."

A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She cannot really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..."

A statement from CNA #5, dated 06/28/21 at 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..."

A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..."

A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling

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LL815	Continued From page 152 Rape multiple times and saying the police are coming..." On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text On 06/25/21, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a thorough investigation had been conducted and appropriate corrective actions were taken for allegation of abuse. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse. An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work. The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse. Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the	LL815		

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allegation was made.

Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigtion was on going.

At 11:04 a.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 11:28 a.m., the Administrator (ADM) was notified of the IJ.

An acceptable plan of removal was provided by the administrator on 06/25/21 at 9:55 p.m. It documented the following:

"All residents will be interviewed 06/25/2021. All staff on shift will be educated on updated policy immediately, and if not currently working will be inserviced by phone call by midnight on 06/25/2021. (see attached) (amended to be 9 am on 06/26/2021)
** if unable to be contacted, we will document date and time, and the staff member will be taken off the schedule until completed**
The following texts will be sent to all staff immediately...Surveyors have identified serious deficiencies in Abuse reporting. All staff are required to complete in-service. Someone from The Commons will be calling you before midnight tonight...If you have been not contacted to complete an in-service by midnight, call [director of nursing] or will be removed from the schedule...Beginning IMMEDIATELY-reporting of ANY abuse allegations will be need to be texted

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or called to [administrator]...[assistant administrator]...This is any time- DAY or NIGHT! If no response to a text, then CALL...All staff that have been identified as not timely reporting abuse will be given a 1 day suspension. [Resident #5] -Staff member with physical abuse allegation will be terminated immediately. At every allegation of abuse, a text will be sent to all staff to remind staff that we take abuse very seriously...An allegation has been reported, this is a reminder NO forms of abuse will be tolerated Administrator, Asst Administrator and DON have learned that a thorough investigation includes resident safe surveys on all halls that the alleged abuser has worked. Handwritten statements from those questioned should be included in an investigation. We have reviewed the different types and examples of abuse and will follow our policies that have been updated. We will in-service all staff members on the attached education. We learned that the witness is the person that has reported the incident during the investigation. We learned that to properly assess the resident we must conduct medical, psychosocial, and mental status assessment at the time, and an assessment each shift for 3 days for 9 occurrences"

On 06/28/21, six nurse aides (CNA), seven certified medication aides (CMA), six licensed practical nurses (LPN), one registered nurse (RN), seven housekeepers and one maintenance staff from across all shifts, were interviewed and able to state accurate information related to abuse.

At 6:57 a.m., the ADM was asked what the facility did to further educate the administrative staff on abuse. She stated she looked through the state operations manual and reached out to some of

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her administrator forums online. She was asked if she shared that information with her administrative staff. She stated they looked up information themselves. She was asked if there was anything specific they educated the administrative staff on. She stated, "No, nothing specific."

The facility reported resident #8 made an allegation of rape by staff on 06/28/21 and the staff contnued to work over six hours after the allegation. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted.

At 3:30 p.m., the administrator was made aware that an amended plan of removal was needed due to ongoing abuse and neglect allegations without protecting residents and conducting thorough investigations.

An acceptable plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

"Plan of AMENDED Removal for IJ's - ALL THESE items will be completed by June 30th, 2021 [By 8:00 p.m.]...Abuse, Neglect, Misappropriation Investigation POLICY was updated...An outside agency will provide in-service on PRN [as needed] pain medication administration for CMA, and Nursing on June 30th. This inservice will focus on neglect, and not withholding medications. All staff that have not been in serviced by June 30th, 8pm may not work until in serviced, by the DON [director of nursing], ADON [assistant director of nursing], or the outside agency. Due to further consideration on

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LL815	Continued From page 156 06/28/21 [staff name deleted] was terminated. [CNA #6] and [LPN #3] will be terminated on 06/30/21... An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/21 with advanced traing on Abuse. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure all thorough investigation has been completed." On 07/01/21, two LPNs, one RN and three CMAs were interviewed and able to state accurate information related to abuse and neglect and five administrative staff were interviewed and were able to state accurate information related to abuse and neglect. The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern. Based on record review, resident and staff interviews, it was determined the facility failed to: ~ ensure a thorough investigation had been completed and	LL815		

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LL815	Continued From page 157 ~ implement appropriate corrective actions when abuse had been idenitified for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse. The facility identified 95 residents resided in the facility. Findings: An abuse policy, dated 12/08/2020, documented, "Reporting Requirements...allegations shall be reported immediately to the administrator, DON and to other officials in accordance with State law. Allegations that involve abuse...must be reported within 2 hours...These allegations must be thoroughly investigated and must prevent further potential abuse while the investigation is in progress...appropriate action must be taken including report to the appropriate licensing board...Prevention...It [sic] the policy of The Commons that each resident will be free from abuse, neglect...All facility staff will be in-serviced upon first employment, and at least annually thereafter, regarding...neglect or abuse...Immediately report any suspicion of abuse, neglect or mistreatment to your immediate supervisor...The supervisor WILL CALL the CELL phone of the ADMINISTRATOR [admin], then the DON ...Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician; families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed...Investigation...Procedure...1st ...Care for, treat and PROTECT the resident-DON, ADON, or house supervisor should do a medical assessment immediately...documenting any injury in detail...Take a statement from the	LL815		

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resident...2nd...Isolate the perpetrator...3rd ...Immediately notify the Administrator, then DON ..."

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally every day, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to

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administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurrences, [Resident] won't receive pain meds until sometimes 10 a.m. or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..."

A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..."

Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications.

The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m.

The employee continued to work during the investigation of the alleged neglect.

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LL815	Continued From page 160 The facility did not complete a thorough investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld. On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader. At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that. On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He	LL815		

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was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that withheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me because when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her

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LL815	Continued From page 162 Employee Assistance information..." The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH). A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..." A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic]	LL815		

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your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO

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reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred.

The facility failed to protect residents from further abuse during the investigation.

The facility failed to report the allegation timely to the administrator and a thorough investigation was not completed.

On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras,

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took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were in serviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for

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approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employed by the facility.

The facility failed to complete a through and accurate investigation into the allegation of verbal abuse.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[Resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on

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his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then

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LL815	Continued From page 168 [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..." An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..." A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."	LL815		

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CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

The facility had documented the allegation was unsubstantiated even through there was a witness, and failed to complete a thorough investigation by interviewing other staff members and residents.

On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She

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LL815	Continued From page 170 was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner. LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved. 4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain. A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m. A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m. A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..."	LL815		

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LL815	Continued From page 171 On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago." At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home." An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached... A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..." A statement from RN #2 documented,	LL815		

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"...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She cannot really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..."

A statement from CNA #5, dated 06/28/21 at 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..."

A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..."

A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..."

On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and

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get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us."

The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN.

The ADM was asked how she protected the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."

On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.

Reviewed, with the ADM, her interview from

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06/28/21, where she reported the charge nurse texted her that the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated, "Yes", referring to the discrepancies in information. She was asked if she was concerned about the discrepancies. She stated, "What does the report say." Reviewed her interview from yesterday that she stated the nurse reported to her the description the resident stated "looks like us" and the report documented the resident was unable to describe the perpetrator. There was no response given.

The two employees remained working at the facility all night after the allegation of rape and the resident identifying the RN and CNA as the ones who raped her.

The facility failed to have an accurate a thorough investigation into the allegations.

5. Resident #6 had diagnoses which included Huntington's disease.

A resident assessment, dated 02/15/21, documented the resident's cognition was intact.

A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m.

A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..."

An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity

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director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.

There was no documentation in the resident's clinical record of the alleged abuse against the resident.

The facility did not report the allegation of abuse to the Oklahoma State Department of Health within the required two hours.

A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m.

A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the following...For 5 day and final reports, please include a summary of the investigation...Face Sheet attached, investigation attached..."

Safe surveys were conducted with three residents on 03/23/21. The following questions were asked:
1. Do you feel like when you turn on your call light, you get everything you need taken care of?
2. Have you heard staff using inappropriate language?
3. Has staff ever yelled or spoken harsh to you?
4. If you feel like your needs aren't met, do you know who to talk to?
No negative answers were documented.

LPN #1 remained working after the allegation of verbal abuse had been made and throughout the

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investigation.

There were no written staff statements from the reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur.

On 06/24/21 at 1:35 p.m., the DON was asked when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation had been completed. She stated the investigation was completed, but the documentation was not. She stated there was conflict between the activity aide and LPN #1. She was asked if LPN #1 had worked during the investigation. The DON stated, "Yes." She was asked what was put in place to prevent reoccurrence and to protect the residents. She stated there were no changes. She was asked, how residents had been protected if the LPN worked during the investigation. She stated the complainant was re-interviewed and had a discussion about how the allegation could not have occurred. She was asked if was reported timely. She stated she was not notified until the next day.

On 06/25/21 at 3:09 a.m., the activity aide was asked if she recalled the incident on 03/21/21. She stated she did. She stated LPN #1 had cursed at the resident when she reported to her that he had fallen. She stated, LPN #1 said,

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LL815	Continued From page 177 "Jesus F*** Christ, [Resident]. Really." She was asked who she had reported the incident to. She stated she reported it to her supervisor that day and that her supervisor was going to call the administrator. The facility failed to protect residents during an investigation of abuse, thoroughly investigate an allegation of abuse and failed to report the allegation to the administrator and appropriate agencies timely. 6. Resident #1 was admitted to the facility with diagnoses which included Parkinson's disease. A quarterly resident assessment, dated 06/12/21, documented the resident's cognition was severely impaired. A state incident report form, dated 06/12/21, documented, "...Resident...Involved...[resident #1]...Incident Type...Allegations of Abuse/Mistreatment..." A notification of nurse aide report, dated 06/12/21, documented, "...CNA #1...was employee terminated...Yes...termination date 6/12/2021...ALLEGATIONS/FACTS OF ABUSE...On June 12, 2021 at approximately 11:00 am a incident was reported by a staff member in which a Resident [resident #1] was involved. CNA #1 recorded [resident #1] tying her shoe for her and she posted the video on her personal SnapChat story with the caption "But does your resident ever tie your shoes for no reason??" The caption was followed by a laughing face emoji and heart emoji. [CNA #1] was terminated for mistreatment of a resident and violation of our facility Social Media Policy..."	LL815		

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LL815	Continued From page 178 On 06/23/21 at 8:59 a.m., the DON was asked when the staff were in serviced related to cell phone use and social media. She stated they are in serviced when they are hired during orientation. She was asked what the cell phone and social media restrictions were. She stated not to post anything about residents, the facility and no pictures. She stated staff were only to have their cell phones in break room and not to have a cell phone in resident areas. The DON was asked if the staff were in serviced related to the incident. She stated they planned on in servicing staff in July. She stated they were going to in June but they had to wait for their board's approval of the updated policy. She was asked if any corrective measures were put in place to protect the residents from further occurrence. She stated they weren't. On 06/24/21 at 2:00 p.m., the DON was asked what staff were interviewed as part as their investigation. She stated CMA #1. She stated they did not interview other staff who were working that same shift. She was asked if other staff members were not interviewed, was a thorough investigation completed. She stated, "Guess not." She was asked how residents were protected from further occurrence. She stated they did not initiate any new interventions. A thorough investigation had not been completed related to this incident. As a result, it is unknown if any other staff or residents had been involved.	LL815		
LL816	310:675-9-1.1.(b)(1)(2) BASIC NURSING AND PERSONAL CARE (b) Basic nursing and personal care shall be provided for residents as needed.	LL816		

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LL816	Continued From page 179 (1) Nursing care shall include, but not be limited to: (A) Encouraging residents to be active and out of bed for reasonable time periods. (B) Measuring resident temperature, blood pressure, pulse and respirations at least once every thirty days and more frequently if warranted by the resident's condition, with the results recorded in the clinical record. (i) Measuring resident weight at least once every thirty days and more frequently if warranted by the resident's condition, with the results recorded in the clinical record. (ii) Measuring resident pain whenever vital signs are taken and more frequently if warranted by the resident's condition, with the results recorded in the clinical record. (C) Offering fluids, and making fluids available, to maintain proper hydration. (D) Following proper nutritional practices for diets, enteral and parenteral feedings and assistance in eating. (E) Providing proper skin care to prevent skin breakdown. (F) Providing proper body alignment. (G) Providing supportive devices to promote proper alignment and positioning. (H) Turning bed residents every two hours or as needed, to prevent pressure areas, contractures, and decubitus. (I) Performing range of motion exercises in accordance with individual assessment and care plans. (J) Ensuring that residents positions are changed every two hours or as needed when in a chair and are toileted as needed. (K) Establishing and implementing bowel and bladder programs to promote independence, or developing toileting schedules to promote	LL816		

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continence.
(L) Performing catheter care with proper positioning of bag and tubing at all times.
(M) Recording accurate intake and output records for residents with tube feedings or catheters.
(N) Assessing the general mental and physical condition of the resident on admission.
(O) Updating the assessment and individual care plan when there is a significant change in the resident's physical, mental, or psychosocial functioning.
(P) Recognizing and recording signs and symptoms of illness or injury with action taken to treat the illness or injury, and the response to treatments and medications.
(2) Personal care shall include, but not be limited to:
(A) Keeping residents clean and free of odor.
(B) Keeping bed linens clean and dry.
(C) Keeping resident's personal clothing clean and neat.
(D) Ensuring that residents are dressed appropriately for activities in which they participate; bedfast/chairfast residents shall be appropriately dressed and provided adequate cover for comfort and privacy.
(E) Ensuring that the resident's hair is clean and groomed.
(F) Providing oral hygiene assistance at least twice daily with readily available dental floss, toothbrush and dentifrice. A denture cleaning/soaking device and brush shall be available and maintained for each resident as needed.
(G) Keeping toenails and fingernails clean and trimmed.

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This Rule is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure physician's orders were followed for one (#3) of three sampled residents reviewed for following physician's orders.

The facility identified 95 residents resided in the facility.

Findings:

Resident #3 had diagnoses which included fractured left humerus.

On emergency department final report, dated

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LL816	Continued From page 182 02/05/21, documented, " ...Shoulder pain-swelling ...Follow up with: [physician name deleted] ...Within 1-2 days ..." A progress note, dated 02/05/21 at 9:54 p.m., documented the resident returned to the facility with no new orders. A progress note, dated 02/12/21 at 9:14 a.m., documented a virtual visit with the resident's physician had been conducted. This was the first visit since the emergency department visit. On 06/30/21 at 1:50 p.m., the director of nursing was shown the emergency department final report and the progress note of the virtual visit. She was asked if physician's orders had been followed for the follow-up appointment. She stated, "No, not specifically." Based on record review and staff interview, it was determined the facility failed to ensure physician's orders were followed for one (#3) of three sampled residents reviewed for following physician's orders. The facility identified 95 residents resided in the facility. Findings: Resident #3 had diagnoses which included fractured left humerus. On emergency department final report, dated 02/05/21, documented, " ...Shoulder pain-swelling ...Follow up with: [physician name deleted]	LL816		

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LL816	Continued From page 183 ...Within 1-2 days ..." A progress note, dated 02/05/21 at 9:54 p.m., documented the resident returned to the facility with no new orders. A progress note, dated 02/12/21 at 9:14 a.m., documented a virtual visit with the resident's physician had been conducted. This was the first visit since the emergency department visit. On 06/30/21 at 1:50 p.m., the director of nursing was shown the emergency department final report and the progress note of the virtual visit. She was asked if physician's orders had been followed for the follow-up appointment. She stated, "No, not specifically."	LL816		
LL902	310:676-13-3. ADMINISTRATOR (a) The administrator shall be licensed by the State Board of Examiners for Nursing Home Administrators and has the authority and responsibility for the total operation of the facility, subject only to the policies adopted by the governing authority. (b) The facility shall designate a person to act for the administrator during his/her absence. The designated person shall have the authority to exercise normal management responsibilities. This Rule is not met as evidenced by: On 06/28/21, an Immediate Jeopardy (IJ) situation was determined to exist related to facility failed to have an effective administration to implement an abuse program for	LL902		

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LL902	Continued From page 184 ~thoroughly investigating allegations of abuse and neglect; ~ protecting residents during investigations of abuse and neglect; ~ ensure residents were free from abuse and neglect; and ~ staff could report allegations without fear of reprisal. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse. An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work. The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse. Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made. Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the	LL902		

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perpetrator remaining at work and continued to work while the investigation was on going.

At 3:03 p.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation.

At 3:30 p.m., the Administrator (ADM) was notified of the IJ.

An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following:

An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to the Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/2021 with advanced training on ABUSE. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure a thorough investigation has been completed.

On 07/01/21, the administrative staff were interviewed and were able to state the seven components of abuse.

The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice

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remained at a level of actual harm at a pattern.

Based on observation, record review and staff interview it was determined the facility failed to have an effective administration to implement an abuse program for:

~ thoroughly investigating allegations of abuse and neglect;

~protecting residents during investigations of abuse and neglect;

~ensuring residents were free from abuse for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse; and

~ have an envrironement were staff could report allegations of abuse/negelect without fear of reprisal.

The facility Censeus was

Findings:

1. Resident #9 had diagnoses which included chronic pain and osteoarthritis.

A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired.

A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented,

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LL902	Continued From page 187 "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN... Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain... Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..." A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally every day, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..." An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them.	LL902		

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LL902	Continued From page 188 Resident is cognitive and needs no family called..." A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..." Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications. The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m. The employee continued to work during the investigaion of the alleged negelct. The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld. On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the	LL902		

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conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader.

At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that witheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me because when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN #3 would have her administer Tylenol or Ultram instead of the Norco.

2. Resident #7 was admitted to the facility with diagnoses which included convulsions and

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anxiety disorder.

A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired.

A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..."

The allegation of abuse was not reported to the administrator until the next day after it occurred.

The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH).

A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up

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and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..."

A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from

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[administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..."

A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."

An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was

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suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..."

A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred.

The facility failed to protect residents from further abuse during the investigation.

The facilty failed to report the allegation timely to the administrator and a through investigation was not completed.

On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected

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abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were in serviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employed by the facility.

3. Resident #5 was admitted to the facility with diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

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LL902	Continued From page 195 An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..." A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..." A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would	LL902		

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never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s) from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was

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the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."

CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

The facility had documented the allegation was unsubstantiated even through there was a witness, and failed to complete a thorough investigation by interviewing other staff members and residents.

On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She

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stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been

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LL902	Continued From page 199 involved. 4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain. A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m. A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m. A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..." On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago." At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home." An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S	LL902		

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LL902	Continued From page 200 [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached... A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..." A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She cannot really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..." A statement from CNA #5, dated 06/28/21 at 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..." A statement, dated 06/28/21, from CNA #7,	LL902		

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documented, "Resident stated she was being abused and raped repeatedly..."

A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..."

On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us."

The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She stated it was a CNA and an RN.

The ADM was asked how she protected the residents once she was made aware of the allegation of rape. She stated, "I told her to go in

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with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No."

On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements.

Reviewed with the ADM her interview from 06/28/21, where she reported the charge nurse texted her that the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated, "Yes", referring to the discrepancies in information. She was asked if she was concerned about the discrepancies. She stated, "What does the report say." Reviewed her interview from yesterday that she stated the nurse reported to her the description the resident stated "looks like us" and the report documented the resident was unable to describe the perpetrator. There was no response given.

The two employees remained working at the facility all night after the allegation of rape and the resident identifying the RN and CNA as the ones who raped her.

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The facility failed to have an accurate a thorough investigation into the allegations.

5. Resident #6 had diagnoses which included Huntington's disease.

A resident assessment, dated 02/15/21, documented the resident's cognition was intact.

A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m.

A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..."

An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m.

There was no documentation in the resident's clinical record of the alleged abuse against the resident.

The facility did not report the allegation of abuse to the Oklahoma State Department of Health within the required two hours.

A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m.

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LL902	Continued From page 204 A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the following...For 5 day and final reports, please include a summary of the investigation...Face Sheet attached, investigation attached..." Safe surveys were conducted with three residents on 03/23/21. The following questions were asked: 1. Do you feel like when you turn on your call light, you get everything you need taken care of? 2. Have you heard staff using inappropriate language? 3. Has staff ever yelled or spoken harsh to you? 4. If you feel like your needs aren't met, do you know who to talk to? No negative answers were documented. LPN #1 reamained working after the allegation of verbal abuse had been made and throughout the invesitigation. There were no written staff statements from the reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur. On 06/24/21 at 1:35 p.m., the DON was asked when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation had b	LL902		

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LL902	Continued From page 205 On 06/28/21, an Immediate Jeopardy (IJ) situation was determined to exist related to facility failed to have an effective administration to implement an abuse program for ~thoroughly investigating allegations of abuse and neglect; ~ protecting residents during investigations of abuse and neglect; ~ ensure residents were free from abuse and neglect; and ~ staff could report allegations without fear of reprisal. A staff member alleged that LPN #3 had been refusing/withholding pain medications to resident #9. The allegation was not reported timely to the administrator and a thorough investigation was not conducted. The employee remained working during the investigation and no action was taekn against the nurse. An allegation of staff being verbally abusive to resident #7 on 02/22/21 was not reported until 02/23/21, one day after the allegation occurred. The residents were not protected as the staff member was allowed to work. The facility documented an incident of resident #5 being physically abused by staff witnessed and reported by staff. The facility failed to protect the resident, complete a thorough investigation and implement corrected measures to prevent further abuse. Resident #8 made an allegation of rape by staff on 06/28/21 and the staff had been allowed to continue to work over six hours after the allegation was made.	LL902		

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LL902	Continued From page 206 Staff witnessed verbal abuse to Resident #6, by an employee and reported it. The allegation was not reported to the administrator timely and a thorough investigation was not conducted. The residents were not protected due to the perpetrator remaining at work and continued to work while the investigation was on going. At 3:03 p.m., the Oklahoma State Department of Health (OSDH) was notified and verified the existence of the IJ situation. At 3:30 p.m., the Administrator (ADM) was notified of the IJ. An acceptable, amended plan of removal was provided by the administrator on 06/29/21 at 7:20 p.m. It documented the following: An ADMINISTRATIVE team was formed called the INCIDENT RESPONSE TEAM on June 29th, and includes the Administrator, Assistant Administrator, DON, ADON, and HealthCare Center Resident services Director. The administrator or designee will report to the Board of Director any allegation of abuse at regularly scheduled monthly meetings at a minimum. The INCIDENT response team will be in-serviced by an outside source on all aspects of ABUSE - including screening, preventing, identifying, Investigating, protecting, and reporting/response on 06/30/2021 with advanced training on ABUSE. To always protect our residents, the INCIDENT response team will meet to collaborate and respond to allegations to ensure a thorough investigation has been completed. On 07/01/21, the administrative staff were interviewed and were able to state the seven components of abuse.	LL902		

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LL902	Continued From page 207 The immediate jeopardy deficiency was lifted as of 06/30/21 at 5:10 p.m. when all elements of the plan of removal and the amended plan of removal had been implemented. The deficient practice remained at a level of actual harm at a pattern. Based on observation, record review and staff interview it was determined the facility failed to have an effective administration to implement an abuse program for: ~ thoroughly investigating allegations of abuse and neglect; ~protecting residents during investigations of abuse and neglect; ~ensuring residents were free from abuse for six (#1, 5, 6, 7, 8 and #9) of six sampled residents reviewed for abuse; and ~ have an envrironement were staff could report allegations of abuse/negelect without fear of reprisal. The facility Censeus was Findings: 1. Resident #9 had diagnoses which included chronic pain and osteoarthritis. A resident assessment, dated 01/14/21, documented the resident's cognition was moderately impaired. A care plan, effective date 01/07/21, documented, "...Resident is at risk for pain r/t [related to] muscle spasms and chronic pain	LL902		

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syndrome...Resident will have pain treated/relieved in a timely manner...Administer medications as prescribed..."

Physician's orders, dated 06/08/21, documented, "hydrocodone 7.5 mg [milligrams]-acetaminophen 325 mg tablet (Norco) give 1 tablet by oral route every 8 hours as needed FOR CHRONIC PAIN...

Tylenol 325 mg capsule give 2 tablets by oral route every 6 hours as needed for pain...

Ultram 50 mg tablet give 1 tablet (50 mg) by oral route every 6 hours as needed for pain..."

A statement from CMA #3, dated 06/26/21 at 12:35 a.m., documented, "Generally every day, on multiple occasions, typically beginning first thing in the morning after the CNA has helped [Resident #9] get up out of bed for the day, he will ask for a pain pill. He will specifically ask for a Norco and rate his pain at an 8 out of 10 for leg or butt pain. As protocol, as the CMA, I report the request to the charge nurse, the charge nurse will go to the resident to evaluate the resident and report back to me, the CMA, with guidance to administer a pain med and instruct me with the level of the pain that was reported and the location of th [sic] pain. On many occurrences, [LPN #3], will deny the resident, [Resident's name], pain meds stating 'He just got up, he doesn't need a pain pill' or 'He's going outside to smoke a cigarette, he's not hurting bad enough if he can go outside to smoke' or 'He can't have a pain pill because he hasn't eaten anything yet.' On these occurances, [Resident] won't receive pain meds until sometimes 10 a.m or as late a 2 p.m. as reflected on the MAR [medication administration record]..."

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LL902	Continued From page 209 An OSDH incident form, dated 06/26/21, documented, "...[Resident #9]...Allegations of Abuse/Mistreatment...Description of Incident...Staff reported Nurse not approving PRN pain meds when resident asked for them. Resident is cognitive and needs no family called..." A statement from LPN #3, dated 06/27/21 at 12:23 [did not document a.m. or p.m.], documented, "Sometimes resident asks for pain pills when it is not time as he had it earlier. Med is scheduled [every] 8 [hours] prn. Resident is offered Tylenol if Norco can't be given yet..." Safe surveys were conducted with five residents. The questions asked to the residents were not related to receiving pain medications. The facility documented the allegation was unsubstantiated and completed on 06/27/21 at 5:30 p.m. The employee continued to work during the investigaion of the alleged negelct. The facility did not complete a through investigation and interview residents and staff to include the alleged victim regarding pain medications being withheld. On 06/28/21 at 12:40 p.m., the administrator and assistant administrator were asked about the conclusion of the investigation. The assistant administrator stated she had made an excel spreadsheet of which nurse had given Tylenol versus the Norco. She stated the accused nurse had administered the medications as much as the other nurses. She was asked if there was documentation of the times the resident had	LL902		

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requested the Norco. She stated she didn't think you could tell when he had requested it. She was asked if there was no documentation of when the resident requested it and the CMA stated LPN #3 withheld the medication, how did they come to the conclusion the allegation was unsubstantiated. She stated she went to the resident and asked him about it. She stated the resident is this nurse's biggest cheerleader.

At 1:19 p.m., the ADM provided resident surveys. There were no questions asked to the residents related to staff withholding pain medications. She stated the executive director had made the surveys and thought that the question "Do staff members respect your requests and allow you to make decisions regarding your care" covered that.

On 06/29/21 at 6:35 p.m., the resident was asked if he was in pain. He stated he had pain in his right side, leg and knee. She stated he would rate it at an 8 out of 10. He stated it was usually a 9 in the mornings. He was asked how he felt if he did not get his Norco when he requested it. He stated, "If I don't get them, I get mad." He was asked if his Norco was ever withheld. He stated it was and then stated he would not disclose who the employee was that witheld the medication.

At 7:02 p.m., CMA #3 was asked about the allegations made regarding LPN #3 withholding Norco. She stated, "Norco is what he asks for all the time." She stated, "It's upsetting to me because when he asks for something, I have protocol I have to follow." She stated that LPN #3 would give the same responses CMA #3 had put in her statement. She stated she was taught to take their pain as they stated it. She stated LPN

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LL902	Continued From page 211 #3 would have her administer Tylenol or Ultram instead of the Norco. 2. Resident #7 was admitted to the facility with diagnoses which included convulsions and anxiety disorder. A quarterly resident assessment, dated 02/18/21, documented the resident's cognition was severely impaired. A state incident report form, dated 02/23/21, documented, "...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Administrator was notified today of an allegation of verbal abuse occurring on 02/22/21 from a staff member against a nurse. The nurse is not on the schedule until Thursday. She will not be working until the allegation has been investigated. Investigation is in progress...For 5 day and final reports, please include a summary of the investigation...and corrective measures implemented to prevent recurrence...See attached for investigation: Nurse yelled at resident. She was suspended and counseled on ways to recognize burnout. Also gave her Employee Assistance information..." The allegation of abuse was not reported to the administrator until the next day after it occurred. The facility failed to report the allegation of abuse within two hours to the appropriate agencies such as the Oklahoma State Department of Health (OSDH). A written statement by CMA #3, dated 02/23/21, documented, "The day of 2-22-21, [resident #7] spent a majority of the day sitting in the North Hall hallway outside of [another resident]s room. At	LL902		

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approximately 2 p.m. [resident #7] wheeled himself in his wheelchair up closer to the nurse's station area and parked himself in his wheelchair outside of the wound care nurse's office. Immediately the charge nurse, [LPN #3], stood up and yelled to [resident #7] "get the hell out of here, you're not going to sit up here while I'm here." [Resident #7] did raise his hands and yelled at [LPN #3]. I do not know what he yelled at her, his speech is often hard to make out due to health conditions. [LPN #3] then yelled at him again "get the hell out of here, you're not going to talk to me that way." After this occurrence, [resident #7] wheeled himself away from the nurse's station area back down the hall towards his room...During this occurrence, [CMA #4] was sitting in a chair beside me and witnessed the entire event..."

A written statement by CMA #4, dated 02/24/21, documented, "On Monday February 22nd I [CMA #4] came into work I was on North Hall. I was sitting at nurses station [resident #7] the resident came strolling up to the Common Area by the nurses station [LPN #3] the nurse told him to turn around and go back he said he has rights She said I dont care Im not gonna [sic] deal with you and he said he wanted to sit up here She screamed at him and said "I dont give a dam [sic] your [sic] not sitting up here Im not gonna [sic] deal with your Ass. so [resident #7] sat in the Corner til [LPN #3] left he was very upset the rest of the evening..."

A written statement by CNA #3, dated 02/24/21, documented, "The other day I was in the office getting something when I heard [LPN #3] yelling at [resident #7]. And telling him to go to his room. [Resident #7] started yelling back at her and [LPN #3] got louder and told him she wasn't going to

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LL902	Continued From page 213 listen to it. Go to your room. [LPN #3] then said Im sick of him acting like this..." A written statement by LPN #3, dated 02/24/21 at 5:00 p.m., documented, "Missed a call from [administrator (admin)] [at] the Commons. Called back [and] was told there was an allegation against me for yelling [at] a male on North Hall on Monday February 22nd [at] approx [approximately] [2:00 p.m.]...Not only did I yell [at] the man but supposedly I cussed [at] him also per [admin] via the cameras. No Audio...Was also told I told male resident to go away, go down the hall or go to his room. I had asked residents not to sit in the area by wound care Nurse's office as it congests the hallway...May of raised my voice towards the resident..." A investigative summary, undated, documented, "...Who is/are the reported victim...[resident #7]...Who is/are the reported perpetrator...[LPN #3]...Who witnessed the incident...[CMA #3], [CNA #3], [CMA #4]...What happened...Resident...was in his wheelchair sitting near the nurse's desk. [LPN #3] the nurse came down the hall and started yelling at him to leave the desk...What is the history of the resident(s)? Was the incident foreseeable...The resident has had outbreaks lately, but there is NO reason a staff member should yell at a resident. A staff member should Never yell at resident, but this incident was not foreseeable...What does the victim want to happen...[resident #7] would not discuss the incident, but when asked what he would like to happen, he just shrugged his shoulder...When did the incident happen...Around 2pm on Feb [February] 22nd...When was facility supervisory/management staff first contacted about the incident...On Feb 23rd..."	LL902		

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LL902	Continued From page 214 An Oklahoma Board of Nursing complaint form, submitted date 02/26/21, documented, "...Nurse's Name: [LPN #3]...Did incident include Misconduct or Criminal Behavior...Yes: Patient abuse...Description of Investigation...LPN was suspended pending the investigation and returned to work on 02/26/2021. She received disciplinary action write up for raising her voice at a resident and for conducting herself in a manner contrary to recognized standards. Her employment at the facility is being retained..." A time sheet for pay period from 02/14/21 to 02/27/21, documented LPN #3 worked til 6:48 p.m. on 02/22/21. LPN #3 worked approximately 4 hours and 48 minutes after the abuse occurred. The facility failed to protect residents from further abuse during the investigation. The facilty failed to report the allegation timely to the administrator and a through investigation was not completed. On 06/23/21 at 2:24 p.m., the admin was asked to describe the incident that happened on 02/22/21 with resident #7. She stated the resident is hard of hearing and LPN #3 stated she didn't yell. She stated she reviewed the cameras, took statements from the witnesses and LPN #3 and discussed the incident with the resident's wife. She was asked when LPN #3 worked on 02/22/21. She stated she didn't know. She was asked when the incident was reported. She stated she was notified on the following day. She was asked what the outcome of her investigation was. She stated it was substantiated that LPN #3 did it. She stated she was suspended and had a write up. She was asked if the facility had a zero tolerance for abuse. She stated, "If I say yes, my	LL902		

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hand book is wrong." She was asked what was done to protect and prevent this from happening to other residents. She stated they didn't add anything else other than what was in place. She was asked who the staff can report suspected abuse to. She stated, "Any authority." She was asked when the staff had witnessed the abuse, did they report timely. She stated, "No." She was asked if the staff who witnessed the abuse were in serviced about reporting timely. She stated, "Nothing in writing."

On 06/24/21 at 1:09 p.m., the DON was asked if verbal abuse happened on 02/22/21 around 2:00 p.m. She stated "Yes." She was asked if LPN #3 continued to work after. She stated, "Yes." She was asked if LPN #3 continued to work with residents, how were the resident protected. She stated," They couldn't be, because we didn't know about it." She was asked, since the staff failed to report the abuse immediately, were the residents protected. She stated, "No."

The ADM was asked if the resident was assessed after the incident. She stated, "No."

The staff members who witnessed the abuse did not immediately report it. As a result, LPN #3 worked with the victim and other residents for approximately four hours and 48 minutes.

The facility did not put any corrective measures in place to prevent abuse from reoccurring. As a result, one of the witnesses [CMA #4] had an allegation of verbally abusing a different resident. The facility substantiated allegation and terminated CMA #4 while LPN #3 continued to be employed by the facility.

3. Resident #5 was admitted to the facility with

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diagnoses which included dementia.

A quarterly resident assessment, dated 05/02/21, documented the resident's cognitive skills for daily decision making was severely impaired.

An initial incident report form, dated 06/07/21, documented, "...Resident...Involved...[resident #5]...Incident Type...Allegations of Abuse/Mistreatment...Description of Incident...Received an allegation of abuse towards a resident by staff member. Staff member suspended pending investigation..."

A written statement from CMA #2, dated 06/07/21, documented "Around [8:30 a.m.] [CNA #2] asked me if I could come help her I told her yes just give me a second because I was in the middle of taking care of another Resident. When I walked into [resident #5]'s room [CNA #2] had ahold [sic] of his Right arm yanking [and] pulling on him while she was slapping at his left leg,-on bare skin-. I yelled at her to stop doing him that way [and] she was like what [and] just kind of dropped him back on the bed, she went to pull on his arm to get him up I told her to just leave that I would take care of him. I brought him out for breakfast [and] told the Charge Nurse...what had just happened. When [LPN #2] talked to [CNA #2] she told her to stay away from direct care of [resident #5]. When I seen [sic] D.O.N...around [10:00 a.m.] I asked if [LPN #2] had talk to her [and] I told [DON] what had happened She told me she was not aware but now she is [and] asked me to write out a statement..."

A written statement from LPN #2, dated 06/07/21, documented, "[CMA #2] came to me and stated "I yelled at [CNA #2] because she came out to ask me to help get him [resident #5] up I went into the

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room where she was and he was mad and hitting at her states she saw her grab his arm and swat at his left leg so I told her to leave and I would finish him, I went to [CNA #2] and asked what happened she said I was just playing and I would never hurt anyone was told by nurse to stay out of room..."

A written statement from CNA #2, dated 06/07/21, documented, "...[resident #5] was awake. So desided [sic] to get him up. got his clothes ready then uncovered him started talking to him while was getting him dressed. I started by putting [sic] his pull-up on the [sic] then i put his pants on. after that I took his hospital gown off. got his shirt ready to put his arm in. then put the arm in as I went to put his head his shirt, I told him not to Bite me. got his head in the whole [sic] [and] pull his shirt down. tried to sit him up By Putting my arm on leg to Push Leg in a sitting position while i have my other hand around upper back to help him sit up. then hollered [sic] at [CMA #2] to help stand him to finish getting dressed. Because he was fighting me. I was patting his...leg to clam [sic] him down to resure [sic] it was ok. then [CMA #2] came in their [sic] saw i was trying to hold him up. then told me Let him lay Back down the [sic] she would get him. then said was abusing him. I Left the room and went the Break room. then the nurse...ask me if i hit him I told her no i was patting him to try come [sic] him down. [LPN #2] told me not go around him again. until told other wise..."

An investigative summary, undated, documented, "...Who is...the reported victim...[resident #5]...who is...reported perpetrator...[CNA #2]...What happened...Allegation that CNA was yanking on Residents arm and slapping his leg...What was done to protect the resident(s)

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from further harm...Staff member was told not go around the resident until further notice by the nurse on the hall and then was suspended and sent home pending investigation by the DON...What is the history of the resident...Was the incident foreseeable...Resident has a history of being combative to staff when cares are delivered...When did the incident happen...06/07/21, [7:30 a.m.]...When was facility supervisory/management staff first contacted about the incident...[10:00 a.m.]..."

A final state report, dated 06/08/21, documented, "...A skin sweep was completed on the resident by two nurses with no injuries noted...The Accused perpetrator was suspended on 06/07/2021 pending an investigation. On 06/08/2021 she was counseled by the DON and the Administrator. She received verbal education or what could be considered to be abuse. She also completed a Relias Training entitled Understanding Dementia. The accused perpetrator was allowed to return to work on 06/08/2021..."

CNA #2's time sheet, dated 06/06/21 to 06/19/21, documented she worked on 06/07/21 from 6:30 a.m. to 10:04 a.m., and from 10:36 a.m. to 11:37 a.m. and on 06/08/21 from 8:27 a.m. to 1:27 p.m., and from 1:57 p.m. to 2:32 p.m.

The facility had documented the allegation was unsubstantiated even through there was a witness, and failed to complete a thorough investigation by interviewing other staff members and residents.

On 06/24/21 at 12:48 p.m., the DON was asked to describe her investigation process. She stated she would complete an incident report, remove

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and suspend staff, take statements from other staff on the hall that the incident occurred and complete safe surveys on cognitive residents on the section of the hall the incident occurred. She was asked if staff worked the same hall. She stated not always. She was asked if she considered interviewing other staff and residents on other halls. She stated she has interviewed other staff but not other residents. She was asked when the investigation was started. She stated on 06/07/21 at 10:00 a.m. She was asked when the investigation was completed. She stated late on 06/07/21. She was asked if a thorough investigation was conducted. She stated, "I feel it was thorough." She was asked if the resident was assessed after incident for delayed injury. She stated, "No."

She was asked when CNA #2 had worked on 06/07/21. She stated she left at 10:04 a.m. for lunch and when she returned, she was suspended and sent home. She was asked when she worked on 06/08/21. She stated she was here at 8:30 a.m. to meet with DON and watch Relias training then returned to the floor. She was asked what disciplinary actions CNA #2 received. She stated she watched Relias video about dementia, she was suspended on the 7th and two and a half hours on the 8th. The DON was asked what corrective actions were put in place to prevent further abuse and protect the residents. She stated there were no changes. The DON stated she didn't feel the allegation happened because CNA #2 left the door open and she called the CMA for help. She acknowledged staff did not notify DON or ADM of the incident in a timely manner.

LPN #2 did not report incident to the DON immediately and as a result, CNA #2 continued to

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work with other residents for approximately one and a half to two and a half hours. A thorough investigation was not completed by not interviewing other staff and residents. As a result, it is unknown if other residents had been involved.

4. Resident #8 had diagnoses which included pressure ulcer to the sacrum requiring a wound vacuum (vac) and pain.

A time record for RN #2, dated 06/27/21, documented she worked from 5:33 p.m. to 5:39 a.m.

A time record for CNA #5, dated 06/27/21, documented she worked from 10:01 p.m. to 5:39 a.m.

A progress note, dated 06/28/21 at 4:23 a.m., documented, "...She than [sic] began saying that she was raped by 50 females every 30 minutes...Staff is not to go in her room by themselves. This was reported to administration per policy..."

On 06/28/21 at 5:20 a.m., two police officers were observed to be at the front door to the facility. When approached, they stated they had received a call that a resident had been sexually abused. They were asked when they had received the call. One stated, "About five minutes ago."

At 5:25 a.m., the administrator stated, "I need to talk to you guys." She stated, "We have a crazy lady who says she was raped and I didn't send the two ladies home."

An OSDH incident report, dated of 06/27/21, documented, "...Final...[Resident #8]...Allegations

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of Abuse/Mistreatment...Description of Incident...Resident makes allegation that she was being raped by 50 people every 30 minutes. She was also saying we were trying to poison her when staff CMA gave her ultram...No S/S [signs/symptoms] of physical rape noted...For 5 day and final reports, please include a summary of the investigation...See attached...

A report summary, date and time of report completion 06/28/21 at 5:10 p.m., documented, "...Who is/are the reported perpetrator(s)...A woman and 50 of them...What happened...Accusation of Rape and bed bugs...What was done to protect the resident(s) from further harm...Staff was to always go in room 2 at a time...What was done upon discovery of the incident...Notified Administrator...What is the resident's current physical status...Assessment done at 5PM 06/28/21...When was facility supervisor/management staff first contacted about the incident...11:47 PM [06/27/21]..."

A statement from RN #2 documented, "...2305-2315 [11:05 p.m. to 11:15 p.m.] Resident began saying that there was bed bugs in her bed. The bed was checked by 2 staff and found no sign of bugs. She than [sic] began saying that she was raped. She has been yelling these allegations. She said that the rapest [sic] is a woman and there is 50 of them every 5 minutes. She cannot really describe them...Staff has been going in her room with 2 people and then after being told by Administration we have been going in with 2 Licensed nurses..."

A statement from CNA #5, dated 06/28/21 at 12:32 p.m., documented, "At 11:14 pm [Resident #8] started yelling...Shortly after she started

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yelling rape. She said she was raped and that everyone has been raped. She said that she has been raped every 30 minutes by 50 people..."

A statement, dated 06/28/21, from CNA #7, documented, "Resident stated she was being abused and raped repeatedly..."

A statement, dated 06/28/21, from CMA #5 documented, "...On 6-28-2021, resident in RM [resident #8's room number] has been yelling Rape multiple times and saying the police are coming..."

On 06/28/21 at 6:27 a.m., the ADM stated she had received a text message from the charge nurse last night at 11:14 p.m. that stated the resident's wound vac had alarmed. The ADM was observed to be reading the text messages from the charge nurse as we spoke. She stated when the nurse went in to check the alarm, the resident alleged rape. The administrator stated the nurse had informed her she had told staff not to go in there alone. The administrator stated she told the nurse to go ask when it happened and get a description of what the person looked like. The nurse told the ADM the resident reported a female rapist and 50 people every 30 minutes. The charge nurse told the ADM that the rapist "looks like us."

The ADM was asked how many staff had worked with the resident last night. She stated, "Two." She stated she had instructed the nurse to inform the family and physician and to assess the resident. She stated the resident refused to be assessed. The administrator stated she told the nurse, "You can't rape someone you can't get close to." She was asked who the two staff were that had been working with the resident. She

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LL902	Continued From page 223 stated it was a CNA and an RN. The ADM was asked how she protected the residents once she was made aware of the allegation of rape. She stated, "I told her to go in with two, always two." She was asked what the facility policy was for protecting residents if there was an allegation of abuse. She stated, "Let me find the policy." She located the policy and began reading it. She stated, "Immediately remove them, suspend." She was asked if either of the two staff had been suspended. She stated, "Not at the time." She stated, "I came and did it later." She was asked what time she suspended them. She stated, "I don't know, I was with the police." She was asked if her policy for suspending employees for allegations of abuse had been followed. She stated, "No." On 06/29/21 at 11:30 a.m., the investigation regarding resident #8 allegation of rape was reviewed with the ADM. She stated she based her report on the staff statements. Reviewed with the ADM her interview from 06/28/21, where she reported the charge nurse texted her that the resident described the perpetrators as "looks like us" and that the investigative report documented the resident was unable to give a description. The ADM stated, "Yes", referring to the discrepancies in information. She was asked if she was concerned about the discrepancies. She stated, "What does the report say." Reviewed her interview from yesterday that she stated the nurse reported to her the description the resident stated "looks like us" and the report documented the resident was unable to describe the perpetrator. There was no response given.	LL902		

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LL902	Continued From page 224 The two employees remained working at the facility all night after the allegation of rape and the resident identifying the RN and CNA as the ones who raped her. The facility failed to have an accurate a thorough investigation into the allegations. 5. Resident #6 had diagnoses which included Huntington's disease. A resident assessment, dated 02/15/21, documented the resident's cognition was intact. A time record, dated 03/21/21, documented LPN #1 worked from 5:42 a.m. to 3:21 p.m. A nurse's note, dated 03/21/21 at 1:44 p.m., documented, "Resident observed on floor lying on back..." An initial OSDH incident report, dated 03/21/21, documented, "...Allegations of Abuse Mistreatment...Description of Incident...Administrator was notified by Activity director that activity aide reported to her in a statement, that she overheard a nurse say "Jesus F****** Christ, [Resident #6] really? when she was notified he had fallen. Nurse is not on shift today. The nurse is suspended until investigation is complete..." A facsimile (fax) cover sheet, documented the report was sent to the OSDH on 03/22/21 at 4:22 p.m. There was no documentation in the resident's clinical record of the alleged abuse against the resident. The facility did not report the allegation of abuse to the Oklahoma State Department of Health	LL902		

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within the required two hours.

A time record for LPN #1 documented she worked on 03/23/21 from 5:42 a.m. to 2:34 p.m.

A final OSDH report, faxed to OSDH on 03/23/21 at 6:38 p.m., documented the following...For 5 day and final reports, please include a summary of the investigation...Face Sheet attached, investigation attached..."

Safe surveys were conducted with three residents on 03/23/21. The following questions were asked:
1. Do you feel like when you turn on your call light, you get everything you need taken care of?
2. Have you heard staff using inappropriate language?
3. Has staff ever yelled or spoken harsh to you?
4. If you feel like your needs aren't met, do you know who to talk to?
No negative answers were documented.

LPN #1 reamained working after the allegation of verbal abuse had been made and throughout the invesitigation.

There were no written staff statements from the reporting staff member, the perpetrator (LPN #1) or other staff with the investigation. The administrator documented that she had spoken to the staff member making the allegation and three others. She documented she spoke with resident #6. She documented the only person who reported hearing the comments was the staff member who had made the allegation. The administrator documented her conclusion was the incident did not occur.

On 06/24/21 at 1:35 p.m., the DON was asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2407	A. BUILDING: _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
LL902	Continued From page 226 when LPN #1 worked on 03/21/21. She stated she worked til 3:21 p.m. What disciplinary action did the LPN receive. The DON stated, "None." She was asked when the investigation had b	LL902		