STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375499	A. BUILDING _____ B. WING _____	06/23/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOOD MANOR NURSING CENTER	**2800 NORTH HICKORY STREET CLAREMORE, OK 74017**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 06-19-14 at 5:00 p.m., an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to complete a thorough investigation for an allegation of sexual abuse and failure to ensure residents were protected until a thorough investigation was completed. On 06-19-14 at 5:20 p.m., Oklahoma State Department of Health was notified and verified the Immediate Jeopardy situation. On 06-19-14 at 5:40 p.m., the administrator and director of nursing were notified of the IJ situation. On 06-19-14 at 8:00 p.m., an acceptable plan of removal was presented to the survey team. The Plan of Removal documented: Plan of Correction dated 06/19/14 DON (director of nursing) or designee will be in charge of completing in person or via phone an all staff in-service regarding abuse and neglect within the next 48 hours. All further reports of abuse and neglect will be monitored by the DON or designee for the next 3 months. Abuse Policy will be updated to include the following: Any employee reported for abuse, or suspected of abusing a resident will immediately be placed on un-paid suspension pending an investigation. Administrator will terminate employee in question, (name deleted) effective immediately. Staff has at this time been unable to notify him via phone. Shift supervisors will be alerted to direct him from the building should he come to the building. Administrator will complete pending investigation and faxed completed report to state. This investigation will be completed in the next 48 hours. The IJ was removed on 06-20-14 at 4:30 p.m. after all components of the plan of removal had been completed. The deficient practice remained at an isolated level with potential for more than minimal harm. Based on observation, interview, and record review, it was determined the facility failed to: a. thoroughly investigate in a timely manner an allegation of sexual abuse for 1 (#1) of 3 sampled residents who were reviewed for abuse allegations. b. protect other residents in the facility during an investigation of an allegation of sexual abuse for 1 (#1) of 3 sampled residents who were reviewed for abuse allegations. The administrator identified 118 residents in the facility. Findings: A facility abuse policy, undated, documented, .It is the policy of (facility name deleted) that every resident has the right to be free from abuse.Residents may not be subjected to abuse by anyone.The facility procedure to follow upon witnessing, or receiving an allegation of resident abuse or an unusual occurrence that needs to be reported to State Department of Health and Department of Human Services is as follows.7. The Administrator or their designee will then suspend or place the accused employee in an area of non-patient contact, if abuse is the issue, until the allegations are thoroughly investigated and/or cleared. A second facility abuse policy given to this surveyor during the investigation, undated, documented, .The facility procedure to follow upon witnessing or receiving an allegation of resident abuse or an unusual occurrence that needs to be reported to the State Department of Health and Department of Human Services is as follows.8. The resident will be removed from potential harm during an investigation by transferring the resident to a hospital, suspending a suspected staff member, and/or removing the resident or reassignment of staff member from the immediate area. Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. An admission assessment, dated 06-13-13, documented resident #1 was severely impaired cognitively, required extensive assistance with activities of daily living, did not ambulate, was incontinent of bowel and bladder, and had no episodes of [MEDICAL CONDITION] or behaviors. The resident's care plan, dated 06-17-13 and updated 12-20-13, documented the resident experienced a cognitive deficit related to decision making and periods of confusion. The care plan documented the resident was incontinent of bowel and bladder with interventions for staff to check and change the resident every two to four hours and as needed, and that the resident wore personal protection products for incontinence. A quarterly assessment, dated 03-13-14, documented resident #1 was severely impaired cognitively, required extensive assistance with activities of daily living, did not ambulate, was always incontinent of bowel and bladder and on a toileting program to manage bowel incontinence, had no episodes of [MEDICAL CONDITION] or behaviors, was usually able to make self understood, and could usually understand others. An initial incident report filed with the Oklahoma State Department of Health, dated 06-12-14, documented, .(name deleted) requested a meeting with me regarding her mother, (resident #1). She reported that a man had been in her mother's room and had tried to touch her inappropriately. Both (name deleted) and resident #1 were unable to provide a for sure time line but thought it was this morning. With multiple male staff members on the shift in question and no clear description. For the safety of the resident in question, all male aides were instructed not to provide care to resident #1 until further notice. A notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment or Misappropriation of Property, dated, 06-12-14, documented certified nurse assistant (CNA) #1 was not suspended or terminated pending investigation. On 06-19-14 at 12:15 p.m. the administrator was asked about the incident on 06-12-14. The administrator stated she was made aware of a statement by the resident to the assistant director of nursing (ADON) that resident #1 had been touched inappropriately. The administrator stated a meeting with resident #1 and her daughter had taken place that afternoon. The administrator was asked when she became aware of who the staff person was, did she suspend them. She stated no. The administrator stated she was placed on another care area and all males were instructed to not enter or care for resident #1 pending investigation. The administrator was asked why she waited 5 days to notify police of the investigation. She stated her initial investigation showed nothing inappropriate had happened and did not feel police involvement was necessary. The administrator was asked if she had interviewed other alert and oriented residents on the same hall as resident #1, and if they had observed anything suspicious or if they had experienced inappropriate touching. She stated no, only resident #1's roommate. The administrator was asked if the physician had been notified and asked to examine resident #1. She stated no. The administrator was asked if over the course of her investigation had she spoken with resident #1 about the allegation, her concerns, or her feelings. She stated no, that resident #1's family had asked her not to do this. The administrator was asked if she had finished her investigation within 5 working days. She stated she was continuing to investigate and had not completed the investigation. On 06-19-14 at 1:10 p.m., resident #1 was interviewed along with resident #2, her roommate. Resident #1 was observed sitting in her wheelchair in her room. She was asked about the events on 06-12-14. She stated, I was getting ready to get up and he was doing something 'down there' and I yelled for him to stop and get out as I was married. Resident #1 stated she was very upset but did not tell the nurses. Resident #1 was asked if she recognized the person who touched her. She stated no, she had never seen him before. Resident #2 was observed sitting in her wheelchair in her room. Resident #2 stated she was asleep at the time and did not hear resident #1 yell. Resident #2 stated resident #1 was known to yell for help instead of using the call light for staff assistance. Resident #2 was asked if she recognized the CNA in question. She stated yes that he was a new employee and had taken care of her on several occasions during the night. Resident #2 was asked if he had touched her inappropriately. She stated no. On 06-19-14 at 2:40 p.m., a call was placed to the (name deleted) police department to obtain a copy of the police report.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) The officer who had responded to the call to investigate the complaint was not available at that time. The officer who answered the phone stated a return call to this surveyor by the lieutenant in charge of the division would take place that day. On 06-23-14 at 8:40 a.m., CNA #1 was interviewed regarding the alleged incident on 06-12-14. CNA #1 stated he was a float aide that night and was asked by the assigned CNA to get resident #1 up for the morning. CNA #1 was asked what did that mean. He stated between 5:00 a.m. and 6:00 a.m., resident #1 was awakened, taken to the toilet, and dressed for the morning. CNA#1 stated there was nothing unusual about that morning. He stated when resident #1 sat up on the side of the bed, he felt her brief to see if it was wet. CNA #1 was asked if resident #1 yelled for him to stop and get out of her room. He stated no. CNA #1 stated she was her usual self that morning and when he finished with her care, he pushed her to the front lobby by the nurses' station where she sat each morning. CNA #1 was asked when he touched resident #1's brief, did he put his hand inside the brief. He stated no, only the outside. CNA #1 was asked if he had cared for resident #1 in the past. He stated yes, on several occasions. On 06-23-14 at 12:35 p.m., a follow-up telephone call was made to the (name deleted) police department as no return telephone call had been received by this surveyor from the officer in charge. The phone call was re-directed to the records division and a copy of the police report was faxed to the surveyor that day. On 06-23-14 at 1:30 p.m., a police department report was obtained. The report showed documentation an officer responded to the facility on [DATE] at 10:08 a.m. to obtain information regarding the alleged incident. The police report contained only a summary of the incident as presented by the facility. The police report showed no documentation of a determination of findings.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 06-19-14 at 5:00 p.m., an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to complete a thorough investigation for an allegation of sexual abuse and failure to ensure residents were protected until a thorough investigation was completed. On 06-19-14 at 5:20 p.m., Oklahoma State Department of Health was notified and verified the Immediate Jeopardy situation. On 06-19-14 at 5:40 p.m., the administrator and director of nursing were notified of the IJ situation. On 06-19-14 at 8:00 p.m., an acceptable plan of removal was presented to the survey team. 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The IJ was removed on 06-20-14 at 4:30 p.m. after all components of the plan of removal had been completed. The deficient practice remained at an isolated level with potential for more than minimal harm. Based on observation, interview, and record review, it was determined the facility failed to implement abuse policies and procedures for 1 (#1) of 3 sampled residents who were reviewed for abuse allegations. The facility failed to: a. thoroughly investigate in a timely manner an allegation of sexual abuse for resident #1. b. protect other residents in the facility during an investigation of an allegation of sexual abuse for resident #1. The administrator identified 118 residents in the facility. Findings: A facility abuse policy, undated, documented, .It is the policy of (facility name deleted) that every resident has the right to be free from abuse.Residents may not be subjected to abuse by anyone.The facility procedure to follow upon witnessing, or receiving an allegation of resident abuse or an unusual occurrence that needs to be reported to State Department of Health and Department of Human Services is as follows.7. The Administrator or their designee will then suspend or place the accused employee in an area of non-patient contact, if abuse is the issue, until the allegations are thoroughly investigated and/or cleared. A second facility abuse policy given to this surveyor during the investigation, undated, documented, .The facility procedure to follow upon witnessing or receiving an allegation of resident abuse or an unusual occurrence that needs to be reported to the State Department of Health and Department of Human Services is as follows.8. 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The administrator was asked when she became aware of who the staff person was, did she suspend them. She stated no. The administrator stated she was placed on another care area and all males were instructed to not enter or care for resident #1 pending investigation. The administrator was asked why she waited 5 days to notify police of the investigation. She stated her initial investigation showed nothing inappropriate had happened and did not feel police involvement was necessary. The administrator was asked if she had interviewed other alert and oriented residents on the same hall as resident #1, and if they had observed anything suspicious or if they had experienced inappropriate touching. She stated no, only resident #1's roommate. The administrator was asked if the physician had been notified and asked to examine resident #1. She stated no. 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Resident #2 stated she was asleep at the time and did not hear resident #1 yell. Resident #2 stated resident #1 was known to yell for help instead of using the call light for staff assistance. Resident #2 was asked if she recognized the CNA in question. She stated yes that he was a new employee and had taken care of her on several occasions during the night. Resident #2 was asked if he had touched her inappropriately. She stated no. On 06-19-14 at 2:40 p.m., a call was placed to the (name deleted) police department to obtain a copy of the police report. The officer who had responded to the call to investigate the complaint was not available at that time. The officer who answered the phone stated a return call to this surveyor by the lieutenant in charge of the division would take place that day. On 06-23-14 at 8:40 a.m., CNA #1

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) was interviewed regarding the alleged incident on 06-12-14. CNA #1 stated he was a float aide that night and was asked by the assigned CNA to get resident #1 up for the morning. CNA #1 was asked what did that mean. He stated between 5:00 a.m. and 6:00 a.m., resident #1 was awakened, taken to the toilet, and dressed for the morning. CNA#1 stated there was nothing unusual about that morning. He stated when resident #1 sat up on the side of the bed, he felt her brief to see if it was wet. CNA #1 was asked if resident #1 yelled for him to stop and get out of her room. He stated no. CNA #1 stated she was her usual self that morning and when he finished with her care, he pushed her to the front lobby by the nurses' station where she sat each morning. CNA #1 was asked when he touched resident #1's brief, did he put his hand inside the brief. He stated no, only the outside. CNA #1 was asked if he had cared for resident #1 in the past. He stated yes, on several occasions. On 06-23-14 at 12:35 p.m., a follow-up telephone call was made to the (name deleted) police department as no return telephone call had been received by this surveyor from the officer in charge. The phone call was re-directed to the records division and a copy of the police report was faxed to the surveyor that day. On 06-23-14 at 1:30 p.m., a police department report was obtained. The report showed documentation an officer responded to the facility on [DATE] at 10:08 a.m. to obtain information regarding the alleged incident. The police report contained only a summary of the incident as presented by the facility. The police report showed no documentation of a determination of findings.