STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375443	A. BUILDING _____ B. WING _____	09/19/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEVELAND MANOR NURSING & REHAB	900 NORTH DIVISION CLEVELAND, OK 74020

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 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 09/15/17, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect a resident from abuse. At 5:12 p.m., the Oklahoma State Department of Health verified the existence of the IJ situation. At 5:14 p.m., the administrator and director of nursing were notified of the IJ situation related to the facility's failure to protect a resident from abuse. On 09/15/17 at 7:54 p.m., an acceptable plan of removal was provided. The plan of removal documented, .FAILURE TO PROTECT RESIDENTS FROM ABUSE A. Employees will be educated on the facility Abuse Policy and Procedure on 9-15-17 before midnight. B. Quarterly in services will include signs of symptoms of burnout / excessive stress in staff and behavioral or physical changes in residents that could detect potential abuse. C. Any signs or symptoms of staff burnout/excessive stress in staff or changes that any staff may recognize with residents shall be reported to charge nurse immediately. D. Any staff member with a concern about another staff members behavior shall be ensure of confidentiality and protected from retaliation. The immediate jeopardy was removed on 09/15/17 at 11:45 p.m., when all components of the plan of removal were carried out. The deficient practice remained at an isolated level with a potential for more than minimal harm. Based on interview and record review, it was determined the facility failed to protect a resident from abuse for one (#3) of three sampled residents who were reviewed for allegations of abuse. Resident #3 was found to have an estimated 12 wipes pushed up into his rectum. The facility identified 52 residents who resided at the facility. Findings: The facility's abuse policy and procedures, which was not dated, documented, .A licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally abuse, or harmfully neglect a patient. Physical abuse is the use of physical force that may result in bodily injury, physical pain, or impairment . Resident #3 was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. The resident's care plan, dated 11/14/14, documented the resident needed extensive assist with toilet use, the resident would use the toilet or bedpan as needed for episodes of incontinence, staff would assist him on the toilet or a bedpan every two hours and as needed, and may use an incontinent brief while out of bed and an incontinent pad in bed. A facility inservice on abuse and neglect, dated 07/21/17, documented a signature of certified nurse aide (CNA) #1 which indicated that he had attended the inservice. The resident's quarterly assessment, dated 07/28/17, documented the resident was severely cognitively impaired; required total dependence on staff for transfers, dressing, and bathing; and was always incontinent of bowel and bladder. An interdisciplinary progress note, dated 09/07/17 at 7:00 p.m., documented, This nurse called to pt's (patient's) room by 2x (times) CNAs (certified nurse aides). Pt had a BM (bowel movement) et (and) while providing peri-care CNA pulled rolled/twisted wipes from pt's rectum. (No) apparent injury noted. Redness to buttocks et rectum however pt has had diarrhea throughout the day. D/T (due to) incident pt was transported to ER (emergency room) for eval (evaluation) et tx (treatment). Physician notified. Messages left (with) all contacts. (No) answer. An interdisciplinary progress note, dated 09/07/17 at 8:30 p.m., documented, Pt sent to (name deleted hospital) et then transferred to (name deleted hospital in name deleted town). Still unable to reach any family @ (at) this x (time). An Incident Report form, documented an allegation of abuse/mistreatment and the report was indicated it was the initial report. The report documented the incident date was 09/07/17 and documented, Adult wipes found in pt's rectum during peri-care (with) BM. (No) apparent injury obtained. Pt has had diarrhea throughout the day, redness noted. Investigation initiated, (with) inservice started (with) staff on duty. Employees suspended. Pt send to ER for eval. The report documented the local police were called on 09/07/17 at 7:40 p.m. This report was faxed to the Oklahoma State Department of Health (OSDH) on 09/07/17 at 11:40 p.m. An inservice training form, dated 09/11/17 with no time indicated, documented, .TOPIC use of wipes (with) BM (bowel movement) .Always ensure wipes are removed (after) pt care. Never put wipes into rectum. An Incident Report form documented it was an allegation of abuse/mistreatment and the report indicated it was the final report. The report documented the incident date was 09/07/17 and documented, Police have taken over investigation & informed us that we are not allowed to interview staff or possible suspects, therefore we are unable to complete at this time. Will send f/u (follow-up) info (information). When available. Res, admitted to (name deleted hospital). This report was faxed to OSDH on 09/08/17 at 12:57 p.m. The resident's hospital after care instructions, dated as printed on 09/08/17 at 11:11 a.m., documented, .FEARED CONDITION RULED-OUT (ADULT) .2. The condition you or your doctor were concerned about did not seem like a serious problem. Your doctor does not think you have a medical problem that needs treatment. This is based on your history and physical exam .Note: Our social workers have talked to your family and everyone involved feels comfortable sending you back at this point. Your workup her in the ER did not reveal any concerning abnormalities .CT (cat scan) - Abdomen = Normal. An interdisciplinary progress note, dated 09/08/17 at 1:00 p.m., documented the resident was readmitted back to the nursing facility. An inservice training form, dated 09/11/17 with no time indicated, documented, All prn (as needed) - meds (medications) - nurse must be informed prior to giving. All prn pain meds must be doc. (documented) on MAR (medication administration record) showing location & pain scale before & after administration. Nurses to assess & document findings of request for pain meds prn. A facility Investigative Report Follow Up, dated 09/13/17, documented, On September 07, 2017 we were notified of wipes being found in resident (name deleted resident #3's) rectum. Investigation initiated immediately with this nurse phoning Administrator, who phone the (name deleted) Police Department and began watching surveillance video, with the charge nurse assessing the resident finding redness to rectal area, no other injuries noted. I arrived at the facility to assist with the investigation. Statements were able to be obtained from the two aides who found the resident in this condition, before the police arrived. Attempted to contact (name deleted CNA #1) and to inform of suspension with investigation, but no response at that time. Attempted to interview resident with no response to questioning. An in-service was initiated on the use of wipes to always ensure wipes are removed after care and never to be put into rectum. Police informed us they would be assuming this incident as a criminal act and not to interview further staff or residents, that it is their investigation

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375443	A. BUILDING _____ B. WING _____	09/19/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEVELAND MANOR NURSING & REHAB	900 NORTH DIVISION CLEVELAND, OK 74020

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 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) at this time. Resident was sent to (name deleted hospital) in Tulsa for evaluation. Report was submitted to OSDH, DHS (department of human services), Oklahoma Nurse Aide Registry and the Abuse Hotline, (name deleted physician) and family were notified by phone. CNA #1 returned my call and police instructed him to come to facility to question him. (Name deleted CNA #2) CNA who worked the shift with (name deleted CNA #1) brought him to visit Officer (name deleted Officer #1). While present she stated she made rounds and was with (name deleted CNA #1) all day. At that point Officer (name deleted Officer #1) asked me if she was suspended as well and I stated yes. On September 08, 2017 resident returned to facility with after care instructions stating feared condition ruled out, no treatment was needed and all tests were normal. On September 11, 2017 Administrator converted surveillance video onto thumb drive and provided to (name deleted) Police, Chief (name deleted), with a copy of staff names and phone numbers that had entered resident's room that day. Later that day, Chief of police with Administrator and informed of (name deleted CNA #1) confessing to resident abuse. Administrator inquired on suspended aide, (name deleted CNA #2's) statement to police and Chief informed him that she stated that (name deleted CNA #1) had told her on the way home from work and Chief asked her if she thought to inform the authorities or nursing home and she said no. Chief stated permission to complete our investigation. Resident's roommate and other residents were interviewed about abuse and none have been abused or seen any abuse to others. Staff and hospice caregivers that entered room were interviewed, none were aware of any abuse. Being permitted to continue with our investigation, we learned that the resident had experienced diarrhea and complaint of pain of buttocks. Medication had been given for both pain and diarrhea with an in service initiated to ensure nurse aware of any prn medication and assesses for need, with documentation in MAR (medication administration record) and nurses notes. On September 12, 2017 a new order was received to discontinue Broda chair use geri chair and [MEDICATION NAME] routinely for complaint of pain. With the confession of abuse from (name deleted CNA #1) and failure to report and protect by (name deleted CNA #2), both are substantiated and terminated from this facility. (Name deleted CNA #1) is in jail at this time . The report was signed by the administrator and the director of nursing. This report was faxed to OSDH on 09/13/17 at 1:37 p.m. On 09/15/17 at 1:10 p.m., the surveyor entered the building and asked for various items/information to start the investigation which included allegations of abuse, neglect, or misappropriation which had been investigated since the facility's last annual survey. After a tour of the facility and interviewing some residents the surveyor reviewed the facility's investigation of the above allegation of abuse. The facility's investigation included two pictures. One picture showed what appeared to be a resident's anal area with something whitish in color sticking out of a resident's anus. The object sticking out of the resident's anus was covered with what looked to be bowel movement (BM) except for a few small areas where the whitish color could be seen. The area around the resident's anus looked engorged. The resident's buttocks had BM on them. The other picture was of a resident's buttocks area that was red in various places. On 09/15/17 at 3:30 p.m., the administrator and director of nursing (DON) were interviewed. They were asked how many residents they had interviewed during their investigation. They named the three residents that had been interviewed during their investigation. The administrator and DON were asked, three residents during your investigation. They stated yes. The administrator and DON were asked if they had completed any inservices. They stated yes. The administrator stated that they had immediately started training on pericare for the use of wipes with a BM. They were asked if they had completed any other inservices. The DON stated on 09/11/17 they had done an inservice on prn medications. The DON stated those were the two inservices they had done at that point. The administrator and DON were asked if they had done an inservice related to abuse, neglect, and reporting abuse. They stated no. The DON stated no, because we did it timely, we reported it timely. The administrator and DON were asked if they had identified a problem with reporting. The administrator stated, No, I did not. The surveyor stated the facility's investigative report stated that CNA #1 told CNA #2 and CNA #2 failed to report it to the authorities and the nursing home. The administrator stated yes and stated CNA #2 had been terminated related to CNA #2's failure to report. The administrator was asked so you identified a failure to report. The administrator stated yes. The administrator was asked did you inservice related to failure to report. The administrator stated no. The DON asked should we have. The administrator stated, Yes, we will need to. On 09/15/17 at 3:48 p.m., the chief of police was asked what were the findings of their investigation of the abuse allegation of resident #3 and CNA #1. The police chief stated the CNA had confessed. He stated the wipes were 8 inches by 12 inches in size and they estimated 12 wipes were used. He stated he had the CNA show him, how he had put the wipes into the resident's rectum. The chief showed the surveyor how he had made his hand with his first finger and thumb into a circle. He stated the CNA roughly pushed into the open area of chief's hand. On 09/15/17 at 4:13 p.m., the administrator and DON returned to the surveyor and stated they had started to inservice staff members about reporting abuse. He stated staff were being told if anything was seen, suspected, or heard about to tell the charge nurse, administrator, or DON. The administrator was asked who took the pictures of the resident. The administrator stated that CNA #3 had. The administrator stated the facility had a social media policy. He stated he had seen a picture of the dirty wipes on the DON's phone. The administrator was asked when CNA #1 had left the faciity on [DATE]. He stated at 3:00 p.m., as the staff members had an inservice that day to attend. The administrator was asked what time CNA #1 had stopped providing residents care. He stated at 2:00 p.m. The administrator and DON were asked what time the resident had been found with the wipes in his rectum. They reviewed the investigation documentation and stated at 6:44 p.m. The administrator and DON were asked why were the wipes not found until 6:44 p.m. He reviewed the investigation documentation and stated CNA #4 had been in the resident's room at 3:00 p.m. He stated the resident was gotten up for dinner at 5:00 p.m. The administrator and DON were asked if the CNAs had gotten the nurse to see the wipes while they were still in the resident's rectum or did they just pull the wipes out. He stated he did not know, then he stated he thought the nurse (licensed practical nurse (LPN) #1) had told him she had seen it. The administrator and DON were asked if the resident's anal/buttocks area pictures were on CNA 3's personal cell phone. They stated yes. They were asked if they had the CNA delete the pictures. They stated, no the police wanted them. They were asked who the pictures had been sent to. They stated the pictures had been sent via text message from CNA #3 to the administrator and then the administrator sent them to the DON. On 09/15/17 at 6:39 p.m., CNA #3 was interviewed. The CNA was asked to tell the surveyor about the situation with resident #3 and the wipes. She stated when she took over the floor, CNA #1 had told her the resident had had diarrhea several times that day and he had put wipes by his bottom in his brief to take care of the diarrhea. She stated before the resident was gotten out of bed for dinner she had checked the resident's brief and he was not wet or dirty. She stated she did take pictures. The surveyor showed her the two pictures that were in the facility's investigation file and asked her if those were the pictures she had taken. She stated yes. CNA #3 was asked when she had notified the nurse. She stated as soon as she had seen what was going on with the resident. The CNA was asked if the nurse had seen the wipes in the resident's rectum. She stated, no she had slowly pulled it out. She stated it was covered in BM. She stated she thought it was BM. The CNA was asked if the resident had done anything while she pulled them out. She stated, no. She stated he did when she wiped him. She stated it was really red. The CNA was asked what the resident did when she wiped him. She stated he cinched his butt cheeks together and called out nurse, nurse. She was asked if nurse was all the resident could say. She stated, yes. CNA #3 was asked where the wipes were when she went to go get the nurse. She stated she had them in a trash bag. The CNA was asked if they had finished cleaning up the resident when she went to go get the nurse. She stated, no. The CNA was asked what she had told the nurse. She stated she had told the nurse that she thought there was something wrong with resident #3's bottom that she needed to see. The CNA was asked if the nurse came right then to see the resident. The CNA stated yes. The CNA was asked which nurse came to check the resident. She stated she thought it was LPN #1. CNA #3 was asked what the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375443	A. BUILDING _____ B. WING _____	09/19/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEVELAND MANOR NURSING & REHAB	900 NORTH DIVISION CLEVELAND, OK 74020

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 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) LPN had done. She stated the nurse came to the resident's room, checked the resident, looked at the wipes, and asked the resident if he was in any pain. The CNA was asked what the nurse did next. The CNA stated the nurse called the administrator and DON. The CNA was asked who had the wipes. She stated she did until someone working that night had accidentally thrown them away. She stated she had dug them out of the garbage to show the police. On 09/15/17 at 7:13 p.m., CNA #4 was asked to tell the surveyor about the incident related to resident #3. She stated she and CNA #3 had put the resident to bed after dinner. She stated they went to pull down his brief. She stated he was all dirty. She stated she could see one white spot then the resident looked like he started to have a BM and it (the wipes) started to come out. She stated CNA #3 started to carefully slowly pull it out. She stated she went to go get the nurse. She stated she was in shock. She stated, that was in his rectum. When asked she stated she was not in the resident's room when the nurse came into the resident's room. When asked she stated she did not know what the nurse did because she got busy. She stated she did see the DON and then the police came to the facility. She stated she had filled out a statement for the DON and the police. CNA #4 was asked what the resident did while the wipes were coming out. She stated he called out oh nurse and cinched his buttocks. The CNA was asked what the resident did while he was getting cleaned up. She stated he called out, oh nurse. On 09/15/17 at 7:59 p.m., LPN #1 was asked to tell the surveyor about the incident with resident #3. She stated it was rolled up like a tampon. She stated CNA #3 had to pull them out of his rectum. She stated she immediately left the room and called the DON. She stated the DON called the administrator and the administrator called the police. She stated the police came to the facility. She stated she and the DON started getting paperwork together and called the physician. She stated the police asked if the resident was getting an abdominal xray. She stated the resident was sent to the hospital. On 09/15/17 at 8:15 p.m., with LPN #1 the resident's buttocks and anal area was observed. The resident's anal area and buttocks were not red and had no open areas. On 09/19/17 at 4:17 p.m., a phone interview was conducted with CNA #3. The CNA was asked when she took a picture of the resident's buttocks and anal area. She stated before she touched it or anything, she took a picture. CNA #3 was asked why she took the pictures. She stated, Evidence.
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 09/15/17, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to implement their abuse policy and procedure to prevent resident abuse. At 5:12 p.m., the Oklahoma State Department of Health verified the existence of the IJ situation. At 5:14 p.m., the administrator and director of nursing were notified of the IJ situation related to the facility's failure to protect a resident from abuse. On 09/15/17 at 7:54 p.m., an acceptable plan of removal was provided. The plan of removal documented, .FAILURE TO IMPLEMENT POLICY AND PR(NAME)EDURES ON PREVENTING ABUSE A. Employees will be educated on the facility Abuse Policy and Procedure on 9-15-17 before midnight. B. A thorough investigation to include statements from all cognitive residents on abuse by midnight 9-15-17. B (C). Thorough reference checks on any new employees will be conducted. C (D). All employees will be interviewed 9-15-17 by midnight related to the substantiated allegation of abuse on 9-7-17. The immediate jeopardy was removed on 09/15/17 at 11:45 p.m., when all components of the plan of removal were carried out. The deficient practice remained at a pattern level with a potential for more than minimal harm. Based on interview and record review, it was determined the facility failed to implement their abuse policy and procedure to: ~ prevent resident abuse for one (#3) of three sampled residents who were reviewed for allegations of abuse; ~ conduct a thorough investigation; ~ ensure staff members reported the allegation immediately; ~ report the allegation in a timely manner; and ~ failed to ensure pictures were not taken of a resident. Resident #3 was found to have an estimated 12 wipes pushed up into his rectum. The facility identified 52 residents who resided at the facility. Findings: The facility's abuse policy and procedures, which was not dated, documented, .A licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally abuse, or harmfully neglect a patient. Physical abuse is the use of physical force that may result in bodily injury, physical pain, or impairment . The facility must have evidence that all alleged violations are thoroughly investigated , and must prevent further potential abuse while the investigation is in progress . A licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally abuse, or harmfully neglect a patient. A nursing home employee who becomes aware of an act prohibited by this section immediately shall report the matter to the nursing home Administrator of Nursing Director . Any employee who suspects or witnesses abuse or neglect toward a resident must report it to the facility administrator or his /her designee. The provider ensures that any suspected or alleged incidents of abuse and neglect are thoroughly, objectively and expeditiously investigated and substantiated incidents are reported to the state and local law enforcement and regulatory agencies as required. The facility's photography/video/audio recording policy, which was not dated, documented, There shall be NO picture taking, videotaping or audio recording of staff, residents, or property of (name deleted nursing facility) without approval from the Administrator. Resident #3 was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. The resident's care plan, dated 11/14/14, documented the resident needed extensive assist with toilet use, the resident would use the toilet or bedpan as needed for episodes of incontinence, staff would assist him on the toilet or a bedpan every two hours and as needed, and may use an incontinent brief while out of bed and an incontinent pad in bed. A facility inservice on abuse and neglect, dated 07/21/17, documented a signature of certified nurse aide (CNA) #1 which indicated that he had attended the inservice. The resident's quarterly assessment, dated 07/28/17, documented the resident was severely cognitively impaired; required total dependence on staff for transfers, dressing, and bathing; and was always incontinent of bowel and bladder. An interdisciplinary progress note, dated 09/07/17 at 7:00 p.m., documented, This nurse called to pt's (patient's) room by 2x (times) CNAs (certified nurse aides). Pt had a BM (bowel movement) et (and) while providing peri-care CNA pulled rolled/twisted wipes from pt's rectum. (No) apparent injury noted. Redness to buttocks et rectum however pt has had diarrhea throughout the day. D/T (due to) incident pt was transported to ER (emergency room) for eval (evaluation) et tx (treatment). Physician notified. Messages left (with) all contacts. (No) answer. An interdisciplinary progress note, dated 09/07/17 at 8:30 p.m., documented, Pt sent to (name deleted hospital) et then transferred to (name deleted hospital in name deleted town). Still unable to reach any family @ (at) this x (time). An Incident Report form, documented it was an allegation of abuse/mistreatment and the report indicated it was the initial report. The report documented the incident date was 09/07/17 and documented, Adult wipes found in pt's rectum during peri-care (with) BM. (No) apparent injury obtained. Pt has had diarrhea throughout the day, redness noted. Investigation initiated, (with) inservice started (with) staff on duty. Employees suspended. Pt send to ER for eval. The report documented the local police were called on 09/07/17 at 7:40 p.m. This report was faxed to the Oklahoma State Department of Health (OSDH) on 09/07/17 at 11:40 p.m. An inservice training form, dated 09/11/17 with no time indicated, documented, .TOPIC use of wipes (with) BM (bowel movement) .Always ensure wipes are removed (after) pt care. Never put wipes into rectum. An Incident Report form documented it was an allegation of abuse/mistreatment and the report indicated it was the final report. The report documented the incident date was 09/07/17 and documented, Police have taken over investigation &

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375443	A. BUILDING _____ B. WING _____	09/19/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEVELAND MANOR NURSING & REHAB	900 NORTH DIVISION CLEVELAND, OK 74020

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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) informed us that we are not allowed to interview staff or possible suspects, therefore we are unable to complete at this time. Will send f/u (follow-up) info (information). When available. Res, admitted to (name deleted hospital). This report was faxed to OSDH on 09/08/17 at 12:57 p.m. The resident's hospital after care instructions, dated as printed on 09/08/17 at 11:11 a.m., documented, .FEARED CONDITION RULED-OUT (ADULT) .2. The condition you or your doctor were concerned about did not seem like a serious problem. Your doctor does not think you have a medical problem that needs treatment. This is based on your history and physical exam .Note: Our social workers have talked to your family and everyone involved feels comfortable sending you back at this point. Your workup her in the ER did not reveal any concerning abnormalities .CT (cat scan) - Abdomen = Normal. An interdisciplinary progress note, dated 09/08/17 at 1:00 p.m., documented the resident was readmitted back to the nursing facility. An inservice training form, dated 09/11/17 with no time indicated, documented, All prn (as needed) - meds (medications) - nurse must be informed prior to giving. All prn pain meds must be doc. (documented) on MAR (medication administration record) showing location & pain scale before & after administration. Nurses to assess & document findings of request for pain meds prn. A facility Investigative Report Follow Up, dated 09/13/17, documented, On September 07, 2017 we were notified of wipes being found in resident (name deleted resident #3's) rectum. Investigation initiated immediately with this nurse phoning Administrator, who phone the (name deleted) Police Department and began watching surveillance video, with the charge nurse assessing the resident finding redness to rectal area, no other injuries noted. I arrived at the facility to assist with the investigation. Statements were able to be obtained from the two aides who found the resident in this condition, before the police arrived. Attempted to contact (name deleted CNA #1) and to inform of suspension with investigation, but no response at that time. Attempted to interview resident with no response to questioning. An in-service was initiated on the use of wipes to always ensure wipes are removed after care and never to be put into rectum. Police informed us they would be assuming this incident as a criminal act and not to interview further staff or residents, that it is their investigation at this time. Resident was sent to (name deleted) in Tulsa for evaluation. Report was submitted to OSDH, DHS (department of human services), Oklahoma Nurse Aide Registry and the Abuse Hotline, (name deleted physician) and family were notified by phone. CNA #1 returned my call and police instructed him to come to facility to question him. (Name deleted CNA #2) CNA who worked the shift with (name deleted CNA #1) brought him to visit Officer (name deleted Officer #1). While present she stated she made rounds and was with (name deleted CNA #1) all day. At that point Officer (name deleted Officer #1) asked me if she was suspended as well and I stated yes. On September 08, 2017 resident returned to facility with after care instructions stating feared condition ruled out, no treatment was needed and all tests were normal. On September 11, 2017 Administrator converted surveillance video onto thumb drive and provided to (name deleted) Police, Chief (name deleted), with a copy of staff names and phone numbers that had entered resident's room that day. Later that day, Chief of police with Administrator and informed of (name deleted CNA #1) confessing to resident abuse. Administrator inquired on suspended aide, (name deleted CNA #2's) statement to police and Chief informed him that she stated that (name deleted CNA #1) had told her on the way home from work and Chief asked her if she thought to inform the authorities or nursing home and she said no. Chief stated permission to complete our investigation. Resident's roommate and other residents were interviewed about abuse and none have been abused or seen any abuse to others. Staff and hospice caregivers that entered room were interviewed, none were aware of any abuse. Being permitted to continue with our investigation, we learned that the resident had experienced diarrhea and complaint of pain of buttocks. Medication had been given for both pain and diarrhea with an in service initiated to ensure nurse aware of any prn medication and assesses for need, with documentation in MAR (medication administration record) and nurses notes. On September 12, 2017 a new order was received to discontinue Broda chair use geri chair and [MEDICATION NAME] routinely for complaint of pain. With the confession of abuse from (name deleted CNA #1) and failure to report and protect by (name deleted CNA #2), both are substantiated and terminated from this facility. (Name deleted CNA #1) is in jail at this time . The report was signed by the administrator and the director of nursing. This report was faxed to OSDH on 09/13/17 at 1:37 p.m. On 09/15/17 at 1:10 p.m., the surveyor entered the building and asked for various things to start the investigation which included allegations of abuse, neglect, or misappropriation which had been investigated since the facility's last annual survey. After a tour of the facility and interviewing some residents the surveyor reviewed the facility's investigation of the above allegation of abuse. The facility's investigation included two pictures. One picture showed what appeared to be a resident's anal area with something whitish in color sticking out of a resident's anus. The object sticking out of the resident's anus was covered with what looked to be bowel movement (BM) except for a few small areas where the whitish color could be seen. The area around the resident's anus looked engorged. The resident's buttocks had BM on them. The other picture was of a resident's buttocks area that was red in various places. On 09/15/17 at 3:30 p.m., the administrator and director of nursing (DON) were interviewed. They were asked how many residents they had interviewed during their investigation. They named the three residents that had been interviewed during their investigation. The administrator and DON were asked, three residents during your investigation. They stated yes. The administrator and DON were asked if they had completed any inservices. They stated yes. The administrator stated that they had immediately started training on pericare for the use of wipes with a BM. They were asked if they had completed any other inservices. The DON stated on 09/11/17 they had done an inservice on prn medications. The DON stated those were the two inservices they had done at that point. The administrator and DON were asked if they had done an inservice related to abuse, neglect, and reporting abuse. They stated no. The DON stated no, because we did it timely, we reported it timely. The administrator and DON were asked if they had identified a problem with reporting. The administrator stated, No, I did not. The surveyor stated the facility's investigative report stated that CNA #1 told CNA #2 and CNA #2 failed to report it to the authorities and the nursing home. The administrator stated yes and stated CNA #2 had been terminated related to CNA #2's failure to report. The administrator was asked so you identified a failure to report. The administrator stated yes. The administrator was asked did you inservice related to failure to report. The administrator stated no. The DON asked should we have. The administrator stated, Yes, we will need to. On 09/15/17 at 3:48 p.m., the chief of police was asked what were the findings of their investigation of the abuse allegation of resident #3 and CNA #1. The police chief stated the CNA had confessed. He stated the wipes were 8 inches by 12 inches in size and they estimated 12 wipes were used. He stated he had the CNA show him, how he had put the wipes into the resident's rectum. The chief showed the surveyor how he had made his hand with his first finger and thumb into a circle. He stated the CNA roughly pushed into the open area of chief's hand. On 09/15/17 at 4:13 p.m., the administrator and DON returned to the surveyor and stated they had started to inservice staff members about reporting abuse. He stated staff were being told if anything was seen, suspected, or heard about to tell the charge nurse, administrator, or DON. The administrator was asked who took the pictures of the resident. The administrator stated that CNA #3 had. The administrator stated the facility had a social media policy. He stated he had seen a picture of the dirty wipes on the DON's phone. The administrator was asked when CNA #1 had left the faciity on [DATE]. He stated at 3:00 p.m., as the staff members had an inservice that day to attend. The administrator was asked what time CNA #1 had stopped providing residents care. He stated at 2:00 p.m. The administrator and DON were asked what time the resident had been found with the wipes in his rectum. They reviewed the investigation documentation and stated at 6:44 p.m. The administrator and DON were asked why were the wipes not found until 6:44 p.m. He reviewed the investigation documentation and stated CNA #4 had been in the resident's room at 3:00 p.m. He stated the resident was gotten up for dinner at 5:00 p.m. The administrator and DON were asked if the CNAs had gotten the nurse to see the wipes while they were still in the resident's rectum or did they just pull the wipes out. He stated he did not know, then he stated he thought the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375443	A. BUILDING _____ B. WING _____	09/19/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEVELAND MANOR NURSING & REHAB	900 NORTH DIVISION CLEVELAND, OK 74020

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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) (licensed practical nurse (LPN) #1) had told him she had seen it. The administrator and DON were asked if the resident's anal/buttocks area pictures were on CNA 3's personal cell phone. They stated yes. They were asked if they had the CNA delete the pictures. They stated, no the police wanted them. They were asked who the pictures had been sent to. They stated the pictures had been sent via text message from CNA #3 to the administrator and then the administrator sent them to the DON. On 09/15/17 at 6:39 p.m., CNA #3 was interviewed. The CNA was asked to tell the surveyor about the situation with resident #3 and the wipes. She stated when she took over the floor, CNA #1 had told her the resident had had diarrhea several times that day and he had put wipes by his bottom in his brief to take care of the diarrhea. She stated before the resident was gotten out of bed for dinner she had checked the resident's brief and he was not wet or dirty. She stated she did take pictures. The surveyor showed her the two pictures that were in the facility's investigation file and asked her if those were the pictures she had taken. She stated yes. CNA #3 was asked when she had notified the nurse. She stated as soon as she had seen what was going on with the resident. The CNA was asked if the nurse had seen the wipes in the resident's rectum. She stated, no she had slowly pulled it out. She stated it was covered in BM. She stated she thought it was BM. The CNA was asked if the resident had done anything while she pulled them out. She stated, no. She stated he did when she wiped him. She stated it was really red. The CNA was asked what the resident did when she wiped him. She stated he cinched his butt cheeks together and called out nurse, nurse. She was asked if nurse was all the resident could say. She stated, yes. CNA #3 was asked where the wipes were when she went to go get the nurse. She stated she had them in a trash bag. The CNA was asked if they had finished cleaning up the resident when she went to go get the nurse. She stated, no. The CNA was asked what she had told the nurse. She stated she had told the nurse that she thought there was something wrong with resident #3's bottom that she needed to see. The CNA was asked if the nurse came right then to see the resident. The CNA stated yes. The CNA was asked which nurse came to check the resident. She stated she thought it was LPN #1. CNA #3 was asked what the LPN had done. She stated the nurse came to the resident's room, checked the resident, looked at the wipes, and asked the resident if he was in any pain. The CNA was asked what the nurse did next. The CNA stated the nurse called the administrator and DON. The CNA was asked who had the wipes. She stated she did until someone working that night had accidentally thrown them away. She stated she had dug them out of the garbage to show the police. On 09/15/17 at 7:13 p.m., CNA #4 was asked to tell the surveyor about the incident related to resident #3. She stated she and CNA #3 had put the resident to bed after dinner. She stated they went to pull down his brief. She stated he was all dirty. She stated she could see one white spot then the resident looked like he started to have a BM and it (the wipes) started to come out. She stated CNA #3 started to carefully slowly pull it out. She stated she went to go get the nurse. She stated she was in shock. She stated that was in his rectum. When asked she stated she was not in the resident's room when the nurse came into the resident's room. When asked she stated she did not know what the nurse did because she got busy. She stated she did see the DON and then the police came to the facility. She stated she had filled out a statement for the DON and the police. CNA #4 was asked what the resident did while the wipes were coming out. She stated he called out oh nurse and cinched his buttocks. The CNA was asked what the resident did while he was getting cleaned up. She stated he called out, oh nurse. On 09/15/17 at 7:59 p.m., LPN #1 was asked to tell the surveyor about the incident with resident #3. She stated it was rolled up like a tampon. She stated CNA #3 had to pull them out of his rectum. She stated she immediately left the room and called the DON. She stated the DON called the administrator and the administrator called the police. She stated the police came to the facility. She stated she and the DON started getting paperwork together and called the physician. She stated the police asked if the resident was getting an abdominal xray. She stated the resident was sent to the hospital. On 09/15/17 at 8:15 p.m., with LPN #1 the resident's buttocks and anal area was observed. The resident's anal area and buttocks were not red and had no open areas. On 09/19/17 at 1:52 p.m., the administrator was asked who took the two pictures of resident #3's buttocks and anal area. He stated he thought it was CNA #3. He stated he thought she had sent the pictures to him. He was asked who saw the pictures. He stated he had sent them to the DON. He stated he did not think he had sent them to anybody else. He was asked if anyone else had the pictures. He stated, not that he was aware of. The administrator was asked who normally takes pictures of the residents. He stated he was the only one that took the new residents' pictures for their medication administration record. He stated he emailed them to himself then deleted the pictures. He was asked what was his process for taking the residents' pictures. He stated he just takes a picture of the residents' face, on his phone, then sends it to his email, with no identifying information in the subject line. The administrator was asked how he was protecting resident #3's privacy with the two pictures of his buttocks and anal area on electronic devices. He stated he was gong to speak to the DON and CNA #3 about not sharing the pictures with anybody. The administrator was asked if he had spoken to them about not sharing or showing the pictures. He stated he had not. The administrator was asked if they had shown the pictures to anyone else. He stated not that he was aware of. The administrator was asked if LPN #1 had seen the pictures. He stated yes, probably. On 09/19/17 at 2:02 p.m., the DON was asked if she had received the pictures of resident #3's buttocks and anal area. She stated yes the administrator had sent them to her. The DON was asked where were the pictures. She stated on her work phone she stated the police told the administrator to keep the pictures as they may be needed. The DON was asked if her phone was purely a work phone. She stated yes. She was asked how the resident's privacy was being protected with the pictures on her phone. She stated with a code or her fingerprint. On 09/19/17 at 2:18 p.m., the administrator was asked if his phone that had the pictures of resident #3 was it a personal phone. He stated no it was a business phone and the business paid for the phone. The administrator was asked if he also used the phone for personal use. He stated yes he did. On 09/19/17 at 2:23 p.m., the DON was asked if she used her business phone for personal use. She stated yes. Then she stated she was not on Facebook and she had not posted it anywhere else. On 09/19/17 at 2:34 p.m., LPN #1 was asked if she had seen the pictures of resident #3's bottom. She stated yes on the DON's phone. The LPN was asked if the pictures had been sent to her. She stated no. She was asked if she had seen the pictures on CNA #3's phone. She stated no. On 09/19/17 at 4:17 p.m., a phone interview was conducted with CNA #3. The CNA was asked when she took a picture of the resident's buttocks and anal area. She stated before she touched it or anything, she took a picture. She stated she had deleted the pictures from her phone. She was asked when she deleted the pictures. She stated two to three days after she took them. The CNA was asked if she had went into her delete file on her phone and deleted the pictures from there. She stated no. She then stated she would have to. CNA #3 was asked if she had showed the pictures of the resident to anyone. She stated the DON, the investigators, and the police officers. She stated she had sent them to the administrator because she was asked to send them to him. She was asked how she sent the pictures to the administrator. She stated in a text message. She was asked if she showed anyone else the pictures. She stated no. She was asked if she sent the pictures to anyone else. She stated no. CNA #3 was asked why she took the pictures. She stated, Evidence. She was asked why did she not go get the nurse when you took the picture. She stated she did get the nurse. She was asked when did she go get the nurse. She stated after she took it (the wipes) out.