STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375463	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PAULS VALLEY CARE CENTER	**1413 SOUTH CHICKASAW PAULS VALLEY, OK 73075**

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview and record review, it was determined the facility failed to implement their abuse policy and procedure. The facility failed to complete a thorough investigation for allegations of misappropriation of medications for five (#1, 2, 3, 4, and #5), and allegation of misappropriation of funds for one (#9) of nine residents reviewed. Findings: A facility abuse policy, documented any allegation of abuse would be investigated by the administrator (ADM) and the director of nursing (DON). The policy documented the ADM and the DON would at a minimum interview the person reporting the incident, witnesses to the incident, residents, and other staff members during the period of the alleged incident. The policy documented a written report would be completed and sent to the Oklahoma state department of health (OSDH) within 24 hours of the incident. An investigation of alleged drug diversion report, dated 08/24/20, contained no interviews with staff who reported the allegation. The report contained no interviews with residents who were named in the allegation. The clinical records contained no documentation a thorough investigation had been completed for residents #1, 2, 3, 4, and #5. The clinical record contained no documentation an incident report had been sent to OSDH. An OSDH incident report, dated 08/26/20, documented resident #9 reported an allegation of missing funds. The clinical records contained no documentation a thorough investigation had been completed. On 09/17/20 at 9:41 a.m., the RDO (regional director of operations)reported the facility had not completed a thorough job with internal investigation of the allegations. On 09/17/20 at 2:09 p.m., a telephone interview was conducted with the previous ADM, who was employed by the facility at the time of the allegations. The ADM reported she failed to complete an OSDH incident report. On 09/17/20 at 3:00 p.m., the COO (chief operations officer) reported an OSDH incident report had been completed but no internal investigation related to the allegation of misappropriation of funds for resident #9. The COO reported an investigation should have been completed.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview and record review it was determined the facility failed to report to the Oklahoma state department of health (OSDH) an allegation of misappropriation of medications for residents #1, 2, 3, 4, and #5 of nine residents reviewed. Findings: A facility abuse policy, documented a written report would be completed and sent to the Oklahoma state department of health (OSDH) within 24 hours of the incident. An investigation of alleged drug diversion report, dated 08/24/20, contained no interviews with staff who reported the allegation. The report contained no interviews with residents who were named in the allegation. The clinical records contained no documentation a thorough investigation had been completed for residents #1, 2, 3, 4, and #5. The clinical record contained no documentation an incident report had been sent to OSDH. On 09/17/20 at 2:09 p.m., a telephone interview was conducted with the previous ADM, who was employed by the facility at the time of the allegations. The ADM reported she failed to complete an OSDH incident report.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to initiate and complete a thorough investigation. The facility failed to complete a thorough investigation for allegations of misappropriation of medications for five (#1, 2, 3, 4, and #5), and an allegation of misappropriation of funds for one (#9) of nine residents reviewed. Findings: 1) Resident #1 had a physician's orders [REDACTED]. The resident was out of the facility throughout the investigation. 2) Resident #2 had a physician's orders [REDACTED]. 3) Resident #3 had a physician's orders [REDACTED]. 4) Resident #4 had a physician's orders [REDACTED]. On 09/16/20 at 11:30 a.m., the resident reported he missed a couple of doses of pain medication. The resident reported the staff had told him the medication had not been received from the pharmacy. 5) Resident #5 had a physician's orders [REDACTED]. An investigation of alleged drug diversion report, dated 08/24/20, contained no interviews with staff who reported the allegation. The report contained no interviews with residents who were named in the allegation. The clinical records contained no documentation a thorough investigation had been completed for residents #1, 2, 3, 4, and #5. 6) An OSDH incident report, dated 08/26/20, documented resident #9 reported an allegation of missing funds. The clinical records contained no documentation a thorough investigation had been completed. On 09/17/20 at 9:41 a.m., the RDO (regional director of operations) reported the facility had not completed a thorough job with internal investigation of the allegations. On 09/17/20 at 11:30 a.m., the resident reported the ADM and the local police department took a report from him regarding the missing funds. The resident reported he never heard anything from the ADM or the police. On 09/17/20 at 3:00 p.m., the COO (chief operations officer) reported an OSDH incident report had been completed but no internal investigation related to the allegation of misappropriation of funds for resident #9. The COO reported an investigation should have been completed for both allegations of misappropriation of funds and medication.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on interview and record review, it was determined the facility failed to provide adequate staff to meet the residents needs. The facility reported 28 residents resided in the facility. Findings: 1. An unidentified resident reported showers had been reduced to once a week instead of twice a week due to the facility being short staffed. The resident reported the call light was often not answered in a timely manner. 2. An unidentified resident reported the facility was frequently short staffed. The resident reported care was often delayed due to no staff. The resident reported staff had quit or had been fired, leaving the facility short staffed. The resident reported he sometimes did not receive his medications as ordered. 3. The facility staffing report for the month of August 2020, documented 11 of 93 shifts had been understaffed. On 9/16/20 at 3:40 p.m., the regional director of operations reported the facility had ongoing staffing problems.

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.