STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375174	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Extended Care & Rehab	841 North 38th Street Muskogee, OK 74401

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46216 Based on record review and interview, the facility failed to ensure a resident's legal representative was notified of inappropriate sexual behavior for three (#1, 3 and #4) of four sampled residents reviewed for abuse. The administrator identified 52 residents resided in the facility. Findings: An undated Management of Suspected Abuse/Neglect policy, read in parts, The charge nurse should complete an incident report, being very precise about the incident .physician and family notification will occur at this time. 1. Resident #1 had diagnoses which included PVD and essential hypertension. An OSDH incident report, dated 12/01/24, documented Resident #1 was sexually inappropriate with multiple female residents (Resident #3 and Resident #4). The clinical health record did not contain documentation of family notification of the inappropriate sexual behavior. 2. Resident #3 had diagnoses which included anxiety disorder and depression. The clinical health record did not contain documentation of family notification after an allegation of inappropriate sexual behavior by Resident #1. 3. Resident #4 had diagnoses which included dementia and major depression disorder. The clinical health record did not contain documentation of family notification after an allegation of inappropriate sexual behavior by Resident #1. On 12/27/24 at 9:34 a.m., the administrator stated, The LPN did not feel it necessary to notify the family.

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 Based on record review and interview, the facility failed to ensure a resident was free from abuse for one (#1) of four sampled residents reviewed for abuse. The administrator identified 52 residents resided in the facility. Findings: An undated facility policy, Management of Suspected Abuse/Neglect, read in parts, The nursing facility resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents .Physical Abuse .Physical injury that results in substantial harm: to the person, or the genuine threat of substantial harm from physical injury to the person .Failure to make a reasonable effort to prevent an action by another person that results in physical injury. Resident #2 was admitted on [DATE] with diagnoses which included cerebrovascular accident and PVD. Resident #2's admission assessment, dated 09/09/24, documented their cognition was intact and they were dependent on staff for transfers. An Initial Incident Report OSDH form, dated 10/20/24 at 10:00 a.m., documented the resident reported to the nurse staff were rough with assisting them in bed. It documented staff told the resident you're gonna die in here. It was documented there was a red area noted to the resident's right upper arm. It documented the resident complained of pain 6/10 on a 0/10 scale. It was documented staff were suspended pending investigation. A Initial/Final Incident Report OSDH form, dated 10/24/24 at 8:16 a.m., documented the resident reported CNA #1 used a mechanical lift to transfer them and hurt their right upper arm. It documented the resident was alert and oriented times four, cooperative with care, and was wheelchair bound. It documented the resident had a history of CVA. It documented sit to stand with transfers or slide board. It documented CNA #1 was terminated and CNA #2 was suspended and educated on reporting suspected abuse. On 11/07/24, an in-service related to resident rights and abuse was conducted. On 12/26/24 at 10:52 a.m., Resident #2 stated CNA #1 purposefully put the straps on wrong and they had significant bruising. They stated CNA #1 was no longer in the facility. On 12/27/24 at 12:24 p.m., the administrator stated, I don't have documentation of QA being involved, no formal QA involvement. We discussed steps to be taken to prevent further incident. After review of the in-service logs, interviews with staff, documentation of monitoring and interviews with residents it was determined the facility had corrective action in place on 11/07/24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46216 Based on record review and interview, the facility failed to ensure the results of an abuse investigation were submitted to the SSA within five business days of the incident for one (#1) of four sampled residents reviewed for abuse. The administrator identified 52 residents resided in the facility. Findings: An undated facility policy titled Management of Suspected Abuse/Neglect, read in part, It is the policy of this facility, under the guidance of applicable laws, that any person having reasonable cause to believe that any person in a state of abuse .shall report the information to the Oklahoma State Department of Health. 1. Resident #1 had diagnoses which included PVD and Diabetes Mellitus type two. An Initial State Reportable Incident form, faxed on 12/01/24 at 4:19 p.m., documented an allegation of abuse/mistreatment. It documented (unknown) resident reported to (unknown) nurse, Resident #1 was sexually inappropriate with multiple female residents. It documented Resident #1 was placed on one on one supervision during investigation. There was no documentation the results of the investigation were submitted to the SSA. On 12/27/24 at 12:12 p.m., the administrator stated the policy for reporting abuse was to turn in an initial within two hours, remove the threat, call the police, and turn in a five day/final within five days. On 12/27/24 at 1:37 p.m., the administrator stated they did not think they had turned in a five day or final report. They stated they thought the DON had done it, but the DON did not. They stated, I'm just gonna be honest, it wasn't done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46216 Based on record review and interview, the facility failed to assess a resident after allegation of inappropriate sexual behavior for two (#3 and #4) of four sampled residents reviewed for abuse. The administrator identified 52 residents resided in the facility. Findings: An undated facility policy titled Management of Suspected Abuse/Neglect, read in part, A complete assessment of both the resident's should be done by the charge nurse. An Initial State Reportable Incident form, faxed on 12/01/24 at 4:19 p.m., documented an allegation of abuse/mistreatment. It documented (unknown) resident reported to (unknown) nurse, Resident #1 was sexually inappropriate with multiple female residents (Resident #3 and Resident #4). 1. Resident #3 had diagnoses which included anxiety disorder and depression. There was no documentation in the clinical record of Resident #3 being assessed after the sexual abuse allegation. On 12/27/24 at 10:35 a.m., LPN #1 reviewed the resident's clinical record for nurses notes and assessments. They were unable to locate nursing notes or assessments related to the sexual abuse. 2. Resident #4 had diagnoses which included dementia and major depression disorder. There was no documentation in the clinical record of Resident #4 being assessed after the sexual abuse allegation. On 12/27/24 at 12:14 p.m., the administrator stated if there was no documentation in the clinical record then the resident had not been assessed after the allegation of sexual abuse.