STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375206	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindsay Nursing & Rehab	1103 West Cherokee Lindsay, OK 73052

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 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. Based on observation, record review, and interview, the facility failed to ensure a resident was free from verbal abuse by a staff member for 1 (#1) of 5 sampled residents reviewed for abuse.The administrator identified 76 residents resided in the facility. Findings:On 03/30/26 at 11:45 a.m., Resident #1 was up in a wheelchair and self-propelled into the dining room.An undated Abuse Prevention Program policy, read in part, As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individuals.A quarterly assessment, dated 02/03/26, showed Resident #1's cognition was intact with a BIMS score of 15. The assessment showed Resident #1 was independent with most ADLs and they had an indwelling urinary catheter. The assessment showed the resident had a diagnosis of paraplegia.A grievance form, dated 02/26/26, showed Resident #1 approached RN #1 on 02/25/26 to discuss their catheter bag. The form showed RN #1 looked mad and told Resident #1, I don't want any part of that. I don't give a damn. Go talk to [name removed] about it. It made me feel embarrassed, and I rolled back to my room. The form showed that the grievance was investigated, and verbal abuse was substantiated.An incident report, dated 02/26/26, showed the administrator received a grievance for a RN #1 being verbally aggressive towards Resident #1 on 02/25/26. The report showed an investigation was conducted, and abuse was substantiated based on resident and staff interviews. The report showed the resident showed no further signs of emotional distress, and the staff member was terminated.A facility QAPI plan, dated 02/27/26, showed a quality issue/problem of staff to resident abuse. The plan showed actions of: Staff member placed on suspension then terminated per facility policy,Victim assessed,Primary physician notified,Mental health notified,In-service to all staff,Reported to all applicable agencies. On 03/31/26 at 12:40 p.m., the administrator stated being notified on 02/26/26 of an allegation of verbal abuse that occurred on 02/25/26 between RN #1 and Resident #1. The administrator stated that an investigation was completed, and the allegation of verbal abuse was substantiated by resident and staff interviews.On 03/31/26 at 2:22 p.m., CMA #1 stated on 02/25/26 around 8:45 p.m., Resident #1 told them of RN #1 hollering and cursing at them earlier in the day.On 03/31/26 at 2:51 p.m., Resident #1 stated being happy with everything in the facility and did not want to answer any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375206	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindsay Nursing & Rehab	1103 West Cherokee Lindsay, OK 73052

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, record review, and interview, the facility failed to ensure an allegation of abuse was reported to OSDH within the required 2-hour timeframe for 1 (#1) of 5 sampled residents reviewed for abuse. The administrator identified 76 residents resided in the facility. Findings:On 03/30/26 at 11:45 a.m., Resident #1 was observed up in a wheelchair and self-propelled into the dining room.The Abuse Prevention Program policy, not dated, read in part, Investigate and report any allegations of abuse within timeframes as required by federal requirements.A quarterly assessment, dated 02/03/26, showed Resident #1's cognition was intact with a BIMS score of 15. The assessment showed Resident #1 was independent with most ADL and had an indwelling catheter. The assessment showed the resident had a diagnosis of paraplegia.An incident report form, dated 02/25/26, showed an allegation of abuse for Resident #1 was faxed to OSDH on 02/26/26 at 11:16 a.m.A grievance form, dated 02/26/26, showed Resident #1 approached RN#1 on 02/25/26 to discuss their catheter bag. The form showed RN #1 looked mad and told Resident #1, I don't want any part of that. I don't give a damn. Go talk to [name removed] about it. The form showed the grievance was investigated, and verbal abuse was substantiated.On 03/31/26 at 12:40 p.m., the administrator stated being notified on 02/26/26 of an allegation of verbal abuse that occurred on 02/25/26 sometime around 2:00 p.m. The administrator stated that the activities director was asked to have the resident fill out a grievance form. The administrator stated that after they received the grievance form, they notified OSDH within two hours. The administrator was asked if the CMA #1 should have reported the incident immediately, and they replied: Staff were educated to report immediately, even if they are not sure it is abuse. The administrator stated the incident should have been reported within 2 hours of Res #1 notifying CMA #1 of the incident.On 03/31/26 at 2:22 p.m., CMA #1 stated on 02/25/26 around 8:45 p.m., Resident #1 told them about RN #1 hollering and cursing at them earlier in the day. The CMA stated Resident #1 was told it needed to be reported to the Administrator. The CMA stated that the resident verbalized that they would self-report to the administrator the next morning. The CMA stated the incident was not immediately reported to the administrator at the resident's request.On 03/31/26 at 2:51 p.m., Resident #1 stated being happy with everything in the facility and did not want to answer any questions.