STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375233	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarcrest Care Center	1306 East College Broken Arrow, OK 74012

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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 30267 Based on record review and interview, the facility failed to provide an environment free of abuse. The facility daily census report identified 24 residents on the secured unit and 62 total residents. Findings: 1. Resident #1 had diagnoses which included Alzheimer's dementia. A behavior note, dated 01/20/24, documented Resident #1 was observed to push another resident to the floor. When asked why, Resident #1 replied that they deserved it. A behavior note, dated 01/27/24, documented Resident #1 pushed another resident who had wandered into Resident #1's room. When asked why, Resident #1 replied that it was the only way they would get the other resident out of their room. An incident note, dated 02/07/24, documented in part, .It was reported to this nurse, this res went into another res room last eve and had an altercation with another res .this res has a habit of going into the first room on left as [their] room is in the same place on a different hall .hard to redirect at times . A behavior note, dated 03/01/24, documented Resident #1 threw water on another resident and swung their arms and fists at staff. A progress note, dated 08/09/24 at 8:01 p.m., documented in part, .This nurse heard screaming from residents room. Upon arrival resident was seen choking another resident [Resident #2], laying in a supine position in room-mates bed. This nurse was able to separate aggressive resident and defuse situation. Resident was upset that another resident was in [their] room-mates bed . 2. Resident #2 had diagnoses which included a memory deficit following a cerebral infarction (stroke) and amnesia. (continued on next page)

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
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An incident note, dated 08/09/24, documented in part, .This nurse heard screaming from another residents room. Upon arrival [Resident #2] was in another residents bed, laying in a supine position being choked by [Resident #1]. This nurse was able to pull resident to safety. [Resident #2] was purple colored w/ unsteady gait, and scratches on (L) [left] side of face and neck . An initial incident report, with an incident date of 08/09/24, documented it was faxed to the Oklahoma State Department of Health date of 08/10/24 at 12:31 p.m., and documented an incident of resident to resident abuse occurred on 08/09/24 between Resident #1 and Resident #2. On 08/22/24 at 12:50 p.m., LPN #1 stated on 02/08/24 they noticed scratches on a resident's arms and when asked, they pointed to Resident #1 and stated Resident #1 had entered the other resident's room and attacked them. LPN #1 stated they thought Resident #1 had wandered down the opposite hall and into a room they thought was theirs and attacked the other resident, thinking the other resident who actually resided in the room had intruded into their room. LPN #1 stated Resident #1 had more than a few instances of aggression which usually happened in the evening hours. LPN #1 stated Resident #1 was real protective of their roommate and had expressed that the roommate was their child. LPN #1 stated when Resident #1 saw Resident #2 was in the roommates bed, Resident #1 attacked Resident #2. LPN #1 stated when Resident #1 was aggressive, they tried to separate them from others and get them to relax in their recliner in their room and when Resident #1 was in the common room, the staff tried to keep the resident separated from others sitting in the chairs or on the couches. LPN #1 stated to help mitigate resident behaviors, they had organized activities scheduled for the day shift to keep residents busy but there were no organized activities scheduled for the evening shift. The LPN stated they did not know what interventions the evening shift used to mitigate resident to resident abuse. On 08/22/24 at 1:40 p.m., CMA #1 stated Resident #1 was aggressive with other residents, pushing them to the floor, tripping them, or otherwise physically attacking them. CMA #1 stated Resident #1 was better in the daytime hours but as the day continued would get more confused and agitated. The CMA stated to help any feelings of anxiety or agitation, they tried to keep all the residents engaged throughout the day with different activities. On 08/22/24 at 3:55 p.m., LPN #2 stated they were present when the resident to resident altercation occurred. The LPN stated they heard screaming and choking sounds coming from the hall and responded immediately by running down the hall where the sound originated. They stated it was a second choked scream which allowed them to find Resident #2 being choked by Resident #1. LPN #2 stated they immediately asked Resident #1 to stop and the resident complied. LPN #2 stated Resident #1 appeared to have a brief look of startlement as though they just realized what they were doing with their hands around the neck of Resident #2. LPN #2 stated they did not see Resident #2 wander into the other residents room or they would have redirected Resident #2 from wandering in there. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/22/24 at 4:00 p.m., CMA #2 stated the staff watched Resident #1 because the resident had tripped a number of other wandering residents as they past close to where Resident #1 sat and could get aggressive without warning or provocation. On 08/23/24 at 12:15 p.m., a family member for Resident #2 stated they had concerns about another resident choking their family member for wandering into a room and laying on the roommates bed. The family member stated they often see residents wandering in and out of other residents room and laying in one another's beds. They stated during many of their visits, they entered their family member's room only to find another resident laying in their family member's bed. The family member stated the staff were quick to respond but could not be everywhere. On 08/23/24 at 1:45 p.m., the DON was asked what was the root cause of the resident to resident abuse which occurred on 08/09/24. The DON stated Resident #2 wandered into the room of Resident #1 and layed down in the unoccupied bed of Resident #1's roommate. Resident #1 did not like Resident #2 being in the roommates bed and attacked. The DON stated the staff try to redirect residents who wander into other residents rooms and to keep the residents busy with activities. The DON said they were unsure if the evening shift had scheduled activities. The DON stated the current interventions had not kept Resident #2 from wandering into the room and being choked by Resident #1. 3. Resident #4 had diagnoses which included dementia with anxiety. A behavior note, dated 01/14/24 at 6:30 p.m., documented the resident started yelling, screaming, confronting, and attempting to pick fights with other residents. The note documented the resident required close observation for safety. A behavior note, dated 01/29/24 at 9:22 a.m., documented the resident would walk up to other residents and talk disrespectfully to them. A behavior note, dated 07/01/24 at 12:57 p.m., documented the resident walked up to another resident and struck them in the abdomen. The other resident then slapped Resident #4 twice in the face. A behavior note, dated 07/02/24 at 9:15 p.m., documented resident was yelling at other residents all shift and hitting staff when they attempted to help the resident. On 08/22/24 at 12:50 p.m., LPN #1 stated the staff watched Resident #4 closely because they were known to be verbally and physically aggressive toward other residents and staff, by cussing, screaming, grabbing, and hitting others without provocation. On 08/23/24 at 1:45 p.m., the DON was asked what the facility planned to do to extirpate abuse on the secured unit. The DON stated they had plans to remodel the unit and were looking at ways to make the environment more engaging and other ideas to reduce the wandering in and out of other residents' rooms. 4. Resident #3 had diagnoses which included dementia with other behavioral disturbances. An incident report, dated 08/16/24, documented on 08/15/24, CNA #1 was observed to repeatedly hit Resident #3 with a wet, soapy towel after the resident allegedly spit on CNA #1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A hand written note attached to the incident report, dated 08/19/24, documented CNA #3 entered the shower room and observed Resident #3 bleeding from their nose, cheek, and above an eye. The note documented when CNA #1 was asked what happened, CNA #1 responded in part, .[Resident #3] spit on me, you ain't think I beat [their] ass . On 08/21/24 at 2:30 p.m., CNA #2 stated they observed CNA #1 to antagonize Resident #3 by repeatedly flicking the resident's nose with their finger and making derogatory comments over and over about the resident's genitalia which agitated Resident #3 to the point the resident spat on CNA #1. CNA #2 stated after Resident #3 spat on CNA #1, CNA #1 grabbed a wet, soapy towel and continually snapped the towel toward the resident's face. CNA #2 stated they could see the resident's eyes were red and irritated from the soap and his nose was bleeding. CNA #1 stated they kept asking for CNA #1 to stop and let them assist the resident but CNA #1 continued until CNA #3 entered the shower room. CNA #2 stated they assisted Resident #3 with assistance from CNA #3 without further incidence. On 08/23/24 at 1:45 p.m., the DON stated to keep abuse from reoccurring, the facility would have two staff members assist Resident #3 with their shower.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 30267 Based on record review and interview, the facility failed to implement their abuse policy related to the reporting of an allegation of abuse within two hours of staff knowledge of the incident to the Oklahoma State Department of Health and failed to report an allegation of verbal and physical abuse, by a certified nurse aide toward a resident, to the Nurse Aide Registry. The facility daily census report identified 24 residents on the secured unit and 62 total residents. Findings: An undated facility policy, titled Allegations of Abuse, documented in part, .All alleged violations involving abuse .are reported immediately, but not later than 2 hours after allegation is made .Report the results of all investigations to: Oklahoma State Health Department, Department of Human Services, Ombudsman, Resident Representative/Family/POA, Physician, Licensing Boards, Police, Other appropriate agencies . Resident #3 had diagnoses which included dementia with other behavioral disturbances. An incident report with an incident dated of 08/15/24, was sent to OSDH and documented the facility received an allegation of staff to resident abuse on 08/16/24 but which occurred on 08/15/24. The incident report documented the physician, family, and APS were notified. An incident audit report, dated 08/19/24, documented an allegation of abuse was reported by staff that another staff member was observed hitting Resident #3 with a wet, soapy towel over and over again. The report documented the incident occurred on 08/15/24 but was not reported to administration until 08/16/24. On 08/20/24 at 1:35 p.m., the ADON stated on 08/16/24, a staff member reported it was a rumored CNA #1 had abused Resident #3 on 08/15/24. The ADON stated CNA #1 worked the day shift on 08/15/24 and 08/16/24. The ADON stated once they were able to confirm there were witnesses to the allegation, they suspended CNA #1 until they completed their investigation. On 08/21/24 at 2:30 p.m., CNA #2 stated they observed CNA #1 to antagonize Resident #3 by repeatedly flicking the resident's nose with their finger and making derogatory comments over and over about the resident's genitalia which agitated Resident #3 to the point the resident spat on CNA #1. CNA #2 stated after Resident #3 spat on CNA #1, CNA #1 grabbed a wet, soapy towel and continually snapped the towel toward the resident's face. CNA #2 stated they could see the resident's eyes were red and irritated from the soap and his nose was bleeding. CNA #1 stated they kept asking for CNA #1 to stop and let them assist the resident but CNA #1 continued until CNA #3 entered the shower room. CNA #2 stated they assisted Resident #3 with assistance from CNA #3 without further incidence. On 08/21/24 at 3:20 p.m., the DON stated they were not notified of the allegation of staff to resident abuse until 08/16/24, the day after the incident occurred. The DON stated they notified OSDH, APS, the police, physician, and family on 08/16/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was asked if the facility reported the incident to the Nurse Aide Registry. The DON stated they faxed the allegation to the Nurse Aide Registry from home. On 08/22/24 at 10:30 a.m., the DON stated the attempted fax to the Nurse Aide Register never completed and they resent the fax from the facility on 08/21/24.

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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. 30267 Based on record review and interview, the facility failed to report an allegation of abuse, within two hours of staff knowledge of the incident,`to the Oklahoma State Department of Health and failed to report an allegation of verbal and physical abuse, by a certified nurse aide toward a resident, to the Nurse Aide Registry for one (Resident #3), and failed to take appropriate corrective action to extirpate the risk of abuse for three (#2 and #3) of four residents whose clinical records were reviewed for abuse. The facility roster identified 62 residents. Findings: An undated facility policy, titled Allegations of Abuse, documented in part, .All alleged violations involving abuse .are reported immediately, but not later than 2 hours after allegation is made .Report the results of all investigations to: Oklahoma State Health Department, Department of Human Services, Ombudsman, Resident Representative/Family/POA, Physician, Licensing Boards, Police, Other appropriate agencies .If alleged violation is verified appropriate corrective action must be taken . Resident #1 had diagnoses which included Alzheimer's dementia. Resident #2 had diagnoses which included a memory deficit following a cerebral infarction (stroke) and amnesia. Resident #3 had diagnoses which included dementia with other behavioral disturbances. An incident note, dated 08/09/24, documented in part, .This nurse heard screaming from another residents room. Upon arrival [Resident #2] was in another residents bed, laying in a supine position being choked by [Resident #1]. This nurse was able to pull resident to safety. [Resident #2] was purple colored w/ unsteady gait, and scratches on (L) [left] side of face and neck . An initial incident report, with an incident date of 08/09/24, documented it was faxed to the Oklahoma State Department of Health date of 08/10/24 at 12:31 p.m., and documented an incident of resident to resident abuse occurred on 08/09/24 between Resident #1 and Resident #2. An incident report with an incident dated of 08/15/24, was sent to the Oklahoma State Department of Health and documented the facility received an allegation of staff to resident abuse on 08/16/24 but which occurred on 08/15/24. The incident report documented the alleged perpetrator was suspended. The incident report documented the physician, family, and APS were notified. An incident audit report, dated 08/19/24, documented an allegation of abuse was reported by staff that another staff member was observed hitting Resident #3 with a wet, soapy towel over and over again. The report documented the incident occurred on 08/15/24 but was not reported to administration until 08/16/24. (continued on next page)

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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	On 08/20/24 at 1:35 p.m., the ADON stated on 08/16/24, a staff member reported it was a rumored CNA #1 had abused Resident #3 on 08/15/24. The ADON stated CNA #1 worked the day shift on 08/15/24 and 08/16/24. The ADON stated once they were able to confirm there were witnesses to the allegation, they suspended CNA #1 until they completed their investigation. On 08/21/24 at 2:30 p.m., CNA #2 stated they observed CNA #1 to antagonize Resident #3 by repeatedly flicking the resident's nose with their finger and making derogatory comments over and over about the resident's genitalia which agitated Resident #3 to the point the resident spat on CNA #1. CNA #2 stated after Resident #3 spat on CNA #1, CNA #1 grabbed a wet, soapy towel and continually snapped the towel toward the resident's face. CNA #2 stated they could see the resident's eyes were red and irritated from the soap and his nose was bleeding. CNA #1 stated they kept asking for CNA #1 to stop and let them assist the resident but CNA #1 continued until CNA #3 entered the shower room. CNA #2 stated they assisted Resident #3 with assistance from CNA #3 without further incidence. On 08/21/24 at 3:20 p.m., the DON stated they were not notified of the allegation of staff to resident abuse until 08/16/24, the day after the incident occurred. The DON stated they notified OSDH, APS, the police, physician, and family on 08/16/24. The DON was asked if the facility reported the incident to the Nurse Aide Registry. The DON stated they faxed the allegation to the Nurse Aide Registry from home. On 08/22/24 at 10:30 a.m., the DON stated the attempted fax to the Nurse Aide Registry never completed and they resent the fax from the facility on 08/21/24. On 08/22/24 at 3:55 p.m., LPN #2 stated they were present when the resident to resident altercation occurred. The LPN stated they heard screaming and choking sounds coming from the hall and responded immediately by running down the hall where the sound originated. They stated it was a second choked scream which allowed them to find Resident #2 being choked by Resident #1. LPN #2 stated they immediately asked Resident #1 to stop and the resident complied. LPN #2 stated Resident #1 appeared to have a brief look of statement as though they just realized what they were doing with their hands around the neck of Resident #2. LPN #2 stated they did not see Resident #2 wander into the other residents room or they would have redirected Resident #2 from wandering in there. On 08/23/24 at 1:45 p.m., the DON was asked what was the root cause of the resident to resident abuse which occurred on 08/09/24. The DON stated Resident #2 wandered into the room of Resident #1 and laid down in the unoccupied bed of Resident #1's roommate. Resident #1 did not like Resident #2 being in the roommates bed and attacked. The DON stated the staff try to redirect residents who wander into other residents rooms and to keep the residents busy with activities. The DON said they were unsure if the evening shift had scheduled activities. The DON stated the current interventions had not kept Resident #2 from wandering into the room and being choked by Resident #1. The DON said that other than frequent monitoring, they could not think of another intervention to reduce wandering or to stop the associated incidents of resident to resident abuse. The DON was asked what the root cause for the staff to resident abuse. The DON stated Resident #3 was known to spit on staff at times and the only intervention they could think of was to have two staff members present at all times when showering the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was asked if there was two staff members present when the incident of abuse occurred. They stated at least two staff were present and possibly a third. The DON was asked if two staff members were present when the alleged abuse occurred, was the facility intervention to have two staff members present at all times when showering the resident an appropriate intervention. The DON stated no.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 30267 Based on record review and interview, the facility failed to: a. provide an environment free from resident to resident abuse; and b. ensure staff accused of abuse did not have access to facility residents until the allegation was thoroughly investigated for one (Resident #3) of four residents reviewed for abuse investigation. The facility roster identified 62 residents. Findings: 1. Resident #1 had diagnoses which included Alzheimer's dementia. A behavior note, dated 01/20/24, documented Resident #1 was observed to push another resident to the floor. When asked why, Resident #1 replied that they deserved it. A behavior note, dated 01/27/24, documented Resident #1 pushed another resident who had wandered into Resident #1's room. When asked why, Resident #1 replied that it was the only way they would get the other resident out of their room. An incident note, dated 02/07/24, documented in part, .It was reported to this nurse, this res went into another res room last eve and had an altercation with another res .this res has a habit of going into the first room on left as [their] room is in the same place on a different hall .hard to redirect at times . A behavior note, dated 03/01/24, documented Resident #1 threw water on another resident and swung their arms and fists at staff. A progress note, dated 08/09/24 at 8:01 p.m., documented in part, .This nurse heard screaming from residents room. Upon arrival resident was seen choking another resident [Resident #2], laying in a supine position in room-mates bed. This nurse was able to separate aggressive resident and defuse situation. Resident was upset that another resident was in [their] room-mates bed . Resident #2 had diagnoses which included a memory deficit following a cerebral infarction (stroke) and amnesia. An incident note, dated 08/09/24, documented in part, .This nurse heard screaming from another residents room. Upon arrival [Resident #2] was in another residents bed, laying in a supine position being choked by [Resident #1]. This nurse was able to pull resident to safety. [Resident #2] was purple colored w/ unsteady gait, and scratches on (L) [left] side of face and neck . An initial incident report, with an incident date of 08/09/24, documented it was faxed to the Oklahoma State Department of Health date of 08/10/24 at 12:31 p.m., and documented an incident of resident to resident abuse occurred on 08/09/24 between Resident #1 and Resident #2. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/22/24 at 12:50 p.m., LPN #1 stated on 02/08/24 they noticed scratches on a resident's arms and when asked, they pointed to Resident #1 and stated Resident #1 had entered the other resident's room and attacked them. LPN #1 stated they thought Resident #1 had wandered down the opposite hall and into a room they thought was theirs and attacked the other resident, thinking the other resident who actually resided in the room had intruded into their room. LPN #1 stated Resident #1 had more than a few instances of aggression which usually happened in the evening hours. LPN #1 stated Resident #1 was real protective of their roommate and had expressed that the roommate was their child. LPN #1 stated when Resident #1 saw Resident #2 was in the roommates bed, Resident #1 attacked Resident #2. LPN #1 stated when Resident #1 was aggressive, they tried to separate them from others and get them to relax in their recliner in their room and when Resident #1 was in the common room, the staff tried to keep the resident separated from others sitting in the chairs or on the couches. LPN #1 stated to help mitigate resident behaviors, they had organized activities scheduled for the day shift to keep residents busy but there were no organized activities scheduled for the evening shift. The LPN stated they did not know what interventions the evening shift used to mitigate resident to resident abuse. On 08/22/24 at 1:40 p.m., CMA #1 stated Resident #1 was aggressive with other residents, pushing them to the floor, tripping them, or otherwise physically attacking them. CMA #1 stated Resident #1 was better in the daytime hours but as the day continued would get more confused and agitated. The CMA stated to help any feelings of anxiety or agitation, they tried to keep all the residents engaged throughout the day with different activities. On 08/22/24 at 3:55 p.m., LPN #2 stated they were present when the resident to resident altercation occurred. The LPN stated they heard screaming and choking sounds coming from the hall and responded immediately by running down the hall where the sound originated. They stated it was a second choked scream which allowed them to find Resident #2 being choked by Resident #1. LPN #2 stated they immediately asked Resident #1 to stop and the resident complied. LPN #2 stated Resident #1 appeared to have a brief look of statement as though they just realized what they were doing with their hands around the neck of Resident #2. LPN #2 stated they did not see Resident #2 wander into the other residents room or they would have redirected Resident #2 from wandering in there. On 08/22/24 at 4:00 p.m., CMA #2 stated the staff watched Resident #1 because the resident had tripped a number of other wandering residents as they past close to where Resident #1 sat and could get aggressive without warning or provocation. On 08/23/24 at 12:15 p.m., a family member for Resident #2 stated they had concerns about another resident choking their family member for wandering into a room and laying on the roommates bed. The family member stated they often see residents wandering in and out of other residents room and laying in one another's beds. They stated during many of their visits, they entered their family member's room only to find another resident laying in their family member's bed. The family member stated the staff were quick to respond but could not be everywhere. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375233	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarcrest Care Center	1306 East College Broken Arrow, OK 74012

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/23/24 at 1:45 p.m., the DON was asked what was the root cause of the resident to resident abuse which occurred on 08/09/24. The DON stated Resident #2 wandered into the room of Resident #1 and laid down in the unoccupied bed of Resident #1's roommate. Resident #1 did not like Resident #2 being in the roommates bed and attacked. The DON stated the staff try to redirect residents who wander into other residents rooms and to keep the residents busy with activities. The DON said they were unsure if the evening shift had scheduled activities. The DON stated the current interventions had not kept Resident #2 from wandering into the room and being choked by Resident #1. 2. Resident #3 had diagnoses which included dementia with other behavioral disturbances. An incident report, dated 08/16/24, documented on 08/15/24, CNA #1 was observed to repeatedly hit Resident #3 with a wet, soapy towel after the resident allegedly spit on CNA #1. A hand written note attached to the incident report, dated 08/19/24, documented CNA #3 entered the shower room and observed Resident #3 bleeding from their nose, cheek, and above an eye. The note documented when CNA #1 was asked what happened, CNA #1 responded in part, .[Resident #3] spit on me, you ain't think I beat [their] ass . On 08/21/24 at 2:30 p.m., CNA #2 stated they observed CNA #1 to antagonize Resident #3 by repeatedly flicking the resident's nose with their finger and making derogatory comments over and over about the resident's genitalia which agitated Resident #3 to the point the resident spat on CNA #1. CNA #2 stated after Resident #3 spat on CNA #1, CNA #1 grabbed a wet, soapy towel and continually snapped the towel toward the resident's face. CNA #2 stated they could see the resident's eyes were red and irritated from the soap and his nose was bleeding. CNA #1 stated they kept asking for CNA #1 to stop and let them assist the resident but CNA #1 continued until CNA #3 entered the shower room. CNA #2 stated they assisted Resident #3 with assistance from CNA #3 without further incidence. On 08/23/24 at 1:45 p.m., the DON stated to keep abuse from reoccurring, the facility would have two staff members assist Resident #3 with their shower.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 30267 Based on interview and record review, the facility failed to update care plans for two (#1 and #3) of four resident whose clinical records were reviewed for abuse. The facility daily census report identified 24 residents on the secured unit and 62 total residents. Findings: 1. Resident #1 had diagnoses which included Alzheimer's dementia. A progress note, dated 08/09/24 at 8:01 p.m., documented in part, .This nurse heard screaming from residents room. Upon arrival resident was seen choking another resident [Resident #2], laying in a supine position in room-mates bed. This nurse was able to separate aggressive resident and defuse situation. Resident was upset that another resident was in [their] room-mates bed . An incident note, dated 08/09/24, documented in part, .This nurse heard screaming from another residents room. Upon arrival [Resident #2] was in another residents bed, laying in a supine position being choked by [Resident #1]. This nurse was able to pull resident to safety. [Resident #2] was purple colored w/ unsteady gait, and scratches on (L) [left] side of face and neck . An initial incident report, with an incident date of 08/09/24, documented it was faxed to the Oklahoma State Department of Health date of 08/10/24 at 12:31 p.m., and documented an incident of resident to resident abuse occurred on 08/09/24 between Resident #1 and Resident #2. On 08/22/24 at 12:50 p.m., LPN #1 stated Resident #1 had more than a few instances of aggression which usually happened in the evening hours. LPN #1 stated Resident #1 was real protective of their roommate and had expressed that the roommate was their child. LPN #1 stated when Resident #1 saw Resident #2 was in the roommates bed, Resident #1 attacked Resident #2. LPN #1 stated when Resident #1 was aggressive, they tried to separate them from others and get them to relax in their recliner in their room and when Resident #1 was in the common room, the staff tried to keep the resident separated from others sitting in the chairs or on the couches. LPN #1 stated to help mitigate resident behaviors, they had organized activities scheduled for the day shift to keep residents busy but there were no organized activities scheduled for the evening shift. The LPN stated they did not know what interventions the evening shift used to mitigate resident to resident abuse. (continued on next page)

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