STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375235	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Nursing Center	310 Brookside Drive Madill, OK 73446

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34333 On 04/10/25 at 11:40 a.m., the Oklahoma State Department of Health was notified and verified the existence of an immediate jeopardy situation related to the facility's failure to protect a resident from sexual abuse from another resident with a known history of sexually inappropriate behaviors. Resident #1 was observed to place their hand under Resident #2's shirt and rub the resident's breast area. On 04/10/25 at 12:03 p.m., the administrator and DON were notified of the immediate jeopardy and provided the immediate jeopardy template. On 04/11/25 at 9:04 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Plan Of Removal 4/10/2025: 1. Facility staff observed the incident reported. Staff intervened and stopped the incident from occurring and made sure resident #2 was safe. Staff separated residents and reported incident to charge nurse immediately. On 4/5/2025, the administrator sent referral to [hospital name withheld] for acceptance due to incident. Resident #1 was observed by staff when out of his room. Resident #1 left with family on 4/6/2025 at 10:58 a.m. to admit to [hospital name withheld] in Ardmore, OK [Oklahoma] due to incident. 2. All residents could be affected. Resident did attempt to contact another resident on 4/6/2025 and staff intervened. 3. All staff to be in-serviced regarding facility abuse policy and reporting 4. Complete audit on all residents to determine sexual behaviors identified. Safe surveys were completed on 4/7/2025 and no further allegations were made. Facility staff utilize target behavior monitoring daily on all residents. 5. Date of compliance: 4/10/2025 at 2000pm (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

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/11/25 after interviews with facility staff, review of in-services, and resident sexual behavior audits, the immediacy was lifted, effective 04/10/25 at 8:00 p.m. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on observation, record review, and interview, the facility failed to prevent resident to resident sexual abuse between 2 (#1 and #2) of 2 sampled residents reviewed for sexual abuse. Resident #1 had a known history of sexually inappropriate behaviors. Resident #1 was observed to place their hand under Resident #2's shirt and rub the resident's breast area. The administrator reported one resident with a history of sexually inappropriate behaviors. Findings: An OSDH Incident Report Form, dated 04/05/25, showed CNA #1 witnessed Resident #1 and Resident #2 in the facility dining room, where Resident #1 was observed to place their hand under Resident #2's shirt and rub their breast area. The form showed an investigation was conducted and video documentation was reviewed. The video showed Resident #1 rubbing Resident #2's back and then putting their hand down the front of Resident #2's shirt. The report showed the administrator interviewed Resident #1 and the resident initially denied the incident. The report showed when informed of the video documentation, Resident #1 stated, Well [they] like it. The report showed when the administrator interviewed Resident #2, the resident stated Resident #1 was rubbing their back and breast area and it made them feel uncomfortable. An Abuse Prevention Program policy, dated December 2016, read in part, As part of the resident abuse prevention, the administration will: Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents. 1. A care plan for Resident #1, with a problem start date of 05/18/21, showed the resident had behaviors of being sexually inappropriate. The care plan showed a resident to resident incident on 05/29/24. The care plan showed a resident to resident incident on 04/07/25. The care plan showed no interventions following either incident to prevent further behaviors. A progress note for Resident #1, dated 05/29/24 at 12:38 p.m., showed it was reported to the nurse Resident #1 was touching a resident of the opposite sex inappropriately in the dining room. A progress note for Resident #1, dated 05/29/24 at 2:15 p.m., showed the resident would be admitted to a hospital behavioral health unit. A physician order for Resident #1, dated 06/12/24, showed to give medroxyprogesterone (a hormone medication) 2.5 mg, 3 tablets to equal 7.5 mg daily, for sexual dysfunction not due to a substance or known physiological condition. The order showed the medication was discontinued on 12/04/24. A progress note for Resident #1, dated 06/22/24 at 1:39 p.m., showed the resident was observed exiting the dining room when they stopped and started tickling the feet of a resident of the opposite sex. The note showed the resident asked multiple times for Resident #1 to stop and the resident had to be redirected away from the other resident. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A MDS assessment for Resident #1, dated 02/18/25, showed a brief interview for mental status score of 9, which indicated the resident was moderately impaired with cognitive function. The assessment showed the resident required substantial to maximal assistance with most activities of daily living. A progress note for Resident #1, dated 04/05/25 at 7:32 p.m., showed CNA #1 witnessed the resident place their hand under Resident #2's shirt and rub their breast area. A progress note for Resident #1, dated 04/06/25 at 10:44 a.m., showed the resident was observed to wheel self to an unidentified resident of the opposite sex. The note showed staff removed Resident #1 from the other resident before Resident #1 could touch them. A care plan for Resident #1, dated 04/07/25, showed diagnoses which included history of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction, peripheral vascular disease, chronic obstructive pulmonary disease, bipolar disorder, anxiety, sexual dysfunction, unspecified psychosis, and depression. 2. A MDS assessment for Resident #2, dated 02/17/25, showed the resident had a memory problem and was severely impaired with cognitive skills for daily decision making. The assessment showed the resident was dependent on staff for assistance with activities of daily living. A progress note, dated 04/05/25 at 7:27 p.m., showed CNA #1 witnessed Resident #1 place their hand under Resident #2's shirt and rub their breast area. The note showed a skin assessment was completed and no visible signs of injury were noted. A care plan for Resident #2, dated 04/07/25, showed a resident to resident incident. The care plan showed psychiatric referrals were made and a trauma informed care observation completed. The care plan showed Resident #2 had diagnoses which included dementia, atrial fibrillation, pseudobulbar affect, depression, insomnia, and muscle weakness. A progress note, dated 04/08/25 at 12:11 p.m., showed a new order for Resident #2, Nuedexta (a central nervous system agent), one tablet by mouth daily for impulsive crying, and Melatonin (an acetamide) 10 mg one by mouth at bedtime as needed for insomnia. On 04/09/25 at 2:15 p.m., CNA #1 reported Resident #1 initially started bringing Resident #2 coffee and sitting near them. CNA #1 reported they had seen Resident #1 touch Resident #2's hair, but had not witnessed anything inappropriate until they saw Resident #1 with their hand inside Resident #2's shirt. CNA #1 reported they separated the residents immediately and told Resident #1 it was not appropriate to touch Resident #2 like that. CNA #1 reported Resident #1 stated, [They] like it. CNA #1 reported Resident #2 did not say anything at the time the incident happened. On 04/09/25 at 3:00 p.m., LPN #1 reported they had noticed Resident #1 sitting closer to Resident #2, bringing them coffee, but had not witnessed anything inappropriate. LPN #1 reported they would occasionally have Resident #1 move a little further away from Resident #2 if they were getting too close. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/09/25 at 5:03 p.m., Resident #2's family member was interviewed by phone. They reported the facility had notified them when the incident happened with Resident #1. The family member reported they asked facility staff how their loved one responded, if they swatted the resident's hand or slapped at the other resident, because that was how they would have responded in the past. The family member reported staff stated they thought the resident was shocked by the incident and did not do anything. On 04/10/25 at 8:35 a.m., this surveyor attempted to interview Resident #2 in their room. The resident did not acknowledge any incident and was only able to answer simple yes or no questions. On 04/10/25 at 8:40 a.m., LPN #2 reported they did not know of any resident they needed to watch for sexual behaviors. LPN #2 reported they did not witness the incident between Resident #1 and Resident #2, but had noticed Resident #1 showing Resident #2 more attention, touching their hair, bringing them coffee, and sitting close in the dining room. LPN #2 reported they did not think the behaviors were anything to be concerned about. On 04/10/25 at 10:00 a.m., the DON was asked what interventions were implemented to protect Resident #2 and other residents before Resident #1 was sent out. The DON reported staff watched Resident #1 closely when they were out of their room following the incident with Resident #2. The DON was asked if there was any documentation to show this monitoring. The DON provided a form, with no name or date, and reported it showed one on one monitoring. The form showed every one hour checks from 8:00 p.m. until 10:00 a.m. The DON then wrote Resident #1's name on the form and the date of the incident (04/05/25). The DON was asked if there were interventions in place for when Resident #1 returned to the facility. The DON stated, Obviously we'll need to do something to make sure it doesn't happen again.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34333 On 04/10/25 at 11:40 a.m., the Oklahoma State Department of Health was notified and verified the existence of an immediate jeopardy situation related to the facility's failure to update Resident #1's care plan related to sexually inappropriate behaviors. Resident #1 was observed to place their hand under Resident #2's shirt and rub the resident's breast area. Resident #1 had a history of a similar incident involving another resident of the opposite sex. Resident #1 was sent to a behavioral health hospital after the first and second incident with no updated interventions to the resident's care plan to prevent recurrence. On 04/10/25 at 12:03 p.m., the administrator and DON were notified of the immediate jeopardy and provided the immediate jeopardy template. On 04/11/25 at 9:04 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Plan Of Removal 4/10/2025: 1. Care plan has been updated to include behavior and interventions to prevent reoccurrence and will be revised upon residents return from hospitalization . 2. All residents could be affected 3. MDS Nurse to be in-serviced regarding updated resident care plans to match resident preferences, behaviors of sexual nature, and interventions that are put in place for behaviors. 4. Audit conducted on all residents to determine sexual behaviors identified. Care plans immediately updated to match resident preferences, behaviors of sexual nature, and interventions that are put in place for behaviors. 5. Date of compliance: 4/10/2025 at 2000pm On 04/11/25 after interviews with facility staff, review of in-services, and resident sexual behavior audits, the immediacy was lifted, effective 04/10/25 at 8:00 p.m. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to update a resident's care plan following sexually inappropriate behavior for 1 (#1) of 1 sampled residents reviewed for care plans. Resident #1 had a known history of sexually inappropriate behaviors. Resident #1 was observed to place their hand under Resident #2's shirt and rub the resident's breast area. The care plan did not document interventions to prevent recurrence. The administrator reported one resident with a history of sexually inappropriate behaviors. Findings: (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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An OSDH Incident Report Form, dated 04/05/25, showed CNA #1 witnessed Resident #1 with a resident of the opposite sex in the facility dining room, where Resident #1 was observed to place their hand under the resident's shirt and rub their breast area. The form showed an investigation was conducted and video documentation was reviewed. The video showed Resident #1 rubbing the other resident's back and then putting their hand down the front of their shirt. The report showed the administrator interviewed Resident #1 and the resident initially denied the incident. The report showed when informed of the video documentation, the resident stated, Well [they] like it. A Resident to Resident Altercations policy, dated September 2022, read in part, Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents .Behaviors that may provoke a reaction by residents or others include .sexually aggressive behavior .inappropriate touching/grabbing .make any changes in the care plan approaches to any or all of the involved individuals .document in the resident's clinical record all interventions and their effectiveness. A care plan for Resident #1, with a problem start date of 05/18/21, showed the resident had behaviors of being sexually inappropriate. The care plan showed a resident to resident incident on 05/29/24. The care plan showed a resident to resident incident on 04/07/25. The care plan showed no interventions following either incident to prevent further behaviors. A progress note for Resident #1, dated 05/29/24 at 12:38 p.m., showed it was reported to the nurse Resident #1 was touching a resident of the opposite sex inappropriately in the dining room. A progress note for Resident #1, dated 05/29/24 at 2:15 p.m., showed the resident would be admitted to a hospital behavioral health unit. A physician order for Resident #1, dated 06/12/24, showed to give medroxyprogesterone (a hormone medication) 2.5 mg, 3 tablets to equal 7.5 mg daily, for sexual dysfunction not due to a substance or known physiological condition. The order showed the medication was discontinued on 12/04/24. A progress note for Resident #1, dated 06/22/24 at 1:39 p.m., showed the resident was observed exiting the dining room when they stopped and started tickling the feet of a resident of the opposite sex. The note showed the other resident asked multiple times for Resident #1 to stop and Resident #1 had to be redirected away from the resident. An MDS assessment for Resident #1, dated 02/18/25, showed a brief interview for mental status score of 9, which indicated the resident was moderately impaired with cognitive function. The assessment showed the resident required substantial to maximal assistance with most activities of daily living. A progress note for Resident #1, dated 04/05/25 at 7:32 p.m., showed CNA #1 witnessed the resident place their hand under the shirt of a resident of the opposite sex and rub their breast area. A progress note for Resident #1, dated 04/06/25 at 10:44 a.m., showed the resident was observed to wheel self to an unidentified resident of the opposite sex. The note showed staff removed Resident #1 from the other resident before Resident #1 could touch them. (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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A care plan for Resident #1, dated 04/07/25, showed diagnoses which included history of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction, peripheral vascular disease, chronic obstructive pulmonary disease, bipolar disorder, anxiety, sexual dysfunction, unspecified psychosis, and depression. On 04/10/25 at 8:40 a.m., LPN #2 reported they did not know of any resident they needed to watch for sexual behaviors. LPN #2 reported they did not witness the incident between Resident #1 and the resident of the opposite sex, but had noticed Resident #1 showing the resident more attention, touching their hair, bringing them coffee, and sitting close in the dining room. LPN #2 reported they did not think the behaviors were anything to be concerned about. On 04/10/25 at 10:00 a.m., the DON was asked what interventions were implemented to protect residents before Resident #1 was sent out. The DON reported staff watched Resident #1 closely when they were out of their room following the incident. The DON was asked if there was any documentation to show this monitoring. The DON provided a form, with no name or date, and reported it showed one on one monitoring. The form showed every one hour checks from 8:00 p.m. until 10:00 a.m., but did not document one on one monitoring. The DON then wrote Resident #1's name on the form and the date of the incident (04/05/25). On 04/10/25 at 10:10 a.m., the DON provided an updated care plan for Resident #1, revised during the survey, which showed the resident to resident incident. The care plan showed the residents were separated immediately and an investigation initiated. The care plan showed a psychiatric referral was obtained. The care plan showed no interventions to prevent recurrence of sexually inappropriate behaviors. The DON was asked if there were interventions in place for when Resident #1 returned to the facility. The DON stated, Obviously we'll need to do something to make sure it doesn't happen again.