| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375285 | A. Building<br>B. Wing | 02/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sand Springs Nursing and Rehabilitation | 1025 North Adams<br>Sand Springs, OK 74063 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>A past noncompliance immediate Jeopardy situation was determined to exist effective 12/01/25 related to the facility's failure to ensure residents were free from abuse by facility staff. Based on record review and interview, the facility failed to protect the resident's right to be free from sexual abuse by staff for 1 (#29) of 2 sampled residents reviewed for allegations of abuse. The administrator identified 59 residents resided in the facility. Findings: A care plan with an imitated date of 11/21/23, and last reviewed on 12/02/25, showed Resident #29 had self-care performance deficit related to decreased mobility. Interventions included Resident #29 was able to dress independently and could do up buttons, tie shoes, do zippers, put on shirts, pull up pants, put on socks, and put on coats. The interventions for transfers and toilet use included Resident #29 required zero staff participation with transfers and to use the toilet. Resident #29 required no assistance with toileting. An annual assessment for Resident #29, dated 11/21/25, showed a BIMS of 15 which indicated Resident #29 was cognitively intact for daily decision making. The assessment showed diagnoses which included heart failure, DVT, HTN, depression, and bipolar disorder. There was no documentation to show Resident #29 had a previous history of seeking out sexual encounters with care givers. Resident #29 hand written statement, dated 11/27/25, read in part, I am [Resident #29] I took a shower about 12:30 am and 1:00 am then I went to my room to get dress and [CNA #1]come in the room and me if I need help with getting dressed I said no and then started with a blow job and then turned over then we had sex. I was not forced A typed statement, dated 11/27/25, signed by the DON, read in part, On November 27, 2025, I Was informed that [Resident #29] had oral sex with one of the CNA's on duty the night before. I spoke with [Resident #29] who told me yes [they] had participated in oral sex with a CAN [sic] during [their] shower and again in [their] room later. [Resident #29] stated multiple times that she was not forced. That it was more out of curiosity. [Resident #29] stated that after the 2nd episode or oral sex they attempted to have intercourse, but [they] was unable to penetrate.A typed statement, dated 11/27/25, signed by the administrator, read in part, On November 27, 2025, I was present when the resident [Resident #29] spoke with police about the abuse allegation. The resident stated that the incident was not forced and was consensual. She also stated that she was touching the CAN [sic] as well. A handwritten statement, from CNA #4, dated 11/27/25, read in part, [Resident #29] told me that after [their] shower [CNA #1] came to her about 12:30 a.m. and tried to have sex but told [them] [they] was to tight so proceeded to do oral sex. A handwritten statement, from CMA #1, dated 12/02/25, read in part, I let [Resident #29] in when [Resident #29] got back from being out with [their] family. [Resident #29] said you have a boyfriend and I said yes why? [Resident #29] said I do too, well we just mess around and I asked who It was and [Resident #29] said [CNA #1], [they] gave me a shower las night and I sucked his [explicit] and [they] liked it. And [Resident #29] said yea, and later on we was in my room and we done it again, but [name deleted] came in and asked what I needed because my call light went off and [CNA #1] hid behind the curtain. Later on I stopped [name deleted] and asked if seen anything and he said no. And then I went to the med [medications] room to help [name deleted] and I reported it to [LPN #1, Business office manager, CNA #4].An investigation for an allegation of sexual abuse, dated 11/27/25, showed an<br>(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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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | investigation began on 11/27/25 when the facility learned of the allegation of an oral sex interaction with a staff member and Resident #29. The investigation showed CNA #1 was suspended pending the investigation. The facility investigation showed the administrator discovered CNA #1 was unable to be located for 45 minutes during their shift and had been providing care to Resident #29 on a hall they were not assigned to. The investigation showed the facility substantiated the allegation of sexual abuse and provided in-service to all staff for sexual abuse, appropriate/inappropriate relationships with residents, conducted safe surveys with all residents and began same sex only care with two staff for Resident #29. An in-service, dated 11/28/25, showed staff were educated on appropriate/inappropriate relationships with residents. A handwritten statement, from CNA #2, dated 12/02/25, read in part, I [CNA #2] was here on the night this occurred. I was working with [CNA #1] for a 16-hour shift and what I saw was [CNA #]1 changing [Resident #29] [they] started changing her around 1:30 a.m. or so. I wasn't aware of the exact time, but I was going to check on [Resident #29] to make sure [they] was well. I opened the door and [CNA #1] said [they] was changing her or helping her. I came back 10-12 minutes later because another resident had fell and me and [CNA #3] needed help so I looked around and couldn't find [CNA #1], so I checked the last place I seen [them] and [they] was sure enough still in there which was odd. So, I walked in the room and all I saw was him just finishing changing her. A QA/QAPI was completed on 12/02/25 with follow up QAPIs on 12/03/25, 12/10/25, 12/11/25 and 12/17/25. Resident safe surveys were completed, Interviews were conducted with staff and showed they had knowledge of the facility abuse policy and confirmed they had in-service on abuse. Resident interviews revealed no concerns with abuse, felt safe and reported anything to nursing staff. A care plan for Resident #29, initiated on 12/02/25, showed a focus for resident relationships related to seeking out sexual relationships with caregivers of the opposite sex. The care plan showed interventions which included, administer medications as ordered, monitor/document for side effects and effectiveness, caregivers to provide opportunity for positive interaction, education for successful coping and interaction strategies, intervene as necessary to protect the rights and safety of others and same sex caregivers for personal care/showers. Prior to the care plan dated 12/02/25, the care plan did not address any behaviors of Resident #29 seeking out sexual relationships with staff. An APS-Report, dated 12/12/25, page 4, read in part, [Resident #29], stated that [CNA #1] came back into [Resident #29] room and was standing by the bed. [Resident 29], stated that [CNA #1] started rubbing on [Resident #29] indicating her chest area, and then put [Resident #29] hand on [their] private parts outside of [CNA #1] pants. [Resident #29], stated that [CNA #1] then took it out and I put it in my mouth, . [Resident #29], stated that when [CNA #1] came back ?We had sex. [Resident #29], stated that [CNA #1] kept saying you are tight. [Resident #29] stated [they] had done this before at another facility with diet. [[[ staff 2 1/2 years ago.An APS-Report, dated 12/12/25, page 5, read in part, On December 2, 2025, at 9:33 AM, I interviewed [Administrator]. [Administrator] stated that [they] verified with [Resident #29] who reported that [they] had given a ?blow job' to staff in the shower and in her room. [Administrator] stated that [Resident #29] told her that it was consensual.On 12/16/25 at 2:00 p.m., the administrator stated they were aware of the sexual abuse allegation against a staff member, and the DON conducted an interview with Resident #29. The administrator stated they had issues in the past with Resident #29 seeking out sexual relationships, with caregivers. The administrator stated Resident #29 had been moved closer to the nurse's desk to observe and the care plan had been updated to address the resident seeking out sexual relationships. On 12/15/25 at 12:10 p.m., Resident #29 stated they and an employee had a sexual relation. Resident #29 stated they were not forced and it was consensual. Resident #29 stated the employee was no longer allowed to come back into the facility. On 02/13/29 at 12:30 p.m., the corporate nurse stated the facility should not have substantiated the allegation because there was no way to prove oral sex took place. On 02/13/26 at 12:47 p.m., the DON stated on 11/27/25 they received a call from the facility stating Resident #29 had performed oral sex on a male staff member. The DON stated they immediately came to the facility and (continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | spoke with Resident #29. The DON stated Resident #29 told them the CNA was their boyfriend and they had performed oral sex on them. The DON stated the allegation was substantiated because the timeline matched up with the interviews of staff and Resident #29 never changed how they described the incident. On 02/13/26 at 3:45 p.m., CNA #1 stated they assisted Resident #29 in the shower because they were going out with family the next day. CNA #1 stated in no way did anything sexual happen between them and they were taken aback by the accusations. CNA #1 denied the resident was ever their girlfriend. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure assessments were accurate for 1 (#28) of 17 sampled residents reviewed for falls.The administrator identified 59 residents resided in the facility. Findings: A quarterly assessment for Resident #28, dated 11/25/25, showed a BIMS of 03 which indicated the resident was severely impaired for daily decision making. The assessment showed diagnoses which included hypertension, non-Alzheimer's disease, anxiety disorder, depression and psychotic disorder. Section J of the assessment showed Resident #28 had no falls since admission/entry, reentry, or prior assessment. On 12/17/25 at 3:36 p.m., the MDS coordinator stated they ensured the accuracy of the MDS by looking at the provided documentation and doing the assessment themself. They stated when a resident had a fall, they added the falls to the assessment and the care plan. The MDS coordinator reviewed the quarterly assessment dated [DATE] for Resident #28 and stated they had not accurately coded the assessment related to falls. |