

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2026
NAME OF PROVIDER OR SUPPLIER Sequoyah Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8515 North 123rd East Avenue Owasso, OK 74055	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document and policy review, the facility failed to report an allegation of abuse to the state survey agency within two hours after the allegation was made for 1 (Resident #16) of 2 residents reviewed for abuse. Specifically, on 08/06/2025 at 7:50 PM, Resident #16 reported that a staff member was rough with them during care. The facility failed to report the abuse allegation to the state agency until 08/06/2025 at 10:06 PM. Findings included: A facility policy titled, Abuse and Neglect-Administrative Protocol, effective 10/05/2022, revealed, 7. Reporting-The facility will send a report to all reporting agencies as required by OSDH [Oklahoma State Department of Health] guidelines. a. The facility will send a report to the Oklahoma State Department of Health and adult protective services immediately, but not later than 2 hours of being notified of the allegation, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. An admission Record revealed the facility admitted Resident #16 on 03/23/2022 with a recent readmission on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of pain in the left hip, manic episode - severe with psychotic symptoms, anxiety disorder, insomnia, bipolar disorder, cognitive communication deficits, schizoaffective disorder, mild cognitive impairments of uncertain or unknown etiology, chronic pain, spondylosis without myelopathy or radiculopathy, spinal stenosis, and age-related osteoporosis without current pathological fracture. A quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/19/2025, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. A typed statement dated 08/07/2025 at 8:35 PM, signed by Licensed Practical Nurse (LPN) #8, revealed that at approximately 7:50 PM (on 08/06/2025), Resident #16 reported to Certified Medication Aide (CMA) #7 that Certified Nursing Assistant (CNA) #1 was too rough with them. According to the statement, upon assessment, Resident #16 told LPN #8 that CNA #1 threw them from side to side instead of counting down before providing care. Resident #16 told LPN #8 that CNA #1 was too rough and that the resident did not want him back in the room. An Oklahoma State Department of Health Initial Incident Report Form dated 08/06/2025 at 10:09 PM, signed by the Director of Nursing (DON), revealed the facility reported to the state agency that Resident #16 made an allegation of abuse against CNA #1. During an interview on 07/24/2026 at 2:42 PM, the DON stated that once an allegation was made, it should be reported to the nurse who then reports to the Administrator or Director of Nursing. The DON stated that the Administrator and/or DON then went to the facility immediately to submit initial reports within two hours of staff knowledge of the allegation. Per the DON, the facility became aware of Resident #16's allegation on 08/06/2025 at 7:50 PM, and staff (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified her at 8:35 PM on 08/06/2025. The DON reviewed the facility initial reportable incident and stated the report was submitted to the state survey agency on 08/06/2025 at 10:06 PM. She stated she expected the facility to report an allegation of abuse to the state survey agency within two hours of staff knowledge of an allegation. During an interview on 07/24/2026 at 3:45 PM, the Administrator stated she expected all allegations of abuse to be reported to the state survey agency within two hours of the facility's knowledge of the allegation.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document and policy review, the facility failed to protect 1 (Resident #16) of 2 residents sampled for abuse, from further potential abuse after an allegation of abuse was made. On 08/06/2025 at 7:50 PM, Resident #16 alleged that Certified Nursing Assistant (CNA) #1 was rough while providing bed mobility assistance. CNA #1 continued to provide resident care to residents other than Resident #16 until 8:48 PM on 08/06/2025, when the CNA was suspended. Findings included: A facility policy titled, Abuse and Neglect-Administrative Protocol, effective 10/05/2022, revealed, 6. Protect - The facility will act immediately to protect the resident when being notified of an allegation. a. Any staff member (s) that is part of the allegation will be immediately suspended and remain suspended throughout the investigation. An admission Record revealed the facility admitted Resident #16 on 03/23/2022 with a recent readmission on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of pain in the left hip, manic episode - severe with psychotic symptoms, anxiety disorder, insomnia, bipolar disorder, cognitive communication deficits, schizoaffective disorder, mild cognitive impairments of uncertain or unknown etiology, chronic pain, spondylosis without myelopathy or radiculopathy, spinal stenosis, and age-related osteoporosis without current pathological fracture. A quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/19/2025, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #16's Care Plan Report, included a focus area initiated on 03/25/2022 and revised on 01/27/2024, that indicated the resident had an activity of daily living (ADL) self-care deficit related to acute and/or chronic illness resulting in deconditioning. Interventions directed staff to provide assistance with bed mobility (undated). An Oklahoma State Department of Health Initial Incident Report Form dated 08/06/2025 at 10:09 PM revealed Resident #16 alleged that CNA #1 was rough while rolling the resident side to side in bed. The form revealed the resident asked the CNA to go slower but the CNA continued to be rough. Per the form, the facility suspended CNA #1 pending an investigation. A typed statement dated 08/07/2025 at 8:35 PM, signed by Licensed Practical Nurse (LPN) #8, revealed that at approximately 7:50 PM, Resident #16 reported to Certified Medication Aide (CMA) #7 that CNA #1 was too rough. CNA #1's Employee Timesheet dated 08/06/2025 revealed the CNA was clocked in from 2:00 PM until 5:26 PM and from 5:57 PM to 8:48 PM. The Employee Timesheet revealed CNA #1 did not work after 08/06/2025. During an interview on 07/22/2026 at 7:11 AM, CNA #1 revealed after the nurse was notified of the allegation, he was allowed to continue to assist other residents at the facility until the ADM and DON arrived. He stated after the Administrator (ADM) and Director of Nursing (DON) arrived he was taken into an office, notified of the allegation, and placed on suspension. During an interview on 07/22/2026 at 7:46 AM, LPN #8 stated he recalled that Resident #16 told him that CNA #1 had provided care in a rough manner while rolling the resident from side to side during incontinence care. LPN #8 stated he notified the DON immediately of Resident #16's allegation. LPN #8 stated he did not have the authority to suspend CNA #1 and told the CNA to go to the nurse's station to write his witness statement. LPN #8 stated he was unsure whether CNA #1 provided any additional care to any resident prior to the DON and ADM's arrival to the facility on the day of the allegation. He stated that he recalled CNA #1 leaving the facility after the DON and ADM arrived. During an interview on 07/24/2026 at 2:42 PM, the DON reviewed the facility's reportable investigation file and stated she expected the nurse on duty to send home any staff member named in an abuse allegation, immediately. The DON stated that once the facility became aware of the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation made by Resident #16 on 08/06/2025 at 7:50 PM, she would have expected CNA #1 to be removed from the facility. The DON stated she could not recall whether CNA #1 had been sent home prior to her arrival at the facility on 08/06/2025. During an interview on 07/24/2026 at 3:45 PM, the ADM stated she expected staff to escort the alleged perpetrator out of the facility immediately upon knowledge of an allegation of abuse.		