STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375351	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Health and Rehab	1251 West Houston 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 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. 35474 Based on record review and interview, the facility failed to ensure allegations of abuse were reported to the Oklahoma State Department of Health within 2 hours for 1 (#1) of 3 sampled residents who were reviewed for abuse. The administrator identified 113 residents who resided in the facility. Findings: Resident #1 had diagnoses which included unspecified dementia. The Abuse, Neglect, Misappropriation and Exploitation Investigation and Reporting policy, dated 10/18/22, read in part, All alleged violations will be reported immediately, but not later than two hours after the allegation is made, 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 no involve abuse and do not result in serious bodily injury. The following persons or entities will be notified, as required by state law, by Facility personnel (Administrator or Administrator Designee): a. Administrator b. State Survey Agency. The ODH form 283 showed an initial report for allegation of abuse/mistreatment, for Resident #1, dated 02/16/25. The ODH form 283 showed on 02/17/25 at approximately 4:00 p.m., Resident #1 reported to the ADON, that sometime during the evening shift on 02/16/25, an unidentified person put their finger in Resident #1's vagina. The fax cover sheet showed the ODH form 283 initial report for the sexual abuse allegation for Resident #1 was not sent to the State Agency within 2 hours. The fax cover sheet showed the ODH form 283 was not sent until the next day, on 02/18/25 at 1:24 p.m. On 03/03/25 at 3:40 p.m., the ADON stated on 02/17/25 Resident #1 had reported an allegation of sexual abuse from 02/16/25 and they immediately notified the administrator and DON. (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	On 03/03/25 at 3:42 p.m., the administrator stated the ADON reported the allegation of sexual abuse, for Resident #1, to them on 02/17/25. The administrator stated they were the abuse coordinator for the facility. The administrator stated they did not know they were to report allegations of abuse to the State Agency within 2 hours. They stated they thought they had 24 hours to report allegations of abuse to the State Agency.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 35474 Based on observation, record review, and interview, the facility failed to ensure assessments were accurate for 1 (#3) of 7 sampled residents whose assessments were reviewed. The administrator identified 113 residents who resided in the facility. Findings: On 02/27/25 at 1:50 p.m., a BiPap was observed on Resident #3's nightstand. Resident #3 had diagnoses which included sleep apnea. A physician's order, dated 09/02/22, showed the resident was to wear a BiPap at bedtime. The quarterly assessment, dated 01/11/25, showed the resident did not utilize a non-invasive mechanical ventilator. On 03/03/25 at 8:51 a.m., Resident #3 stated they utilized their BiPap every night. On 03/03/25 at 1:34 p.m., MDS (minimum data set) coordinator #1 reviewed the quarterly assessment and stated the assessment was inaccurate for Resident #3. They stated the assessment should have shown the resident utilized a non-invasive mechanical ventilator.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35474 Based on record review and interview, the facility failed to ensure medication orders from the physician were implemented for 2 (#2 and #4) and failed to ensure daily weights were obtained as ordered by the physician for 1 (#4) of 3 sampled residents who were reviewed for quality of care. The ADON identified 113 residents who received medications and 20 residents who were ordered daily weights. Findings: 1. Resident #2 had diagnoses which included low back pain and chronic pain. A physician order, dated 02/23/24, showed Resident #2 had been ordered cyclobenzaprine (a muscle relaxer) 10 mg every 12 hours as needed. The progress note by the physician, dated 02/20/25 at 2:01 p.m., read in part, Discontinue cyclobenzaprine. Review of the February 2025 medication administration record showed Resident #2 had been administered cyclobenzaprine 10 mg on 02/20/25 at 7:01 p.m. and on 02/23/25 at 12:36 a.m. The February 2025 medication administration record did not show the cyclobenzaprine had been discontinued per the physician's order. On 02/27/25 at 4:19 p.m., the DON stated the nurses implemented the physician orders and the medical records staff reviewed the physician orders and progress notes every day to ensure orders had been implemented. On 02/27/25 at 4:22 p.m., medical records #1 stated they ran a report of the physician progress notes daily and ensured the physician orders were implemented. They stated they would need to check on the cyclobenzaprine order for Resident #2. On 02/27/25 at 4:48 p.m., medical records #1 stated the order to discontinue the cyclobenzaprine had been missed. On 03/03/25 at 1:53 p.m., the DON stated they did not know why the cyclobenzaprine had not been discontinued or how it was missed during the daily audits. 2. Resident #4 had diagnoses which included hypertension and generalized edema. The progress note by the physician, dated 02/18/25 at 10:16 a.m., read in part, Daily weights. Review of the February 2025 treatment administration record showed a daily weight for fluid retention had not been obtained on 02/24/25 or 02/25/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress note by the physician, dated 02/26/25 at 1:43 p.m., read in part, DC [discontinue] losartan [a medication used for high blood pressure] due to low BP [blood pressure]. Review of the February 2025 medication administration record showed Resident #4 continued to have losartan 25 mg ordered and the medication had been held, due to vital signs outside of parameters, on 02/26/25 and 02/27/25. The Nsg [nursing] Discharge Instructions v5 form, dated 02/27/25, showed Resident #4 had been discharged home from the facility and medications had been given to the family or the resident. The form was signed by LPN #1. The Medications Released on Leave of Absence/Discharge form, dated 02/27/25, showed Resident #4 was discharged with five losartan 25 mg tablets. On 03/03/25 at 1:13 p.m., the DON stated the charge nurses were responsible to obtain daily weights. They stated they had recently had a staffing change and the daily weights for Resident #4 had not been obtained. The DON stated they monitored weights weekly, on Thursdays, to ensure daily weights were obtained per the physician orders. They stated Resident #4 had discharged , from the facility, before the weekly meeting so they had not identified weights were not obtained on 02/24/25 or 02/25/25. The DON stated they sent the medication administration record with residents upon discharge. They stated LPN #1 had discharged Resident #4 so they would need to ask them what medications were sent with the resident upon discharge to home. On 03/03/25 at 1:54 p.m., LPN #1 stated they provided residents who were discharging their medications, discharge instructions, and a list of medications they sent with them. LPN #1 reviewed the Medications Released on Leave of Absence/Discharge form for Resident #4 and stated they had sent the listed medications, including losartan 25 mg, with Resident #4 upon discharge from the facility. On 03/03/25 at 2:19 p.m., the DON stated they reviewed the clinical record for Resident #4. They stated the daily weights had not been obtained on 02/24/25 or 02/25/25 and the losartan had not been discontinued as ordered by the physician. The DON stated the nurses on the second floor of the facility were not aware they needed to review the physician progress notes for orders.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. 35474 Based on record review and interview, the facility failed to ensure labs were completed as ordered by the physician for 2 (#2 and #6) of 3 sampled residents whose labs were reviewed. The ADON identified 113 residents who resided in the facility. Findings: 1. Resident #2 had diagnoses which included chronic obstructive pulmonary disease. The progress note by the physician, dated 02/20/25 at 2:01 p.m., read in part, Please obtain readmit labs. Review of the clinical record did not show the readmission labs had been completed. On 02/27/25 at 4:19 p.m., the DON stated the charge nurses were responsible to ensure physician orders from the progress notes were implemented. They stated medical records staff reviewed the clinical record to ensure orders were implemented. On 02/27/25 at 4:22 p.m., medical records #1 stated they completed daily audits to ensure labs ordered by the physician had been implemented and ordered from the lab company. They stated they would look for the labs for Resident #2. On 02/27/25 at 4:48 p.m., medical records #2 stated they did not have any readmission labs for Resident #2. On 03/03/25 at 1:53 p.m., the DON stated they did not know why the readmission labs were not completed for Resident #2. 2. Resident #6 had diagnoses which included congestive heart failure. A progress note by the physician, dated 01/16/25 at 9:34 a.m., read in part, CBC [complete blood count], CHEM 8 [basic metabolic panel], A1c [glycated hemoglobin]. Review of the clinical record did not show the labs had been completed as ordered by the physician. On 03/03/25 at 1:50 p.m., the DON stated the labs the physician ordered on 01/16/25 had not been completed. They stated they did not know why the lab orders had not been implemented. They stated the medical records department monitored physician progress notes to ensure orders were implemented.