STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025

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 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. On 04/01/25 at 9:18 a.m., an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents were free from abuse and neglect. A nurse's statement, dated 03/27/25 at 11:15 p.m., showed Resident #1 reported to RN #1, CNA #1 on the evening shift was mean and hurt them. Resident #1 reported CNA #1 threw them on the bed hard enough to make the bed move and hurt them every time CNA #1 was their aide. Resident #1 reported CNA #1 had been hurting them for a while and they were afraid to report it because they were afraid CNA #1 would get meaner. RN #1 documented Resident #1 broke down into tears crying and asked to keep CNA #1 out of their room. On 03/31/25 at 11:39 a.m., Resident #1 stated the incident on 03/27/25 made them feel abused in a way. Resident #1 then stated to the surveyor, on 03/30/25 on the night shift, when they called for assistance to the restroom, CNA #2 told them to just go in your brief because they could not lift them to take them to the restroom due to having a bad back. Resident #1 stated CNA #2 changed their brief once, then did not check on them the rest of the night. Resident #1 stated they did not use their call light again because they knew CNA #1 would not assist them to the restroom. Resident #1 stated by the morning they were soaked through their brief, gown, and linens on the bed. On 04/01/25 at 4:44 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 04/01/25 at 4:49 p.m., the administrator was notified of the IJ situation and provided the IJ template. On 04/02/25 at 1:27 p.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: 1. ALL STAFF will be inserviced in-person on the Abuse and Neglect policy PRIOR to their next shift by the ADMINISTRATOR, DON [director of nursing], OR ADON. ALL STAFF will be given a written competency exam on the Abuse and Neglect Policy. Anyone who is on leave for FMLA [The Family and Medical Leave Act] leave, vacation, or otherwise cannot physically come to the facility will be inserviced by phone. ALL STAFF will be inserviced by Wednesday 4/2/25. Any PRN[as needed] or Part-time staff who do not have a scheduled shift, and who do not respond to repeated phone calls, will be inserviced prior to their next scheduled shift. (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: 375351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/1/25 at 4pm, Department Head Staff was brought to conference room, inserviced on the Abuse and Neglect Policy by the Administrator and issued a competency exam on the Abuse and Neglect policy. Once they were inserviced and passed the exam, they were given a phone list to make immediate calls to inform ALL STAFF of the required IN PERSON inservice that they are required to attend prior to their next shift. All dates and times that phone calls were made was documented. Calls to ALL STAFF were completed by 5pm. Any staff who did not answer their phone were left a voicemail with instruction. After the Department Head Staff was inserviced on 4/1/25 at 4pm, ALL STAFF present in the building was relieved from their post one at a time, brought to the conference room, inserviced, and given a written competency exam. ADON will be at the facility at 9:30pm on 4/1/25 to inservice and give competency tests to all 10pm-6am staff. ADON will be at the facility at 5:30am on 4/2/25 to inservice and give competency tests to all 6am-2pm staff. ADMINISTRATOR will give all 2pm-10pm staff inservice and competency tests on 4/2/25. All remaining staff will be contacted by a member of the Department Team by phone to be inserviced and given the exam orally on 4/2/25. 2. ALL STAFF will take a written (oral if by phone) competency exam on the Abuse and Neglect Policy immediately following the inservice. The inservice will be conducted in small groups or one-on-one to ensure understanding. 3. ALL alert and oriented residents will be interviewed for potential abuse allegations by end of business day 4/2/25. 4. IJ will be resolved by 4pm on 4/2/25. The IJ was lifted, effective 04/02/25 at 4:34 p.m., when all components of the plan of removal had been verified as completed, with interviews and review of in-service documentation. The deficient practice remained at pattern level with the potential for more than minimal harm. Based on record review and interview, the facility failed to protect the resident's right to be free from physical abuse and neglect by staff for 3 (#1, 2 and #3) of 3 sampled residents who were reviewed for abuse and neglect. The administrator identified 103 residents who resided at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER: Aspen Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings: 1. An Abuse, Neglect, Misappropriation and Exploitation Investigation & Reporting policy, revised 10/18/22, read in part, The Facility will endeavor to protect residents from abuse neglect and exploitation.It recognizes resident rights to be free from physical, verbal or mental abuse, corporal punishment, involuntary seclusion, and any chemical and physical restraints.Neglect. The failure to provide protection for a vulnerable adult who is unable to protect his or her own interest; the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, .or negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services. Abuse. A caregiver causing or permitting: 1. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or 2. the deprivation of nutrition, clothing, shelter, healthcare, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult. Resident #1 had diagnoses which included polyneuropathy, right knee osteoarthritis, constipation, hypertension, age related physical debility, and a history of transient ischemic attack (mini-stroke). Review of the January grievance log showed on 01/23/25, a resident had a concern with wait times and etiquette. The intervention was shown to be an inservice of floor staff on 01/23/25. No named staff were provided on the form. Review of the March grievance log showed on 03/17/25, a resident had a concern for not being changed when asked. The intervention was shown to be discipline by the ADON. No named staff were provided on the form. An admission assessment, dated 03/23/25, showed Resident #1 had a BIMS of 15, which indicated they were cognitive for daily decision making. Resident #1 required substantial/maximal assistance for toileting hygiene, lower body dressing, putting on/taking off footwear, and toilet transfers. The assessment showed Resident #1 required partial/moderate assistance with upper body dressing, lying to sitting on side of bed, sitting to standing and chair/bed-to-chair transfers. The assessment showed Resident #1 was frequently incontinent of bowel and bladder. A written nurse's statement, dated 03/28/25, showed RN #1 documented Resident #1 broke down into tears crying and asked to keep CNA #1 out of their room. Resident #1 stated it made them feel abused in a way. A care plan, initiated 03/31/25, showed Resident #1 had an ADL (activity of daily living) self-care deficit related to decreased mobility. The care plan showed interventions which included assist of one staff member with bed mobility, dressing, and to encourage the resident to participate to the fullest extent possible with each interaction. (continued on next page)

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	04/02/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/31/25 at 11:39 a.m., Resident #1 recounted the incident which occurred on 03/27/25 at 11:15 p.m. Resident #1 stated they reported to RN #1, CNA #1 on the evening shift, was mean and hurt them. Resident #1 stated CNA #1 threw them in the bed hard enough to make the bed move and hurts them every time CNA #1 was their aide. Resident #1 stated CNA #1 had been hurting them for a while and they were afraid to report it because they were afraid CNA #1 would get meaner. Resident #1 then stated to the surveyor on 03/30/25 on the night shift, when they called for assistance to the restroom, CNA #2 told them to just go in your brief because they could not lift on them to take them to the restroom due to having a bad back. Resident #1 stated CNA #2 changed their brief once, then did not check on them the rest of the night. Resident #1 stated they did not use their call light again because they knew CNA #1 would not assist them to the restroom. Resident #1 stated by the morning they were soaked through their brief, gown, and linens on the bed. The incident on 03/30/25 on the night shift was reported to the administrator by the surveyor on 03/31/25 at 11:54 a.m. On 03/31/25 at 3:05 p.m., the administrator stated they had suspended CNA #1. The administrator stated they had never received a complaint against CNA #1 before. The administrator stated CNA #1 had admitted to rushing Resident #1. The administrator stated CNA #1 had given them a two page statement. The administrator stated CNA #1 will not come back until 04/02/25. The administrator stated they had a conversation about bones, fragility of the elderly with CNA #1. The administrator stated to this point in their investigation they had not found any other residents who were affected by the care of CNA #1. The administrator stated CNA #1 would be shadowed for several weeks before working independently. The administrator stated they did not believe CNA #1 intentionally hurt Resident #1. On 03/31/25 at 3:40 p.m., CNA #1 was interviewed via phone. CNA #1 stated they had been employed by the facility twice for a total of two or three years and had been back approximately six months. CNA #1 stated for the past month they had worked D hall where Resident #1 lived. CNA #1 stated sometimes they felt rushed if they spent a lot of time with a resident and had a lot of call lights on. CNA #1 was asked about types of abuse and they stated forcing residents to do something they do not want to, screaming at residents and touching residents hard would be abuse. CNA #1 stated not providing care and services would be neglect. CNA #1 stated they had told Resident #1 they were too busy to help them and to just go in their brief because they did not have time. They stated it was neglect. On 03/31/25 at 4:10 p.m., staff #1 stated they worked the night shift. Staff #1 stated they had written a statement about CNA #1 being mean and hurting Resident #1 because Resident #1 had reported the incident to them. Staff #1 stated they had spoken to CNA #1 about the incident and CNA #1 admitted to them they were being mean because they were busy and stressed. Staff #1 stated they had reported it to the charge nurse. Staff #1 stated what was reported to them by Resident #1 would be an abuse allegation. On 04/01/25 at 9:30 a.m., the administrator was asked what measure had been implemented to ensure the safety of all residents. The administrator stated CNA #1 would return to work on 04/02/25 and would work with a shadow. The administrator stated they would review abuse/neglect with CNA #1 and reiterate what had been previously discussed before CNA #1 provided any care to the residents. 2. A quarterly assessment for Resident #2, dated 03/11/25, showed the resident's cognition was intact with a BIMS score of 15. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/31/25 at 12:05 p.m., Resident #2 stated CNA #1 would usually come in to turn off the call light, say they would return, but never would. 3. A quarterly assessment for Resident #3, dated 02/02/25, showed the resident's cognition was intact with a BIMS score of 15. On 03/31/25 at 12:42 p.m., Resident #3 stated they could not remember staff names, but a couple of the CNAs were just awful. Resident #3 stated one of them jerked them around in the bed. Resident #3 stated another aide would throw the call light at them when they were finished providing care. Resident #3 stated sometimes the aides would get anxious and turn them really quickly, and it made them feel like they were going to fall off the bed. Resident #3 stated they had been told to just pee in my brief once or twice because the staff did not have time. Resident #3 stated they had not reported the incidents because they did not want to cause problems.