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	06/06/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain comfortable sound levels in halls, by resident rooms, and resident common areas of the facility. The facility alphabetical room roster showed there were 100 residents. On 06/04/25 at 4:30 p.m., several children were observed in the second floor billiard room, playing with the billiard balls on the billiard table by slamming the billiard balls against one another. The children's voices were loud. On 06/04/25 at 6:00 p.m., two children were observed entering the elevator. The children appeared to be under the age of 10 and each wore the walkie-talkie style headset the staff wore for inter-facility communication. On 06/04/25 at 6:15 p.m., a group of children stood in the first floor hallway, near an open office door. Another group of children were observed to access resident snacks off of the snack cart by the first floor nurses' station. On 06/06/25 at 1:00 p.m., Resident #A stated the administrator's child would come through and pass out activity calendars or other things. The resident stated this week, the administrator's child brought another child into the resident's and asked the resident if they wanted ice. On 06/06/25 at 1:17 p.m., Resident #B stated there were kids in the hallways and in the therapy department. The resident stated the children jumped on the trampoline and played on the therapy equipment. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/06/25 at 1:25 p.m., Resident #C stated there were kids everywhere. The resident stated the children would come into the billiard room, slap the billiard cues together like they were [NAME] fighting, throw the billiard balls around, and/or slam the billiard balls together on and off the billiard table. Resident #C stated they had to repeatedly tell the children to quiet down and/or stop and felt it was not their duty to supervise someone else's children. The resident stated a child followed the nurse into the resident's room and laid on the resident's bed. Resident #C stated the child did not belong to the nurse, was not known to the resident, and did not ask permission to enter the room or be on the bed. The resident stated the nurse told the child to get up and that they should not be in the resident's bed/room. Resident #C stated they understood the administrator brought their child to work as well. The resident stated they understood child care was expensive but felt the children should not be left for the residents to supervise. Resident #C stated they did not feel they could bring their concern to the administrator since the administrator also brought their child to work. The resident stated, It's disturbing. On 06/06/25 at 1:35 p.m., Staff #D stated there were kids in the building that were unsupervised. The staff member stated the children did not stay in one room or office, but would wander the halls, enter residents' rooms, enter common areas, slap billiard cues together, slam billiard balls together, and make a lot of noise. Staff #D stated the children had parents that worked in the building, but the parents did not supervise the children. On 06/06/25 at 2:00 p.m., the administrator stated the children were informed of their expected behavior prior to the children being allowed to go about the facility. The administrator stated there were lots of people around providing supervision for the children. The administrator stated they would accept the deficiency every time because the children's presence was therapeutic to the residents.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. Based on record review and interview, facility staff failed to follow the plan of care for 1 (#4) of 6 residents whose clinical records were reviewed. The facility alphabetical room roster showed there were 100 residents. Findings: An undated Closet Care Plan, for resident #4 showed the resident was confused at times, had left side weakness, and transferred with a mechanical lift/sling and two person assistance. The history and physical, dated 05/02/25, showed the resident was recently hospitalized for a stroke as well as a history of stroke with subsequent left side weakness and numbness. The history and physical showed the resident also had a history of dementia and chronic right should pain. The Care Plan, dated 05/02/25, showed the resident had activities of daily living performance deficit related to impaired mobility secondary to a stroke. The interventions showed the resident required partial moderate assistance with upper body dressing and personal hygiene. The interventions showed the resident required substantial to maximal assistance with toileting, showering, lower body dressing, and rolling side to side in bed. The interventions showed the resident was dependent with all other care related to activities of daily living. The comprehensive assessment, dated 05/07/25, showed resident #4 usually could make themselves understood and usually understood others, was moderately impaired in daily decision making with a BIMS score of 10, had functional range of motion in both upper and lower extremities, and was able to wheel themselves 150 feet in a manual wheelchair. The comprehensive assessment documented the resident was 5'9 tall and 201 pounds. A progress note, dated 05/14/25, read in part, Resident family member states that resident [sic] knee was injured during a transfer on Saturday night. Family states that resident was transferred without [the use of a mechanical lift] and leg got caught in wheelchair. Family member refused to let this nurse ask resident or spouse due to dementia diagnosis. The progress note showed the resident's physician was aware of the allegation and an x-ray was ordered. A facility reported incident, dated 05/14/25, showed the facility initiated an allegation of abuse/mistreatment involving CNA #1, LPN #1, and Resident #4. The report showed the CNA and LPN came into the resident's room to transfer the resident from their wheelchair to their bed. The report showed CNA #1 held the back of the wheelchair and LPN #1 stood in front of the wheelchair. The LPN advised the resident to place their hands around the nurse's neck and LPN #1 proceeded to lift the resident from the wheelchair. The note showed the LPN could not lift the resident high enough to clear the arm of the wheelchair and attempted to do so a few times before lifting them over the armrest and onto the bed. The note read in part, In the interim, [family member] stated that (the resident's) feet were caught in the foot pedals and this was also preventing [the resident] from clearing the wheelchair. The note showed that once the resident was on the bed, the (family member) felt LPN #1 was too quick in straightening the resident in bed. The report showed the resident was to transfer with the assistance of two staff members and a mechanical lift. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The report showed LPN #1 admitted to transferring the resident without the use of a mechanical lift, but stated there were no complaints of pain and that family was not in the room at the time of the transfer. The report showed CNA #1 denied being in the room at the time of the transfer. The report showed the administrator reviewed camera footage and determined the family, LPN #1, and CNA #1 were all present at the time of the transfer. The report read in part, [CNA #1] had retrieved the nurse for assistance and both went in the room and shut the door. The Hoyer lift was clearly visible, right outside the resident room. Both staff members walked past the Hoyer lift. The report showed both staff members were terminated and the remaining staff were in-serviced on following the closet care plan. A physician's progress note, dated 05/15/25, showed the x-ray to left knee was performed and the physician's impression of the x-ray was no acute fracture or dislocation present but there was moderate osteoarthritic changes notes. The note showed the resident had a left knee brace in place during the examination. On 06/04/25 at 5:00 p.m., family member #1 stated the resident was to be transferred by mechanical lift per the resident's closet care plan. The family member on a weekend afternoon, a CNA and nurse entered the room to transfer the resident from their wheelchair to their bed. The family member stated the two did not use a mechanical lift and instead transferred the resident by violently jerking the resident up out of the wheelchair. The family member stated the CNA was behind the wheelchair and the nurse was in front of the wheelchair. The family member stated the nurse jerked the resident upward and toward the bed but was unable to clear the left arm rest of the wheelchair. The family member stated the nurse attempted the transfer again and again, each time hitting the resident's hip into the hard arm rest. The family member stated the resident's feet were caught up in the foot pedals and front wheels of the wheelchair and did not have their feet planted for the transfer nor have the space to assist with the transfer. The family member stated the nurse sat the resident back down and then quickly jerked the resident up off their feet and with feet dangling, twisted and let go of the resident over the bed. The family member stated the resident was left with their head dangling off one side of the bed and their legs/feet off the other side of the bed. The family member stated the nurse then grabbed the resident by the arm and quickly reoriented the resident so their head was at the head of the bed. The family member stated this action was done too quickly for the resident. The family member stated this incident left the resident and family distraught. The family member stated after the incident, the resident complained of left knee pain and was unable to participate in physical therapy to the same level as before the transfer. On 06/05/25 at 2:00 p.m., Therapist #1 stated Resident #4 did complain of left knee pain and was not able to participate in therapy to the same level for a few days after the incident but was back to the same level as before the incident within the week. The therapist stated the resident would participate in therapy until the resident complained the left knee would dislocate and they could no longer bear weight on the joint. The therapist stated the resident would move the knee around to get the joint back in place. The therapist stated sometimes the knee joint would go back in place and the resident would resume therapy but most often it did not and any weight bearing therapy was halted for the day. The therapist stated the knee brace helped to some extent and so did the administration of pain medication an hour before therapy. The therapist stated the knee did limit the resident's ability to bear weight but felt it only delayed the resident's plateau in their level of function by a few days. The therapist stated they felt the transfer incident had little overall effect of the resident's course of therapy. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/06/25 at 11:20 a.m., the administrator stated when they were notified of the incident regarding the CNA and nurse not following the plan of care, they immediately reported the incident to the State and licensing agencies. The administrator stated they started their investigation of the incident but could only substantiate that the staff did not follow the plan of care. The administrator stated the closet care plan was one of their primary ways to communicate a resident's personalized care needs and Resident #4's closet care plan showed they were to transfer with a mechanical lift.