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	07/08/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interview, the facility failed to ensure grievances were filed without fear of reprisal for 1 (#3) of 3 sampled residents who were reviewed for grievances. The administrator identified 93 residents resided at the facility. Findings: A grievance form, dated 04/03/25, showed a concern for Resident #3 regarding a resident they did not like. The intervention showed the administrator, AD, and SSD spoke to the resident. A quarterly assessment, dated 04/21/25, showed Resident #3 had a BIMS of 15, which indicate their cognition was intact, and diagnoses which included hypertension, renal insufficiency, and diabetes. A grievance form, dated 06/30/25, showed a concern for Resident #3 as resident to resident. No intervention was provided on the grievance form. A social services/activities note, dated 06/30/25, showed the SSD and AD met with Resident #3 to address their complaints. The note showed the conversation included a question to Resident #3 about if the resident was happy living at the facility and if not, should they consider whether the facility was the right place or not. The note showed Resident #3 became very angry and gestured twisting their mouth and stated, So I'll just shut my mouth and not say a word ever again. The note showed Resident #3 asked the SSD to leave. On 07/03/25 at 2:32 p.m., Resident #3 stated they were told by social services if they kept complaining, there were other homes they could go to. Resident #3 stated they turned in complaints about the multiple staff's children being unsupervised at the facility. Resident #3 stated a couple of days ago, the SSD sort of threatened them when the SSD told them if they kept complaining, they would find them other placement. On 07/07/25 at 9:33 a.m., the representative for Resident #3 stated the SSD and AD had the conversation with Resident #3 on 06/30/25 on video with audio. The representative stated they would bring the video to the facility when they visited Resident #3. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/07/25 at 12:06 p.m., the representative informed the surveyor they were in the room of Resident #3 and had brought the recorded video segment in question. The video was observed. The video segment was dated 06/30/25 and showed the activities director in view but the social services director was not. A conversation was taking place. At 3:54 p.m. in the video, the AD was observed to stand and inform they had a call and left the room. The conversation continued with an unseen visitor. The visitor stated they Were working on the child thing. The visitor continued to say, You gotta be careful how much you complain about things that are not in your control. Resident #3 questioned Not in my control? The visitor responded, Yeah, like the children are not in your control, and that's okay, we are working on that. The puzzles are not in your control, [Resident #2] is not in your control and you complain constantly. After watching the video, Resident #3 was asked how that conversation made them feel. They stated It doesn't matter what I think. You really don't have a lot of rights here. The activities person says it is my home and to come to them with any issues, but when I do, this happens. Resident #3 began to cry. Resident #3 stated it has taken their joy of being around people. On 07/08/25 at 9:49 a.m., the AD stated a resident could not make too many grievances. The AD stated they would turn in anyone who told a resident to stop complaining. The AD stated on 06/30/25, they had to leave the conversation with Resident #3 to take a phone call, but had asked the SSD how the remainder of the discussion went and the SSD informed them it ended ok. The AD stated Resident #3 requested to speak to them several days later and when they followed up the surveyor was in the room. On 07/08/25 at 10:15 a.m., the SSD stated they were involved with resident concerns by providing comfort, education, listening, re-direction, and getting representative involvement when needed. The SSD stated if the concern was something problematic they became involved. They gave an example of what would be problematic, such as interfering with the care of a resident to the point of causing harm. The SSD stated the only reason a resident would be transferred would be if the resident was unhappy at the facility either with peers or conditions. They stated, Otherwise it's people who were unhappy with having rules. The social services director stated, There is a common thread, people start acting like a prisoner when they are consistently unhappy. The SSD was asked to react to the statement, You need to be careful how much you complain. The SSD stated they would not like that and it should not be said. The SSD stated if they had said that they would correct and clarify it. On 07/08/25 at 10:52 a.m., the administrator stated their policy for grievances was a resident could submit a grievance to any administrative staff member in person or in writing, and all grievances came to the administrator. The administrator stated a resident could submit as many grievances as they wished. The administrator stated they usually determined the root cause and either assigned it to the corresponding department or involved social services and activities. They stated they had reviewed cameras to verify if something happened or not in the past. The administrator was asked why a resident would be told to be careful how much you complain about things you have no control over. They stated they had not heard that and did not know what context that would be in.