STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375365	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Pointe Rehabilitation and Care Center	5725 South Ross Oklahoma City, OK 73119

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960 Based on observation, record review and interview, the facility failed to ensure residents were free of neglect for one (#3) of four sampled residents reviewed for neglect. Resident #3 took a water pitcher from the medication cart and proceed down the hall. Resident #2 blocked Resident #3 from leaving down the hall and ended up grabbing Resident #3 on the shoulders and base of the neck forcefully pushing them to the ground. Resident #3 sustained a fractured hip requiring surgery. CNA #1 was present and did not intervene to protect Resident #3 from Resident #2. The DON identifed 13 residents who resided on hall 600 memory care unit. Findings: The Abuse Prevention policy, last revised 10/21/22, read in part, .Neglect: failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any consumer when that failure presents either imminent danger to the health, safety, or welfare of a consumer or substantial probability that death or serious injury would result. This would include, but is not limited to, failure to provide adequate supervision during an event in which one consumer causes serious injury to another consumer . 1. Resident #2 had diagnosis of dementia. Resident #2's care plan, dated 07/10/24 , documented they had impaired cognition with dementia and had impaired process. The care plan documented the resident had difficulty making decisions, impaired decision making and long term memory loss. Resident #2's quarterly MDS, dated [DATE], documented the resident had severe cognitive impairment. 2. Resident #3 had diagnoses which included dementia, depression, psychosis, and schizophrenia. Resident #3's care plan, dated 02/19/24 , documented they had dementia and severe cognitive impairment. Resident #3's quarterly MDS, dated [DATE], documented the resident had severe contrive impairment. (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 0600 Level of Harm - Actual harm Residents Affected - Few	An incident progress note, dated 10/12/24 at 6:03 p.m., documented Resident #3 took a water pitcher and poured it on Resident #2. It documented Resident #2 pushed Resident #3 to the floor. It documented Resident #3 had a skin tear and started to yell when attempting to get off the floor. It documented Resident #3 was sent to the hospital for treatment. An initial OSDH incident report, dated 10/12/24, documented Resident #3 had a water pitcher from the medication cart and tossed water on Resident #2. It documented Resident #2 pushed Resident #3 causing them to fall and sustain a skin tear to their left elbow and pain in their left hip and was sent to the hospital for evaluation. It documented the facility was reporting an allegation of abuse or mistreatment. The emergency department to hospital admission record, dated 10/12/24, documented Resident #3 presented with a fall and was assaulted by another resident. The record also documented Resident #3 had a right hip intertrochanteric fracture and had surgery on 10/13/24. On 10/25/24 at 10:23 a.m., the video footage of the incident between Resident #2 and Resident #3 was viewed with the DON. The video clip was dated 10/12/24 at 4:29 p.m. and was 42 seconds long. Resident #3 was observed at the medication cart taking a pitcher of water when CNA #1 approached them in attempts to get the water pitcher. Resident #3 kept turning away from CNA #1 as they attempted to get the pitcher. Resident #2 was observed coming up the hall towards Resident #3. Resident #3 walked down the hall towards Resident #2. Resident #2 stepped in front of Resident #3 and after several attempts to get by Resident #3 threw water from the pitcher on Resident #2. CNA #1 was observed in the video standing about five feet away and did not intervene to separate Resident #2 and Resident #3. CNA #1 was observed taking a few steps towards the resident and then backed away and did not intervene to protect each resident and separate them. Resident #2 grabbed Resident #3 on the shoulders and neck area pushing Resident #3 forcefully to the ground. LPN #1 was observed entering the video after Resident #3 was pushed to the floor and moved Resident #2 away from Resident #3 who was on the floor. On 10/25/24 at 10:45 a.m., Resident #3's POA stated they had been notified Resident #3 was pushed down and had bloody elbows. They stated Resident #3 went to the hospital and had a fracture that required surgical repair. The POA stated they did not feel the residents were being watched like they should have been and they would have expected staff to intervene when any incident occurred like this. On 10/25/24 at 11:26 a.m., the DON stated CNA #1 went towards Resident #2 and Resident #3, but backed away and looked like they were scared. The DON stated CNA #1 should have intervened and attempted to separate the two residents. On 10/25/24 at 11:55 a.m., CNA #1 stated Resident #3 fell to the ground because Resident #2 pushed them to the floor. CNA #1 stated they were right there, but could not intervene and was not going to try and stop the residents because they were hit in the past by residents. CNA #1 stated they were afraid to intervene. CNA #1 stated they had only worked on the hall two other times and had been trained how to handle residents with dementia. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/25/24 at 12:07 p.m., LPN #1 stated they were working at the time of the incident with Resident #2 and Resident #3. They stated CNA #1 was close to the residents and did not intervene and stop them. LPN #1 stated they counseled the CNA, who responded they were not going to get beat up and was scared. LPN #1 stated the CNA normally worked on another hall and that was the first shift they had worked together. On 10/25/24 at 12:15 p.m., the DON was asked for a policy on dementia care. The DON stated they did not have one. They stated all they had was the abuse policy that had been provided. The DON stated LPN #1 never told them the aide was afraid to intervene. On 10/25/24 at 12:30 p.m., the administrator stated they had copies of CNA #1's statement from the incident. They stated the nurses charted in the record and that was the nurses' statement. They stated Resident #2 stepped in front of Resident #3 and the aide was behind the residents. The administrator stated CNA #1 looked scared, but they did not ask why they looked scared. The administrator then stated the expectations would be for the aide to intervene and attempt to separate the two residents. On 10/25/24 at 1:07 p.m., the DON was asked what the definition of neglect was. They stated, The willful intent to not take care of anybody. The DON was asked what the abuse policy indicated neglect was. They reviewed the policy and stated, Yes it was neglectful act on behalf of the aide. The DON added there was an altercation causing Resident #3 to fracture their hip and require surgery. On 10/25/24 at 1:21 p.m., the administrator stated neglect was not taking care of someone. When asked what the policy indicated neglect was, the administrator stated they disagreed and would see about that. 45583 Ed Roth