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	03/03/2025

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 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** 35389 Based on observation and interview, the facility failed to: a. provide an adequate supply of towels for bathing on resident halls or in the laundry room; b. ensure shower beds were clean and in good repair for two of two shower beds; c. ensure a shower hose was not missing in the shower room located next to room [ROOM NUMBER]; and d. ensure broken tiles on the floor and wall of a shower located in the shower room on Hall 300 were repaired. ADON #1 identified 182 residents resided in the facility. The DON identified the facility had two shower beds and seven shower rooms. Findings: 1. On 02/24/25 at 4:29 p.m., a confidential interview was held with a resident. The resident stated, Sometimes we don't have towels. On 02/25/25 at 9:40 a.m., Resident #3 stated, For a few months we don't have towels. On 02/27/25 at 9:12 a.m., CNA #6 stated they were limited on supplies. They stated they run out of towels a lot. CNA #6 opened room [ROOM NUMBER] with a total of 11 towels observed available for use. They stated, This is all for the 200 residents. On 02/27/25 at 10:15 a.m., CNA #7 was asked to show where the towels used for bathing were. CNA #7 stated there were No towels. They stated they had to go to the closet on station three for towels. On 02/27/25 at 10:27 a.m., LPN #6 was asked to show where they kept their towels for bathing. LPN #6 opened the door by room [ROOM NUMBER] and stated, No towels in there. LPN #6 also looked in the shower room and was unable to locate any towels. On 02/27/25 at 10:30 a.m., the LPN #4 opened the shower room on Hall 600 and stated there were no towels. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/27/25 at 10:43 a.m., CNA #8 opened the room labeled whirlpool room on Hall 100 and stated there were no towels. On 02/27/25 at 2:40 p.m., the laundry room was observed. Laundry #1 was asked to show all bath towels in the room. They pointed to a stack of 11 towels available for use. They stated, Normally they order a lot of them. They stated, This is what I have right now. On 02/27/25 at 4:30 p.m., the DON was provided the opportunity to locate all bath towels in the facility. They went to the storage room on Hall 200 and stated here is one towel. On 02/27/25 at 4:35 p.m., the DON observed two linen carts on Hall 200 and stated there were no towels. They observed the linen cart on Hall 300 and stated, None. On 02/27/25 at 4:36 p.m., the DON observed the storage room on the back of Hall 300 and stated, I don't see any towels. CNA #9 who was standing in the room stated, Usually we have to go to laundry and get towels. On 02/27/25 at 4:37 p.m., the DON observed the linen closet on Hall 600 and stated, No towels. On 02/27/25 at 4:40 p.m., the DON observed the linen cart in the Hall 400 shower room and stated, I don't see any towels. The DON observed one dirty towel in a sack. On 02/27/25 at 4:41 p.m., the DON located two towels in the Hall 500 shower room. The DON stated, So we're up to four. They stated, There's not enough. On 02/27/25 at 4:45 p.m., the DON walked into the laundry room and located two bath towels. The DON stated, We don't have near enough. 2. On 02/24/25 at 4:29 p.m., a confidential interview was held with a resident. They stated sometimes the shower chairs aren't clean. On 02/24/25 at 5:15 p.m., Resident #1 stated they had to go use the shower on Hall 400 because it was the cleanest. They stated once they had observed the shower bed with a bunch of cuticle wooden sticks under it. On 02/25/25 at 9:40 a.m., Resident #3 stated a shower chair was broken, they complained, and the facility fixed it. Resident #3 stated they took a shower yesterday and observed another broken shower chair. They stated the shower was not clean and it smelled bad. On 02/27/25 at 9:22 a.m., the shower room by room [ROOM NUMBER] was observed to have a shower bed with a blue cushion on top of it. The blue cushion was observed to have a white substance smeared on it. The cushion was lifted and a metal nut along with large amounts of brown and white debris was observed scattered throughout the shower bed. The shower bed was observed to be dry. CNA #6 stated, This is usually the state of it. The white undercarriage used for draining was observed to be disconnected on one half of the bed with the hose unattached. CNA #6 stated it was broken and won't stay up to drain. CNA #6 stated they told the nurse, the nurse put it into the electronic maintenance system, but it has not been fixed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/27/25 at 10:15 a.m., CNA #7 stated when something needed repaired, they would put it into the computer for maintenance to fix. The shower bed in the shower room next to room [ROOM NUMBER] was observed to have a blue pad on top of it. The blue pad was lifted up and a pen, rubber band, plastic razor head cover, and lots of yellow, blue, and white debris was observed on the shower bed. CNA #7 stated, They're supposed to clean it. They stated, After each use. The white undercarriage of the shower bed was observed to be held up on one side with a black trash bag. CNA #7 stated, We told them we needed a new one. CNA #7 stated it was weeks ago. CNA #7 stated they did not know who put the trash bag there to hold it up. On 02/27/25 at 9:26 a.m., CNA #6 stated staff were supposed to clean the shower beds after each use. They stated they were supposed to use a chemical and spray them down. CNA #6 stated the shower bed was not clean. On 02/27/25 at 2:02 p.m., the DON stated shower chairs/beds were supposed to be cleaned after every shower. 3. On 02/27/25 at 10:15 a.m., CNA #7 opened the shower room next to room [ROOM NUMBER]. One of the showers was observed to be missing the hose for the shower. CNA #7 was asked how long the shower hose had been missing and stated Its been a long while. CNA #7 stated when something needed repaired, they would put it into the computer for maintenance to fix. 4. On 02/27/25 at 10:24 a.m., LPN #6 opened the shower room by room [ROOM NUMBER]. The first shower was observed to have several missing tiles on the floor as well as two larger broken tiles where the floor meets the wall. LPN #6 stated, I think it's pretty fresh. On 02/27/25 at 2:08 p.m., the maintenance supervisor stated if staff identified items which needed repaired, they would put it into the electronic system used for maintenance repairs. They stated there were no current repairs in the works. On 02/27/25 at 2:15 p.m., the maintenance supervisor was shown the missing hose in the shower by room [ROOM NUMBER]. They stated, No one had reported it's missing. They observed the shower bed and stated they were not aware a trash bag was being used to hold up the undercarriage. They stated, It needs a new bottom tray. On 02/27/25 at 2:35 p.m., the maintenance supervisor was shown the shower bed on Hall 200 and stated they had always seen the bed together. They stated no one reported to them it needed repaired. The maintenance supervisor was asked about the missing tiles in the shower by room [ROOM NUMBER]. They stated staff had reported the missing tiles to them today. They stated before today, they were not aware they were missing. On 03/03/25 at 1:10 p.m., the administrator stated the facility did not have a policy on maintenance, shower beds clean and in good repair, or towels and they followed state and federal regulation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 On 02/27/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect Resident #12 from mental and physical abuse. On 02/25/25 at 3:02 p.m., Resident #12 was interviewed and stated on 01/23/25 at 6:00 p.m. a person came to door 2 (hall 200) pounding on the door. Resident #12 stated CMA #1 let this person in and they immediately staring cussing and making a move to hit CMA #1. Resident #12 stated they took off down towards them and asked the unknown person what they were doing. Resident #12 stated the person took two swings at them and on the second swing hit them on the face. Resident #12 stated it hurt like the [NAME]. Resident #12 stated ever since then, I don't feel safe. Resident #12 stated, It could happen again. Resident #12 stated they did not know who the person was, but they were delivering medications for a company and the administrator and DON would know who they were. Resident #12 stated the cops were called and charges were pressed. Resident #12 stated they needed security at the doors. The Abuse Prevention Policy, dated 10/21/22, read in part, The facility is committed to protecting the facility from abuse by anyone including, but not necessarily limited to: facility staff, other residents, and staff from other agencies providing services to our residents .Abuse: Willful infliction of injury .with resulting physical harm, pain, mental anguish or emotional distress. An Incident Note, dated 01/23/25, showed around 6:30 p.m., LPN #2 witnessed a confrontation between Resident #12 and the med-delivery person. The note showed LPN #2 saw the person flip their hands towards Resident #12's face. The note showed LPN #2 and other staff asked the person to leave the facility. The note showed the police, resident's family, and DON were notified. An unlabeled document, dated 01/24/25, showed Resident #12 stated they were not afraid, but did not feel safe. Resident #12 stated they felt like security needed to be put in place at night time. This note was signed by the social service supervisor. There was not a State incident report form completed for this incident of abuse. There were no interventions in place to address Resident #12 not feeling safe after this incident. On 02/27/25 at 6:22 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 02/27/25 at 6:26 p.m., the DON was notified of the IJ situation. On 02/28/25 at 11:04 a.m., an acceptable plan of removal was approved by the Oklahoma Stated Department of Health. The plan of removal, read in part, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	South Pointe IJ Abatement Plan for Removal 02/28/25 at 3:45 p.m. The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because provisions of State and Federal law require it. 1) Immediate Fix 2) Potential Residents Affected 3) System Changes 4) Monitoring/QAPI 5) DOC 1. a. Trauma informed questionnaire completed for Resident #12 on 2/27/25 by Social Services. Resident #12 stated that [they] had no previous trauma. [Their] intervention to feel safe is journaling which [they] has been provided with a notebook for journaling. Resident #12 has agreed to meeting with social services 5Xs a week and speaking to a psychology service on 2/27/25. b. Social Services educated on psychosocial health regarding abuse incidents by the DON on 2/27/25. Any residents who do not feel safe will have follow up completed by social services regarding obtaining a referral to psychology services and report findings to DON/LNHA. c. All door codes changed by the Maintenance Director on 2/27/25. Signage was placed on 2/28/25 by the Maintenance Director stating 'After 5pm, please go to Unit 400 door and ring doorbell for assistance.' d. Facility staff were educated on the new process on 2/28/25 by Department Heads. Staff will be educated prior to working their next shift. e. Resident safe surveys completed by department heads on 2/27/25. f. Social Services to follow up with resident#12 5Xs a week for one month to ensure no signs of fearfulness. Date of Compliance: 2/28/25 at 10:10am. The IJ was lifted, effective 02/28/25 at 3:45 p.m., when all components of the plan of removal had been verified as complete. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to protect a resident from mental and physical abuse for 1 (#12) of 3 residents sampled for abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ADON #1 identified 182 residents resided in the facility. Findings: The Abuse Prevention Policy, dated 10/21/22, read in part, The facility is committed to protecting the facility from abuse by anyone including, but not necessarily limited to: facility staff, other residents, and staff from other agencies providing services to our residents . Abuse: Willful infliction of injury .with resulting physical harm, pain, mental anguish or emotional distress. Resident #12 had diagnoses which included anxiety disorder and chronic embolism and thrombosis of other specified veins. Resident #12's annual assessment dated [DATE], showed their cognition was intact with a BIMS score of 15. An Incident Note, dated 01/23/25, showed at around 6:30 p.m., during shift, LPN #2 witnessed a confrontation between the Resident #12 and a med-delivery person while observing from the nursing station. The note showed the resident had seen and heard the med-delivery person verbally abuse a staff member by yelling and calling the staff member the B word several times. The note showed the resident then tried to tell the med-delivery person not to speak to the staff member in that manner. The note showed LPN #2 then saw the med-delivery person dip their hand towards the resident's face. The note showed LPN #2 then called 911. The note showed the DON and resident's family member were notified of the incident. The note showed the officer came shortly after and took their statement. On 02/25/25 at 3:02 p.m., Resident #12 stated on 01/23/25 at 6:00 p.m. a person came to door 2 (hall 200) pounding on the door. Resident #12 stated CMA #1 let the person in and they immediately staring cussing and making a move to hit CMA #1. Resident #12 stated they took off down towards them and asked the unknown person what they were doing. Resident #12 stated the person took two swings at them and on the second swing hit them on the face. Resident #12 stated it hurt like the [NAME]. Resident #12 stated ever since then, I don't feel safe. Resident #12 stated, It could happen again. Resident #12 stated they did not know who the person was, but they were delivering medications for a company and the administrator and DON would know who they were. Resident #12 stated the cops were called and charges were pressed. Resident #12 stated they needed security at the doors. On 02/27/25 at 8:52 a.m., CMA #1 stated the med-delivery person was banging on the door. CMA #1 stated they walked by the door and opened it and the med-delivery person stated, Yeah, [expletive], you saw me the first time. CMA #1 stated they told the med-delivery person they had to make a stop first. CMA #1 stated the med-delivery person stated, You heard what the [expletive] I said, and the med-delivery person bucked at them. CMA #1 stated when the med-delivery person bucked at them, Resident #12 came up to them and told the med-delivery person to leave them alone. CMA #1 stated the med-delivery person then swung and hit Resident #12 in the eye. CMA #1 stated they thought the med-delivery person swung two more times. CMA #1 stated Resident #12 and the med-delivery person continued to argue and they told LPN #2 to call the police. On 02/27/25 at 11:49 a.m., the DON stated they had not been notified at the time of the incident. The DON stated they were unaware of Resident #12 not feeling safe. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/27/25 at 11:52 a.m., the DON stated they did not know what else they could have done to make Resident #12 feel safe. On 02/27/24 at 11:54 a.m., the DON stated everyone should come through one door, but that was not the way anymore.

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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 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. 46216 Based on record review and interview, the facility failed to report an allegation of abuse to the OSDH for 1 (#12) of 3 residents sampled for abuse. ADON #1 identified 182 residents resided in the facility. Findings: The Abuse Prevention Policy, dated 10/21/22, read in part, The facility is committed to protecting the facility from abuse by anyone including, but not necessarily limited to: facility staff, other residents, and staff from other agencies providing services to our residents . Abuse: Willful infliction of injury .with resulting physical harm, pain, mental anguish or emotional distress. Resident #12 had diagnoses which included anxiety disorder and chronic embolism and thrombosis of other specified veins. Resident #12's annual assessment, dated 01/23/25, documented Resident #12's cognition was intact with a BIMS score of 15. An Incident Note, dated 01/23/25, showed at around 6:30 p.m., during shift, LPN #2 witnessed a confrontation between the Resident #12 and a med-delivery person while observing from the nursing station. The note showed the resident had seen and heard the med-delivery person verbally abuse a staff member by yelling and calling the staff member the B word several times. The note showed the resident then tried to tell the med-delivery person not to speak to the staff member in that manner. The note showed LPN #2 then saw the med-delivery person dip their hand towards the resident's face. The note showed LPN #2 then called 911. The note showed the DON and resident's family member were notified of the incident. The note showed the officer came shortly after and took their statement. There was no documentation an incident report was sent to the OSDH. On 02/27/25 at 11:48 a.m., the DON stated there was no report sent to the OSDH for the incident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 Based on record review and interview, the facility failed to ensure a care plan was updated for 1 (#12) of 14 sampled residents whose care plans were reviewed. ADON #1 identified 182 residents resided in the facility. Findings: A Comprehensive Person Centered Care Plan policy, dated 01/2019, read in part, Each resident will have a person centered care plan to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. Resident #12 had diagnoses which included anxiety disorder and chronic embolism and thrombosis of other specified veins. Resident #12's annual assessment dated [DATE], showed Resident #12's cognition was intact. An Incident Note, dated 01/23/25, showed at around 6:30 p.m., during shift, LPN #2 witnessed a confrontation between the Resident #12 and a med-delivery person while observing from the nursing station. The note showed the resident had seen and heard the med-delivery person verbally abuse a staff member by yelling and calling the staff member the B word several times. The note showed the resident then tried to tell the med-delivery person not to speak to the staff member in that manner. The note showed LPN #2 then saw the med-delivery person dip their hand towards the resident's face. The note showed LPN #2 then called 911. The note showed the DON and resident's family member were notified of the incident. The note showed the officer came shortly after and took their statement. The care plan did not address any physical altercations toward Resident #12. The care plan had no interventions on how to assist Resident #12 in feeling safe after the altercation. On 02/27/25 at 11:30 a.m., MDS coordinator #1 stated the process for updating the care plan was for a change in events, something like a fall and behaviors. On 02/27/25 at 11:34 a.m., MDS coordinator #1 stated the care plan should have been updated with this altercation and it was not.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 On 02/25/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure safety and supervision for Resident #4 who smoked. On 02/24/25 at 5:40 p.m., Resident #7 was observed in the outside courtyard smoking area without staff present. Resident #7 was observed to remove a cigarette, lit it with a match, and began to smoke. Resident #7 stated they had only been at the facility for a week. Resident #7 stated they smoked whenever they wanted to and kept their own cigarettes and matches. A Smoking Policy, dated 11/06/24, read in part, The facility shall maintain safety for residents who request to Smoke, as well as for those who do not. Residents requesting to smoke during their stay may be permitted with staff assistance of handling, igniting, and extinguishing (as needed) of smoker materials and may only smoke in designated areas .For Safety concerns, Residents will be Supervised during Smoking. Resident #4's Smoking Safety Evaluation, dated 01/13/25, read in part, Supervision will be required for all Residents during designated smoking times. This evaluation showed admission as the description of the assessment. A significant change resident assessment, dated 01/15/25, showed Resident #4's cognition was intact with a BIMS score of 14 and they required substantial/maximum assistance for personal hygiene, shower/bathe self, lower body dressing, and toilet hygiene. A State incident report form, dated 02/14/25, showed at approximately 5:05 p.m., the charge nurse was making rounds and smelled cigarette smoke in the hallway (Hall 200) and began opening doors to investigate. The report showed the charge nurse opened Resident #4's door and observed a Kerlix wound dressing to the resident's leg on fire. The report showed the nurse observed a lit cigarette and lighter on the vanity and the room was filled with smoke. The report showed third degree burns were noted to the resident's right posterior lower extremity. The report showed the skin was charred and fascia exposed. The report showed the resident was sent to the emergency room for an evaluation and treatment. An incident note, dated 02/14/25 at 5:10 p.m., showed LPN #1 entered Resident #4's room and observed flames of fire burning on the bandage wrapped around the entire right foot. The note showed the flame was observed to affect the resident's pants as well. The note showed LPN #1 used a bed pad and extinguished the fire. The note showed upon examination the resident had suffered burns to the right lower leg on the posterior aspect. The note showed LPN #1 was asked to send a picture of the affected area to the DON. The note showed it was then rated as a third degree burn and LPN #1 was instructed to send Resident #4 to the emergency room . A wound progress note, dated 02/21/25, showed Resident #4 had a full thickness burn of the right calf which measured length 9 cm, width 22 cm, depth 0.2 cm. There was no Smoking Safety Evaluation located in Resident #7's clinical record. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/25/25 at 2:24 p.m., the DON stated smoking evaluations were to be completed on admission. They stated all residents who smoked were to be supervised for safety. On 02/25/25 at 2:48 p.m., the DON stated Resident #7 admitted to the facility on [DATE] and there was not a smoking assessment in the computer. They stated they were not sure if the resident smoked. On 02/25/25 at 3:03 p.m., the social services supervisor stated they did not complete a smoking assessment for Resident #7. They stated they were not aware the resident was a smoker. On 02/25/25 at 3:29 p.m., the social service assistant stated they had a mess up. They stated Resident #7 did not smoke until they admitted to the facility. They stated they completed an assessment today and went over the policy for smoking. On 02/25/25 at 5:27 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 02/25/25 at 5:30 p.m., the DON was notified of the IJ situation. On 02/26/25 at 10:41 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, South Pointe IJ Abatement Plan for Removal 2.25.25 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because provisions of State and Federal law require it. 1) Immediate Fix 2) Potential Residents Affected 3) System Changes 4) Monitoring/QAPI 5) DOC 1. a. Resident #4 had a smoking safety evaluation completed on 2/14/25 by the DON. Resident #4 was educated on the smoking policy/procedures/smoking times on 2/14/25. Ad hoc QAPI was completed on 2/14/25 by the DON. b. Resident #7 had a smoking safety evaluation completed on 2/25/25 by Social Services. Resident #7 was educated on smoking policy/procedures/smoking times by Social Services on 2/25/25. c. Resident rooms will be searched on 2/25/25 by Social Services and Unit Managers to ensure no residents have lighters, matches, cigarettes, or vape. Any items found will be added to the smoking cart. (continued on next page)

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	375365	A. Building B. Wing	03/03/2025

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. All residents will have a smoking assessment completed on 2/25/25 by the DON, Unit Managers, and Social Services. Residents that smoke will receive education on smoking policy and smoking times on 2/25/25. 2. Residents who smoke have the potential to be affected. 3. Staff will be educated on 2/25/25 by the DON/LNHA on smoking policy/procedures including rounding between smoking times. No residents will be permitted to smoke without supervision. No staff will work until education is conducted. All new employees will be educated on smoking policies and procedures prior to working. 4. Rounding between smoking times will be completed randomly x 90 days to ensure compliance. Monitored findings will be brought to the monthly QAPI for review. 5. DOC: 2/25/25 at 9:42 PM. The IJ was lifted, effective 02/25/25 at 9:42 p.m., when all components of the plan of removal had been verified as completed. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on observation, record review, and interview, the facility failed to ensure: a. safety and supervision for a resident who smoked for 2 (#4 and #7); and b. smoking assessments were completed on admission and quarterly for 2 (#1 and #7) of 3 sampled residents reviewed for smoking. ADON #1 identified 182 residents resided in the facility. The DON identified 39 residents who smoked resided in the facility. Findings: 1. On 02/24/25 at 5:45 p.m., Resident #4 was observed being assisted to a lying position in bed by CMA #1. Resident #4 was observed to have a dressing in place to their right lower leg. CMA #1 was unable to identify the reason for the resident's dressing. Resident #4's room was observed to have the odor of burned flesh present. Resident #4 was unable to answer questions by the surveyor appropriately. A Smoking Policy, dated 11/06/24, read in part, The facility shall maintain safety for residents who request to Smoke, as well as for those who do not. Residents requesting to smoke during their stay may be permitted with staff assistance of handling, igniting, and extinguishing (as needed) of smoker materials and may only smoke in designated areas .For Safety concerns, Residents will be Supervised during Smoking. Resident #4 had diagnoses which included unspecified lack of coordination, muscle weakness, and muscle wasting and atrophy of the left shoulder. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #4's Smoking Safety Evaluation, dated 01/13/25, read in part, Supervision will be required for all Residents during designated smoking times. This evaluation showed admission as the description of the assessment. A significant change resident assessment, dated 01/15/25, showed Resident #4's cognition was intact with a BIMS score of 14 and they required substantial/maximum assistance for personal hygiene, shower/bathe self, lower body dressing, and toilet hygiene. A State incident report form, dated 02/14/25, showed at approximately 5:05 p.m., the charge nurse was making rounds and smelled cigarette smoke in the hallway (Hall 200) and began opening doors to investigate. The report showed the charge nurse opened Resident #4's door and observed a Kerlix wound dressing to the resident's leg on fire. The report showed the nurse observed a lit cigarette and lighter on the vanity and the room was filled with smoke. The report showed third degree burns were noted to the resident's right posterior lower extremity. The report showed the skin was charred and fascia exposed. The report showed the resident was sent to the ER for an evaluation and treatment. An incident note, dated 02/14/25 at 5:10 p.m., showed LPN #1 entered Resident #4's room and observed flames of fire burning on the bandage wrapped around the entire right foot. The note showed the flame was observed to affect the resident's pants as well. The note showed LPN #1 used a bed pad and extinguished the fire. The note showed upon examination the resident had suffered burns to the right lower leg on the posterior aspect. The note showed LPN #1 was asked to send a picture of the affected area to the DON. The note showed it was then rated as a third degree burn and LPN #1 was instructed to send Resident #4 to the emergency room . Resident #4's care plan, revised 02/17/25, showed the resident was at risk for adverse reactions due to smoking cigarettes. The care plan showed Resident #4 was a supervised smoker secondary to smoking in their room. The care plan showed Resident #4's smoking materials and lighters would be locked up with staff and the resident would attend the supervised smoking times to smoke. A wound progress note, dated 02/21/25, showed Resident #4 had a full thickness burn of the right calf which measured length 9 cm, width 22 cm, depth 0.2 cm. On 02/25/25 at 8:38 a.m., Resident #13 stated the facility should have been enforcing smoking rules before Resident #4 burnt their foot. Resident #13 stated they sat right on their bed and saw what happened. On 02/25/25 at 8:55 a.m. Resident #13 stated Resident #4 was in their room smoking. Resident #13 removed a notebook from their room and stated it was 02/14/25 and the ambulance came and took Resident #4 who had burnt their foot. On 02/25/25 at 9:10 a.m., Resident #4 stated they had been at the facility about a year. When asked to explain the dressing to their right lower leg, the resident replied, It's kind of a long story. Resident #4 stated, It's fear I'm gonna lose my leg. Resident #4 stated, All of a sudden it starts aching. Resident #4 stated, I smoke outdoors I don't smoke inside. Resident #4 started closing their eyes. On 02/25/25 at 9:14 a.m., CMA #2 entered Resident #4's room and assisted the resident to a lying position. Resident #4 closed their eyes and did not continue the interview. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/25/25 at 1:00 p.m., CNA #4 stated the facility really did not have a smoking policy before Resident #4 burnt their leg. CNA #4 stated, It was supervised smoking, but they weren't following protocol. CNA #4 stated residents were going out by themselves and had their own cigarettes. CNA #4 stated now staff were supervising all residents when they smoked and the cigarettes and lighters were kept in the Hall 200 medication room in a lock box. On 02/25/25 at 1:10 p.m., CNA #5 stated the facility just started enforcing the smoking policy after Resident #4 caught themselves on fire. They stated now staff supervised residents on scheduled smoke breaks every two hours. CNA #5 stated before the policy was enforced, residents kept their own cigarettes and lighters and went out on their own. On 02/25/25 at 1:28 p.m., LPN #3 stated residents were not allowed to have cigarettes or lighters on their person or in their room. They stated residents were taken out by staff every two hours for supervised smoke breaks. They stated no residents could safely smoke by themselves. LPN #3 stated this process took place after Resident #4 burnt their leg. LPN #3 stated Resident #4 was smoking in their room due to the cold weather and dropped their cigarette on their bandage. On 02/25/25 at 2:10 p.m., LPN #1 stated the facility had scheduled times to smoke and residents were not allowed to have lighters or cigarettes in their rooms. LPN #1 stated staff had a locked box with smoking supplies. They stated no residents smoked without supervision. LPN #1 stated the day of the incident, they were walking by Resident #4's room and smelt burning. LPN #1 stated they started opening resident rooms, and the second door they opened was Resident #4's room. LPN #1 stated they saw a flame on the resident's leg. LPN #1 stated they immediately called for help, and used a bed pad to get the flame out. LPN #1 stated Resident #4 had a package of cigarettes and a cigarette and lighter on the bed. LPN #1 stated they saw ashes on the bed and smoke spots. LPN #1 stated the flame affected the right foot dressing and they had to peel it off. LPN #1 reported they called the administrator and physician and sent the resident to the hospital. On 02/25/25 at 2:24 p.m., the DON stated the facility had supervised and unsupervised smokers before the incident with Resident #4. The DON stated after the 02/14/25 incident, staff collected all smoking materials and explained to residents and staff the new supervised smoking schedule. The DON stated right now everyone was supervised and staff had to light cigarettes for them. The DON stated smoking evaluations were to be completed on admission. They stated all residents who smoked were to be supervised for safety. The DON stated they received a call immediately when the incident with Resident #4 happened. They stated staff reported seeing flames on Resident #4's leg and used bed pads to extinguish the fire. They stated Resident #4 admitted to smoking in their room and they were sent to the emergency room for an evaluation. On 02/25/25 at 2:40 p.m., the DON stated a smoking schedule was put in place the night it happened. They stated the same policy was in effect when the incident occurred and residents should have been supervised during smoking. The DON stated now all cigarettes were on a count sheet and staff had to sign them out. They stated smoking supplies were locked in the Hall 200 medication room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 02/24/25 at 5:02 p.m., a facility smoke break was observed. CNA #1 stated resident cigarettes had their names on them and they along with the lighters were kept locked up in the medication room. CNA #2 was observed filling out a binder during the smoke break. CNA #2 stated they documented the resident name, date, cigarette time, and how many cigarettes were given in the log book. CNA #3 was observed lighting cigarettes for residents during the smoke break. There were eleven smokers observed during this supervised smoke break. On 02/24/25 at 5:40 p.m., Resident #7 was observed in the outside courtyard smoking area without staff present. Resident #7 was observed to remove a cigarette, lit it with a match, and began to smoke. Resident #7 stated they had only been at the facility for a week. Resident #7 stated they smoked whenever they wanted to and kept their own cigarettes and matches. Resident #7 had diagnoses which included nontraumatic subarachnoid hemorrhage and acute respiratory failure with hypoxia. Resident #7's admission record showed the resident admitted to the facility on [DATE]. There was no Smoking Safety Evaluation located in Resident #7's clinical record. On 02/24/25 at 5:15 p.m., Resident #7 stated the facility staff took all lighters and cigarettes from residents after Resident #4 caught themselves on fire. They stated smoke breaks were now supervised by staff. On 02/25/25 at 2:24 p.m., the DON stated smoking evaluations were to be completed on admission. They stated all residents who smoked were to be supervised for safety. On 02/25/25 at 2:48 p.m., the DON stated Resident #7 admitted to the facility on [DATE] and there was not a smoking assessment in the computer. They stated they were not sure if the resident smoked. On 02/25/25 at 3:03 p.m., the social services supervisor stated they did not complete a smoking assessment for Resident #7. They stated they were not aware the resident was a smoker. On 02/25/25 at 3:29 p.m., the social service assistant stated they had a mess up. They stated Resident #7 did not smoke until they admitted to the facility. They stated they completed an assessment today and went over the policy for smoking. 3. Resident #1 had diagnoses which included paraplegia and anxiety disorder. Resident #1 had a Smoking Safety Evaluation completed on 07/23/24. An annual resident assessment, dated 01/08/25, showed yes for current tobacco use. There was no Smoking Safety Assessment completed in conjunction with this annual resident assessment. On 02/26/25 at 9:10 a.m., the DON reviewed Resident #1's smoking evaluations. They stated they were completed on 02/13/24, 07/23/24, and 02/25/24. The DON stated Resident #1's MDS assessments were completed on 02/13/24, 05/08/24, 07/31/24, 10/23/24, and 01/08/25. The DON stated they could not explain the reason a smoking evaluation/assessment was not completed for Resident #1 between 07/23/24 and 02/25/25. The DON stated, There should have been one with every quarterly and annual.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. 35389 Based on observation and interview, the facility failed to ensure handrails were firmly secure to the wall in 2 (Hall 100 and Hall 200) of 7 shower rooms observed. ADON #1 identified 182 residents resided in the facility. The DON identified seven shower rooms in the facility. Findings: On 02/27/25 at 9:26 a.m., the first shower in shower room on Hall 200 was observed to have loose hand rails underneath both shower heads. Both hand rails wiggled easily and the metal coverings where they meet the wall were loose. CNA #6 stated it scared them to use. CNA #6 stated they reported it to the nurse who put it in the electronic maintenance notification system. They stated the issue was maintenance getting it fixed. The second shower had hand rails that wiggled significantly under each shower head. The metal coverings where the handrails meet the wall were observed loose. There was a third handrail on the back wall of this shower that was observed to be loose from the wall. On 02/27/25 at 10:37 a.m., CNA #8 opened the shower room on Hall 100. The first shower was observed to have a handrail hanging off of the wall. CNA #8 stated they were not sure how long it had been like that, but they thought about two months. CNA #8 stated the staff did not use that side of the shower for that reason. The second shower in this room was observed with the handrail under the shower head loose from the wall with screws exposed. The metal plates where the handrail attaches to the wall was observed to be loose. CNA #8 stated, must be recent. They stated the last time they were in the shower, it was connected. CNA #8 stated when items needed repaired, they had a work order the nurse would sign and send to the maintenance area. On 02/27/25 at 10:15 a.m., CNA #7 stated when something needed repaired, they would put it into the computer for maintenance to fix. On 02/27/25 at 2:08 p.m., the maintenance supervisor stated if staff identified items which needed repaired, they would put it into the electronic system used for maintenance repairs. They stated there were no current repairs in the works. On 02/27/25 at 2:32 p.m., the maintenance supervisor was shown the loose handrails in the Hall 100 shower room. They stated, No one said a word about it. They stated, That's dangerous. On 02/27/25 at 2:35 p.m., the maintenance supervisor was shown the loose handrails in the Hall 200 shower room. They stated they were not aware of them being loose. On 03/03/25 at 1:10 p.m., the administrator stated the facility did not have a policy on handrails and followed state and federal regulation.