

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER South Pointe Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on observation, record review, and interview, the facility failed to ensure the facility was a clean and sanitary homelike environment during 4 of 4 observations made for a clean and sanitary homelike environment. The administrator identified 212 residents resided in the facility. Findings: On 07/10/26 at 2:02 p.m., the following observations were made on the memory care unit:a. spilled liquid covering an area of 3 feet by 3 feet was dried, sticky with trash and dirt in front of the nurse's station,b. the main hallway up the entire length of the hall was dirty with dirt, dust, and shoes would stick to the floor,c. spilled liquid and food debris was on the dining room floor, andd. room [ROOM NUMBER] had dust, dirt, dirty Kleenex, and was sticky when walked on. On 07/10/26 at 3:02 p.m., the medication room on the memory care unit was observed to have dead and live roaches behind the refrigerator and all equipment. On 07/14/26 at 11:24 a.m., the following observations were made while on tour of the facility with Corporate Maintenance #1:a. room [ROOM NUMBER] hall tile was separated and bare concrete exposed,b.the tile in the hall outside of room [ROOM NUMBER] had finish scraped off, wascracked and raised,c. the tile in the hall outside room [ROOM NUMBER] iwas missing a 2-inch strip of tile with bare floor and dirt in 2-inch crack,d. the toilet in room [ROOM NUMBER] was not bolted to the floor and was loose,e. the tile floor in room [ROOM NUMBER] had dirt and grass, the non-slip strip was peeling from the floor, missing tiles were covered with non-slip strips in the bathroom on the vacant side of the room,f. the wall outside of room [ROOM NUMBER] was damaged with black marks and a 2-inch gouge in the sheet rock, and was missing paint,g. the toilet tank lid in room [ROOM NUMBER] was cracked,h. the ceiling vent in room [ROOM NUMBER] was clogged with lint and dust,i. the personal fan in room [ROOM NUMBER] was covered with dust,j. the threshold gap outside room [ROOM NUMBER] was missing tile and full of dirt,k. the vent over bed in room [ROOM NUMBER] was completely covered with dust debris,l. the oxygen tank holder outside the smoking area on hall 200 was full of trash, cigarette butts, and dirt,m. a banana peel and food wrapper was on the floor in the television room on hall 200,n. the ceiling over the bed in room [ROOM NUMBER] had sheetrock damage and the popcorn sheetrock was peeling off,o. floor tiles in room [ROOM NUMBER] were missing at the door,p. floor tiles were missing in room [ROOM NUMBER] and damaged tile near the bed, andq. room [ROOM NUMBER] had sticky and dirty floors, the sheetrock was scraped and was missing paint by the door. On 07/13/26 at 7:52 a.m., the following observations were made with the DON present on the memory care unit;a. the halls were sticky when walking with dirt and were unclean,b. spider eggs and a web were on the handrail with dead roaches on the floor under the web in the dining room,c. live roaches and dead roaches were in the medication room on the floor and behind equipment,d. live roaches and a large live spider was in the shower room, ande. mice feces were on the floor in the whirlpool and shower room. A policy titled Quality of Life - Home Like (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	Environment, dated 02/01/22, read and part, Residents are provided with a safe, clean, comfortable and home like environment and encourage to use their personal belongings to the extent possible. On 07/10/26 at 10:32 a.m., resident representative #2 stated the floors at the facility were always dirty and sticky when they visited their family. They stated the facility was infested with roaches and was concerned for the welfare of the residents that resided in the facility. On 07/10/26 at 2:03 p.m., CNA #4 stated roaches had been present in the facility for one and half years. They stated residents spilled things on the floor and floor technicians did not clean the floors. On 07/10/26 at 2:04 p.m., CNA #11 stated the floors were usually sticky, they did not clean up spills, and it was not clean and sanitary. CNA #11 stated the facility had roaches and mice. CNA #11 stated the residents tried to kill the roaches and the mice. They stated the facility was not a homelike environment. On 07/10/26 at 2:30 p.m., CNA #5 stated the floor and the facility were nasty. They stated the memory care hall was just dirty and there was a spill with dirt embedded in it outside the nursing station. CNA #5 stated the facility had roaches that had been crawling into residents' beds. They stated after dinner, residents had roaches crawling on them in the whole building. CNA #5 stated the facility had mice throughout the building. On 07/10/26 at 2:27 p.m., CNA #12 stated roaches had been a bad problem. CNA #12 stated they saw residents trying to kill the roaches and residents made comments about the roaches. They stated roaches had been observed every day at the facility. On 07/10/26 at 2:44 p.m., LPN #5 stated the facility had roaches and they crawled on the residents at night. They stated the pest treatments had not been effective. LPN #5 stated the floors were sticky and the cleaning products were not effective. LPN #5 stated this could not have been their home, because they would not live like this. They stated housekeeping did not do a good job and did not always get the floors clean. On 07/10/26 at 2:52 p.m., housekeeper #1 stated the floors were sticky on the memory care unit because the supplies they use were not meant for the floors. They stated the floors were always sticky and did not look clean. Housekeeper #1 stated the facility had a mice and roach infestation. On 07/13/26 at 7:52 a.m., the DON stated the pest management program was not effective. The DON stated the floor technician waxed over debris and the floors were sticky, dirty, and looked like crud. The DON stated they observed spider eggs and a web on the memory care hall in the dining room in the corner, live roaches in the medication room, live roaches in the shower room, and mice feces in the whirlpool and shower room. The DON stated the pests made them feel squeamish. On 07/13/26 at 8:16 a.m., the AIT toured the memory care unit and stated the pest control program was not effective, and the facility was not a clean and sanitary homelike environment. On 07/14/26 at 11:24 a.m., Corporate Maintenance #1 stated missing hall tiles could hurt a resident's foot and needed to be repaired. They stated the facility was not a clean and sanitary homelike environment. Corporate Maintenance #1 stated they did not have any open work orders for the repairs.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to maintain safe hot water temperatures accessible to residents for 10 (#24, 27, 29, 33, 72, 90, 96, 130, 124, and #130) of 10 sampled residents hand sinks water temperature measured. The administrator identified 46 residents resided on hall 100 (locked unit) and 56 residents resided on hall 200. Findings: On 07/15/26 at 9:58 a.m., the water temperature in the sink of Resident #202 and Resident #27's room located on hall 100 (locked unit), showed to be 131 degrees F. On 07/15/26 at 10:17 a.m., the water temperature in the sink of Resident #96 and Resident #90's room located on hall 100 (locked unit), showed to be 130 degrees F. On 07/15/26 at 10:22 a.m., the water temperature in the sink of Resident #202 and Resident #27, located on hall 100 (locked unit), showed to be 130 degrees F. On 07/15/26 at 10:24 a.m., the water temperature in the sink of Resident #24 and Resident #29's room located on hall 100 (locked unit), showed to be 127 degrees F. On 07/15/26 at 10:52 a.m., the water temperature on the 100 hall (locked unit) shower room showed to be 129.7 degrees F. On 07/15/26 at 11:17 a.m., the water temperature in the sink of Resident #130 and Resident #33's room located on hall 200 showed to be 130 degrees F, and the shower room located on hall 200 showed to be 121 degrees F. On 07/15/26 at 11:19 a.m., the water temperature in the sink of Resident #72 and Resident #124's room located on hall 200 showed to be 133 degrees F. On 07/15/26 at 12:56 p.m. the water temperature in the sink of Resident #202 and Resident #27's room located on hall 100 (locked unit), showed to be 127 degrees F with maintenance supervisor's digital thermometer and 120 degrees F with their manual thermometer. On 07/15/26 at 10:55 a.m., CNA #5 stated the water temperatures in the shower room came out hot enough to burn a resident. On 07/15/26 at 10:58 a.m., CMA #2 stated the water came out hot enough to burn residents in the shower room on hall 100 (locked unit). On 07/15/26 at 11:00 a.m., Resident #25 stated the hot water got really hot. On 07/15/26 at 11:17 a.m., Resident #33 stated you had to run cold water because it was hot. On 07/15/26 at 11:30 a.m., the maintenance supervisor stated they had never seen a policy for water temperatures. The maintenance supervisor stated their boss told them to set temperatures at 115 degrees F. The maintenance supervisor stated anyone could hurt themselves, be burned, or scalded with water over 120 degrees F and the average water temperature on hall 100 (locked unit) was 125 to 135 degrees F. The maintenance supervisor stated water temperature checks were completed on Wednesdays, and they had only received reports of water not being hot enough. On 07/15/26 at 12:29 p.m., the maintenance supervisor stated they had not been trained in four years on the maximum water temperatures for long term care. On 07/15/26 at 12:49 p.m., the DON stated they did not know the regulations for water temperatures for resident baths. The DON stated there were bedbound, diabetic neuropathy, and wandering residents on hall 100 (locked unit) and hall 200.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to: a. ensure medications were secure for 1 (Hall 400) of 1 medication/treatment carts observed. b. ensure stored medications were monitored at proper temperatures and other appropriate controls to preserve their integrity on 4 (hall 100, 200, 400, and 600) of 4 medication storage rooms observed. The DON identified 209 residents receive nutrition from the kitchen. Findings: Findings: On 07/10/26 at 12:56 p.m., a treatment cart on hall 400 was observed to be unlocked. Supplies observed included insulin needles, lancets, breathing treatment medications, ointments, lotions, and nutrition supplements. A policy Medication Storage in the Facility, dated 01/2026, read in part, Medication rooms, carts, and medication supplies are locked or attended to by person with authorized access. On 07/10/26 at 1:01 p.m., LPN #6 stated the policy was to have their treatment cart and their computer locked when they walked away from it. 07/16/26 at 10:45 a.m., the medication storage room on Hall 400 was observed and did not contain a thermometer to monitor the temperature. 07/16/26 10:45 a.m., the medication storage room on Hall 600 was observed and did not contain a thermometer to monitor the temperature. 07/16/26 11:19 a.m., the medication storage room on Hall 100 was observed. There was a small thermometer on the wall that was not in workable order to monitor the temperature. 07/16/26 11:58 a.m., the medication storage room on Hall 100 was observed and did not contain a thermometer to monitor the temperature. A policy titled Medication Storage in the Facility, dated 01/ 2024, read in part, Medications requiring storage at room temperature are kept at temperatures ranging from 59 degrees F (16 C) and 85 degrees F (30 C). On 07/16/26 at 11:21 a.m., LPN #2 stated there should be a thermometer in the medication storage rooms and the room temperature should be monitored. On 07/16/26 at 11:54 a.m., DON stated the medication storage rooms should have a thermometer to monitor the temperatures and were in the process of getting them now.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observation, record review, and interview, the facility failed to notify the resident and/or resident representative of the risk and benefits of a psychotropic medication for 1 (#4) of 5 sampled residents reviewed for notifications. The DON identified 156 residents were prescribed psychotropic medications. Findings: On 07/13/26 at 11:53 a.m. Resident #4 was observed on the memory care unit with poor cognition and was unable to answer questions regarding their care. A policy titled Psychotropic Management Guidelines, dated 07/26/23, read in part, Upon admission the licensed nurse will implement the following: .b. Psychoactive Medication Consent from Resident/Responsible Party. A hospital discharge record for Resident #4. dated 01/30/26, showed the resident had diagnoses which included bipolar disorder and dementia. A quarterly assessment for Resident #4, dated 02/26/26, showed the resident had a BIMS score of 09 which indicated their cognition was moderately impaired. A medication administration record for Resident #4, dated 06/12/26, showed the resident was being administered divalproex sodium (mood stabilizer) oral capsule 500 mg extended release for mixed bipolar affective disorder. On 07/13/26 at 11:23 a.m., resident representative #1 stated they did not sign consents or receive notification Resident #4 was receiving divalproex sodium 500 mg extended release for bipolar disorder. On 07/13/26 at 11:53 a.m., LPN #1 stated Resident #4 was administered divalproex sodium oral capsule 500 mg extended release (Depakote) 500 mg by mouth at night for bipolar disorder. On 07/13/26 at 12:09 p.m., the DON stated any medications that was mood altering, should have had a consent signed by the resident and/or family representative. They stated Resident #4 and/or the family representative had not been notified and did not sign consent for the divalproex sodium oral capsule 500 mg extended release (Depakote, a mood stabilizer) medication to be administered.		

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F 0600 Level of Harm - Minimal harm or potential for 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. Based on observation, interview, and record review, the facility failed to ensure residents remained free from abuse by failing to protect a resident (#213) from staff's use of physical intervention during meal service. The administrator identified 212 residents resided in the facility. Findings: On 07/09/26 at 12:44 p.m., after finishing their lunch, Resident #213 was observed to stand up and walk with their walker. Resident #213 was observed to approach another resident who was eating at a nearby table. Resident #213 was observed to reach toward the other resident's meal, picked up the food (taco meat) from the plate with their hand, and began raising the food towards their mouth. CNA #10 yelled, [Resident #213], no! CNA #10 then grasped Resident #213's hand containing the food, pulled the resident's hand downward, and removed the food from the resident's hand. CNA #10 redirected the resident from the dining hall, removed the other resident's plate, and left the unit to replace the food. A care plan for Resident #213, dated 07/01/26, showed the resident's prescribed diet consisted of mechanical soft foods and excluded dairy products. These restrictions did not include taco meat. An annual assessment for Resident #213's, dated 12/03/25, showed the resident had memory deficits and could not easily make self-understood. A facility policy titled Abuse, Neglect and Exploitation, reviewed 01/20/26, showed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment. The policy defined willfulness as acting deliberately with or without the intention of harm. The policy defined abuse to include, but not limited to, hitting, shoving, punching, biting, kicking, pinching, spanking, slapping of hands, flicking or hitting residents with objects, and yelling at residents. On 07/09/26 at 1:15 p.m., CNA #4 stated it was never appropriate to pull food or other items from a resident's hand. On 07/09/26 at 1:16 p.m., CNA #10 stated they were a bit intense because lunch served that day had the potential to upset Resident #213's stomach and they did not want the resident to develop diarrhea. CNA #10 stated they intervened and redirected residents when they attempted to eat food from another resident's plate. CNA #10 demonstrated a swiping and slapping motion with their hands when describing their intervention with Resident #213. On 07/16/26 at 1:44 p.m., the DON stated staff should immediately report suspected or witnessed abuse to the abuse coordinator, the DON, or the AIT.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to notify the resident representative of discharge to another facility for 1(#223) of 1 sampled residents reviewed for discharge.The administrator identified 212 residents resided in the facility.Findings: A nurses note for Resident #223, dated 04/16/25, read in part, Resident was discharged to [name withheld] facility The nurses note did not document the representative was notified for Resident #223.On 07/17/26 at 1:08 p.m., Social Services #1 stated they could not find documentation the family was notified of the discharge to another facility.On 07/17/26 at 1:36 p.m., the DON stated the facility did not have documentation the family was notified of the discharge.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interview, the facility failed to ensure that the narcotic controlled substance card count was correctly reconciled for 1 (Hall 200) of 8 medication carts observed. The administrator identified 212 residents resided in the facility. Findings: On 07/16/26 at 12:15 p.m., during the medication cart review on hall 200, CMA #1 was observed counting the narcotic controlled substance cards. CMA #1's final count was 17 cards. The narcotic control substance form showed at 7:00 a.m., there were 15 total narcotic cards. On 07/16/26 at 12:15 p.m., CMA #1 stated there had been no added cards since her original count at 7:00 a.m. and did not know why the count was incorrect. CMA #1 acknowledged their signature on the form and stated they did physically count that morning, but the number 15 had already been written in when she arrived for their shift. On 07/16/26 at 3:55 p.m., the DON stated staff should not pre document the narcotic controlled substance count prior to the shift count. On 07/16/26 at 4:00 p.m., the DON reviewed the narcotic controlled substance card count form and acknowledged with CMA #1 the actual count was 17.		