STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375367	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stroud Nursing & Rehab	721 West Olive Stroud, OK 74079

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. Based on observation, record review, and interview, the facility failed to ensure a resident was not touched sexually by another resident for 1 (#1) of 5 sampled resident reviewed for abuse. The DON stated 55 residents resided at the facility. Findings: On 05/20/25 at 12:05 p.m., Res #1 and Res #2 were observed in the dining area of the facility. They were sitting at opposite ends of the room which was approximately 20 feet apart. The residents did not show any outward signs of distress while in the room together. The residents did not look at each other. On 05/20/25 at 3:18 p.m., Res #1 was observed in an activity with other residents in the dining room. Res #2 was observed in the same activity sitting approximately 20 feet away from Res #1. No obvious signs of distress were observed from Res #1. Neither Res #1 nor Res #2 looked at the other during the activity but did move within 10 of each other during the activity without incident or signs of emotional distress. A facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, read in part, The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to; a. facility staff; b. other residents; c. consultants; d. volunteers; e. staff from other agencies; f. family members; g. legal representative; h. friends; i. visitors; and/or j. any other individual. An MDS quarterly assessment, dated 05/06/25, showed Res #1 had a BIMS score of 8 (this score indicated the resident's cognition was moderately impaired at the time of the test). A progress note, dated 05/12/25 at 4:55 p.m., showed Res #5 had reported to ADON they had observed Res #2 place their hand down the blouse of Res #1. The note further showed Res #1 reported they had moved their arms to protect themselves and told Res #2 to stop which was what Res #1 stated Res #2 did. The note showed Res #1 had been assessed by ADON and no injuries had been identified. (continued on next page)

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	A social services note, dated 05/13/25 at 12:20 p.m., showed the social services director had visited Res #1 to check on them. The note showed Res #1 had been offered the opportunity to talk about the incident, but they declined and stated they were ok. A social services note, dated 05/14/25 at 4:52 p.m., showed Res #1 was offered mental health counseling and the resident declined. The note showed Res #1 reported they were ok and did not need to speak with anyone about the incident with Res #2. On 05/20/25 at 12:50 p.m., Res #5 stated on 05/11/25 at about 9:00 p.m., they had witnessed Res #2 with their hand down the blouse of Res #1. They stated it had occurred in the dining area on the west side of the facility. They stated when they entered the dining room Res #2 was pulling their hand out of the shirt of Res #1 then brushed Res #1 on the cheek with their hand. Res #5 stated Res #2 stopped the behavior when they entered the dining room. They stated they did not tell anyone about it until the next day. They stated they had not seen Res #2 do that type of thing before or since that evening. They stated there were plenty of staff on duty that evening but they were going here and there working. They stated staff did not usually stay around the west sitting area or dining room during the evenings that they had ever seen. On 05/20/25 at 3:26 p.m., Res #1 was asked if they were having any difficulties with staff or other residents. Res #1 stated there was a person at the facility that bothered them. They stated Res #2 had grabbed their breast and asked them if they liked it. They stated they live toward the back of a hallway and Res #2 the other end. They stated they must go past Res #2 every time they went to a meal or activity, and it bothered them. They stated they are not afraid of Res #2 but angry with them every time they look at them. They stated they had not told staff about how they feel and did not want this surveyor to either. They stated they feel safe at the facility and that Res #2 had never done that before or since. They agreed to talk with the surveyor again the next day. On 05/21/25 at 11:00 a.m., Res #1 was observed sitting in the dining room drinking a soda. They were asked if they wanted to speak further about the incident with Res #2. They stated they did. They stated they felt safe at the facility and again stated they did not want anything to happen to Res #2 because they were just like them [Res #1 pointed to their head when they stated Res #2 was like them]. Res #1 stated they were feeling depressed and angry over the incident and disliked having to pass by Res #2's room every day and see them every day. The resident again stated they did not want anything to happen to Res #2 and that they can stay at the facility. They gave this surveyor permission to inform the staff they felt angry and depressed over the situation. Res #1 was asked about staffing in the evening and where they were located during the evening shift. They stated there is enough staff and they usually work in the halls helping residents. They stated they don't stay in that area (indicated the dining room and sitting area on the west side of the building). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 05/21/25 at 12:19 p.m., DON was asked about the incident between Res #1 and Res #2 on 05/11/25. They stated Res #2 had not demonstrated that type of behavior previously and when talked to about it Res #2 admitted they did it and promised not to do it again. They stated they monitored Res #2's movements and they are on a list to see their mental health provider. When asked about Res #1 they stated the resident had not shown or reported any discomfort following the incident and had been offered mental health counseling, but the resident had declined the offer. They stated they continued to visit Res #1 daily and did not appear to show any negative effects from the incident. DON stated they do ensure the two residents are set apart during activities. The DON was informed of the anger and emotional distress reported to this surveyor. The DON stated they were unaware of those feelings but would immediately act on them. They stated they would visit Res #1 immediately.