STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375394	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoyah East Nursing Center, LLC	701 South Taylor Road Roland, OK 74954

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was not physically assaulted by another resident with a history of assaulting others for 1 (#1) of 6 sampled residents reviewed for abuse. The ADON reported 46 residents resided at the facility. Findings: A facility policy titled Abuse Prevention Policy, dated August 2006, read in part, Our facility is committed to protecting our residents from abuse by anyone including, but not limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, and any other individual. 1. A progress note in Res #2's medical record, dated 01/24/25 at 9:34 a.m., showed Res #2 had hit a nurse during a conversation. A progress note in Res #2's medical record, dated 03/03/25 at 9:01 a.m., showed Res #2 had hit and scratched a certified occupation therapy assistant during therapy. A progress note in Res #2's medical record, dated 03/20/25 at 12:47 a.m., showed Res #2 had asked to be cleaned by staff, but then beat the nurse aides assisting them with a clothes hanger. A progress note in Res #2's medical record, dated 03/30/25 at 4:30 a.m., showed Res #2 had been found on the floor and the resident requested to be assisted up. The note further showed Res #2 hit the nurse who was helping them up. A progress note in Res #2's medical record, dated 06/22/25 at 8:00 a.m., showed Res #2 had kicked Res #1 in the lower left leg while they were in the dining area. 2. A quarterly minimum data set assessment for Res #1, dated 06/07/25, showed the resident had a brief interview for mental status score of 10 which indicated a moderate cognitive impairment. A progress note in Res #1's medical record, dated 06/22/25 at 8:00 a.m., showed another resident had kicked Res #1 in their leg while in the dining area. The note further showed Res #1 had not been injured. (continued on next page)

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
	375394	A. Building B. Wing	07/02/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/25 at 12:05 p.m., LPN #1 was asked about Res #2's behavior and if any monitoring had been done. They stated Res #2 had hit several staff members in the past but were unaware if they had ever hurt another resident before Res #1. LPN #1 stated they were not aware of any order to monitor Res #2's behavior, but if they saw anything they would write a note. On 07/02/25 at 12:14 p.m., the ADON was asked about Res #2's behavior and if any monitoring had been done. The ADON stated there was never an order to monitor the resident's behavior except in March of 2025, but that lasted four days then ended. They stated there had been no monitoring of Res #2 outside of those four days, but if someone saw something they would write a progress note. They stated Res #2 was one on one after kicking Res #1 and that lasted until Res #2 was sent out to a hospital on [DATE]. They stated Res #2 remained at the hospital and would go to a new facility after discharging from there. On 07/02/25 at 12:18 p.m., the DON was asked about Res #2's behavior. They stated there had been no behavior monitoring of Res #2, but they did monitor the side effects of their medications. They stated they had always treated abuse towards staff differently than abuse towards a resident and had not considered behavior monitoring based on those incidents. They were asked if Res #2 had ever made statements they would only assault staff and not residents. The DON stated they had not. On 07/02/25 at 1:45 p.m., Res #1 was asked about the incident with Res #2. They stated they had been in the dining area to get a cup of coffee. Res #1 stated when they walked by Res #2, that resident kicked them in the left leg. Res #1 stated Res #2 had not done that before or after that day.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to conduct a thorough investigation of a resident-to-resident physical assault for 1 (#1) of 6 sampled residents reviewed for abuse. The ADON reported 46 residents resided at the facility. Findings: A facility policy titled Abuse Investigations, dated April 2014, read in part, All reports of resident abuse, neglect, injuries of unknown source shall be thoroughly and promptly investigated by facility management. 1. A progress note in Res #1's medical record, dated 06/22/25 at 8:00 a.m., showed another resident had kicked Res #1 in their leg while in the dining area. 2. A progress note in Res #2's medical record, dated 06/22/25 at 8:00 a.m., showed Res #2 had kicked Res #1 in the lower left leg while they were in the dining area. The facility investigative material was reviewed. The material did not contain documentation of residents having been interviewed to determine if other residents other than Res #1 had been harmed by Res #2. On 07/02/25 at 1:25 p.m., the DON was asked to describe the investigation they had conducted following the assault by Res #2 on Res #1. They stated they had interviewed the two residents involved and staff on duty at the time. They were asked if they had interviewed any other residents to see if Res #2 had harmed anyone else. They stated they had not thought about doing that. They stated they should have interviewed other residents to determine if Res #2 had harmed any other residents.