STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375396	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakes	5701 West Britton Road Oklahoma City, OK 73132

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. 48344 Based on record review and interview, the facility failed to ensure a resident was free from abuse for one (#2) of three sampled residents reviewed for abuse. The administrator identified 67 residents resided in the facility. Findings: The Abuse and Neglect Clinical Protocol policy, revised 07/2017, read in part, Sexual abuse is defined .as non-consensual sexual contact of any type with a resident. Resident #2 had diagnoses which included dementia and senile degeneration of brain. Resident #2's quarterly resident assessment, dated 10/23/24, documented the resident had severe cognitive impairment. An Initial State Reportable Incident form, dated 12/02/24, documented an allegation of abuse/mistreatment. It documented Resident #4 was witnessed putting their hand on Resident #2's crotch while sitting at the TV area. It documented Resident #4 was immediately removed from the area and placed on one on one with staff. It documented no injury noted to Resident #2 who was unable to answer any questions regarding the situation. On 12/17/24 at 9:57 a.m., Housekeeper #1 stated they observed Resident #4's hand over Resident #2's crotch over their clothing on their way to the vending machine. They stated they went to get help and it took about five to eight minutes to get help to separate the two residents. On 12/17/24 at 1:23 p.m., the administrator stated they were the abuse coordinator. On 12/17/24 at 1:24 p.m., the administrator and the CNO stated sexual abuse was any unwanted physical contact or any report where a resident felt they were sexually abused. On 12/17/24 at 1:33 p.m., the administrator stated they had completed a safe survey of all residents on 12/01/24 for a different incident and did not complete a safe survey specific to this incident. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 1:39 p.m., the administrator and the CNO stated the incident could be considered sexual abuse and that was why it was reported as abuse to the Department.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48344 Based on observation, record review, and interview, the facility failed to prevent a resident from a fall resulting in a close head injury during the provision of care for one (#3) of three sampled residents reviewed for accidents. The administrator identified 67 residents resided in the facility and 34 residents required assistance with activities of daily living. Findings: The Safety and Supervision of Residents policy, revised 07/2017, read in part, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Resident #3 had diagnoses which included vascular dementia and Alzheimer's disease. Resident #3's care plan for ADLs and falls, revised 10/29/24, documented the resident: a. was dependent on staff for bed mobility, b. was totally dependent on staff for repositioning and turning in bed, c. required total assistance with transfers, and d. was at risk for falls. Resident #3's quarterly resident assessment, dated 10/30/24, documented the resident had severe cognitive impairment and was dependent on staff for toileting hygiene. The assessment documented the resident weighed 222 lbs. A nursing note, dated 12/08/24 at 8:05 a.m., read in part, while given peri care the Resident rolled out of the other side of the bed on to the floor. Nurse noted the Resident lying supine on the floor on the left side of the bed. A knot about the size of a quarter was noted on the right side of the forehead. An After Visit Summary, dated 12/08/24, documented diagnoses of closed head injury and contusion of forehead An Initial State Reportable Incident form, dated 12/09/24, documented certain injuries. It documented Resident #3 rolled out the other side of the bed on to the floor during peri care. It documented a knot about the size of a quarter was noted on right side of the resident's forehead. It documented the resident was sent to the ER due to head injury and being on Eliquis (blood thinner). It documented the resident returned within hours with a diagnosis of closed head injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Final State Reportable Incident form, dated 12/13/24, documented certain injuries. It documented Resident #3 had completed neuro checks. It documented knot resolving to right side of forehead with slight discoloration. It documented staff were educated to use two person assist when the resident was in bed. On 12/17/24 at 8:39 a.m., Resident #3 was observed receiving peri care by CNA #2 and CNA #3. The resident was dependent on staff for turning during the provision of peri care. There was no effort from the resident. On 12/17/24 at 1:07 p.m., CNA #3 stated Resident #3 was incontinent and required two staff assistance with peri care. They stated they always had another staff to assist with peri care. On 12/17/24 at 1:07 p.m., the CNO stated they educated staff on using two person assist with Resident #3 on the day of the incident, but did not have signatures or documentation for the education. On 12/17/24 at 2:58 p.m., CNA #1 stated they were completing peri care when the resident rolled out of the bed onto the floor. They stated they had turned the resident on their left side and their left hand was on the resident to hold them. They stated the resident was slippery due to having a bowel movement. CNA #1 stated everything happened so fast. They stated they tried to pick up the wipes with their right hand and the resident rolled out of the bed onto the floor. They stated there were no rails to prevent the fall. They stated they were informed the resident was a one person assist with peri care. On 12/17/24 at 3:06 p.m., CMA #4 stated they were educated after the incident that Resident #3 would now be a two person assist with peri care. They stated they always used two person assist with the resident because they were obese, used a lift for transfers, shook during care, and there was no support in front of the resident so another staff had to be in front to hold them. They stated sometimes if the resident was shaking badly, it could take up to three staff to assist in the care. On 12/17/24 at 3:21 p.m., LPN #1 stated Resident #3 was a one or a two person assist with peri care, but every time they completed peri care on the resident they got another staff to assist. They stated the resident was a two person transfer with the lift. On 12/17/24 at 3:27 p.m., observation of Resident #3's bed was made. There was no supporting device for the resident to hold on to during the provision of care. On 12/18/24 at 2:21 p.m., MDS Coordinator #1 stated totally dependent on staff meant the staff did 75% or more of the effort. They stated it could require one staff or two staff assistance.