STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375400	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Hills Nursing Center	2416 North Ann Arbor Oklahoma City, OK 73127

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. (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 - Actual harm Residents Affected - Few	Based on observation, record review, and interview, the facility failed to ensure a resident was not touched sexually by another resident for 1 (#3) of 3 sampled residents reviewed for abuse. The facility's failure to prevent this type of inappropriate, unwanted sexual contact would reasonably cause anyone to have psychosocial harm.The administrator identified 54 residents resided in the facility. On 09/08/25 at 10:43 a.m., Resident #3 was observed lying in bed, with the bed in the low position, with fall mat in place. Their room was clutter free and the trash can was empty. Resident #3's room was next to the nurse's station on hall 300. Resident #3 was unable to appropriately respond to surveyor.On 09/09/25 at 1:08 p.m., Resident #27 was in attendance during resident council.On 09/09/25 at 2:00 p.m., Resident #27 was observed playing bingo in the dining room.On 09/10/25 at 10:25 a.m., LPN #2 and CNA #3 were observed coming out of Resident #3's room. Resident #3 was observed in bed repeating well, well, well, okay, okay, okay. The fall mat was observed in place next to bed. The bed was in low position, and the call light was in their hand.An Oklahoma State Department of Health final report, for an incident dated 09/02/25, showed LPN #2 went to Resident #3's room and found Resident #27 with their hand underneath Resident #3's gown near their groin with a fondling motion. Resident #27 asked Resident #3 if they liked it. LPN#2 asked Resident #27 what they were doing and Resident #27 stated they were trying to help Resident #3 into bed. Resident #3 was unaware of their circumstances or surroundings currently. Resident #27 was instructed not to go into other residents' rooms and Resident #27 stated they did not know what LPN #2 was talking about and then left the room. Resident #27 was immediately placed on 1:1 monitoring. Resident #3 had a head-to-toe assessment completed with no abnormalities noted. The physician, administrator, DON, local police and APS were notified. Resident #27 remained on 1:1 observation for 72 hours with no attempts to go into any other resident's room or exhibit any behaviors. The facility sent medical paperwork into numerous behavioral hospitals, and the resident had been accepted for in-patient evaluation once a bed became open. Resident #27's care plan would be updated for any new medication changes upon return from the hospital. If any future incidents occurred after return, the facility would look at alternative placement.A policy Abuse, Neglect and Exploitation, revised 01/18/25, read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Sexual Abuse is non-consensual sexual contact of any type with a resident.Resident #3's Significant Change assessment, dated 07/03/25, showed Resident #3 had a BIMS score of 2 indicating severe problems with thinking and memory. The assessment showed Resident #3 had a diagnosis of metabolic encephalopathy [a brain dysfunction with symptoms that include confusion, memory loss, and altered consciousness]. The assessment showed Resident #3 was dependent upon staff for personal hygiene, dressing, bathing, transfers, toileting, and mobilization.A Nurse Progress Note, dated 09/02/25 at 1:59 p.m., showed Resident #3 was lying in their bed with the door open, and Resident #27 was found fondling underneath Resident #3's gown and asking if they liked it. Resident #3 was unable to respond appropriately to actions or questions from Resident #27. LPN #2 interrupted Resident #27's actions and asked what they were doing. Resident #27 stated they were trying to help Resident #3 get into bed. Resident #27 was instructed not to enter anyone's room without permission or staff presence.A Nurse Progress Note, dated 09/02/25 at 2:42 p.m., showed the evening shift nurse performed a head-to-toe assessment with no physical injuries or bruises noted. Resident #3 refused any pain medication but was anxious. Anxiety medication was last administered at 2:00 p.m.A Quarterly assessment for Resident #27, dated 08/09/25, showed a BIMS score of 6 which indicated severe problems with thinking and memory. The assessment showed Resident #27 had a diagnosis of dementia. The assessment showed Resident #27 required cues from staff for dressing, partial assistance with bathing, and substantial assistance with toileting.On 09/08/25 at 1:30 p.m., Resident #3's emergency contact #1 stated they lived in a different state and did not see Resident #3 often. They stated they were not aware of any abuse, but the facility did inform them of hospitalizations, Resident #3's refusal to eat and their rapid decline a few weeks ago. They stated Resident #3 gets taken care of as far as they know. On 09/09/25 at 9:30 a.m., LPN #2 stated the housekeeper noticed Resident #27 in Resident #3's room and alerted CNA #3, who then proceeded to alert them. LPN #1 stated they heard Resident #27 saying you like that, while they were touching Resident #3 under their gown around the groin area. LPN #2 stated Resident #27 had gotten more confused within the last two weeks. LPN #2 stated they asked Resident #27 about it