STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375452	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Park East	225 Southwest 35th Street Oklahoma City, OK 73109

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure a resident's family was notified of an allegation of abuse for 1 (#5) of 7 sampled residents reviewed for abuse.The administrator identified 42 residents resided in the facility. Findings:A policy titled Change in a Resident's Condition or Status, revised 12/2016, read in part, Our facility shall promptly notify the resident, his or her attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc. A quarterly assessment, dated 07/30/25, showed Resident #5 had a BIMS score of 3, which indicated severe cognitive impairment. The assessment showed they were independent with mobility.An incident report, dated 08/31/25, showed Resident #1 was observed touching Resident #5's breasts. The report showed the family was notified. An order summary, dated 09/04/25, showed Resident #5 had diagnoses which include Alzheimer's disease and dementia. A family representative interview with Resident #5's family stated they were not aware of any incidents with another resident. They stated they were not aware of residents of the opposite sex in the facility and not informed of any incident that occurred over the weekend. On 09/05/25 at 3:00 p.m., the DON stated they were not aware the family had not been contacted. The DON stated the family should have been notified that same night. On 09/08/25 at 10:52 a.m., the DON stated they had looked into the notification for Resident #5 and stated a note showed they attempted to reach but were unable to. They stated there was not a re-attempt noted, and they were to look into that and notify the family today.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/09/25, an IJ situation was determined to exist related to the facility's failure to provide protection from sexual abuse/inappropriate touching from two residents towards three residents sampled for abuse.On 09/09/25 at 11:19 a.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 09/09/25 at 11:54 a.m., the administrator and ADON were notified of the IJ situation and the IJ template was provided.On 09/10/25 at 11:53 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Identification of total number of residents at risk for the same failed practice:42Actions taken to remove the immediacy of the alleged failed practice:o There are 3 residents identified as affected by this alleged deficient practice with the potential for 42 residents overall to be affected including the 2 residents alleged to have had the behaviors affecting others. Resident #1 and Resident #4 have dementia related conditions as does the entire population of this Specialized Dementia Care Facilityo Resident #1 was placed on 1:1 supervision on 08-20-2025 for 72 hours and was no longer exhibiting sexuality toward others-[they] was already on medication to curb sexual impulses at that time and had been on it since 06-07-2025 despite having no behaviors at that time due to making comments toward women staff but no behaviors related to sexual contact or attempts for contact at that point. Resident #1 was placed back on 1:1 supervision on 08-26-2025 and his psychoactive medications were increased (and [they] remained on the previous ordered medication to curb sexuality) by the PA when [they] was notified of an episode of sexuality toward another resident and was removed from 1:1 supervision at 72 hours when no further behaviors of increased sexuality noted and a room change put him into less proximity to women in that room change. On 08-31-2025 a [identity withheld] resident entered Resident #1 room when a contact occurred, so we were unable to determine who initiated that contact since both residents have cognitive impairment. Resident #1 was placed on 1:1 supervision on 08-31-2025 at the time of the identified incident affecting other resident. Resident #1 was sent out to the hospital related to behaviors on 08-31-2025 and returned on 09-01-2025 and remained on 1:1 and continues to be on 1:1 supervision. Resident #4 remains on 1:1 supervision as well since his conduct on 08-31-2025.o The PA was notified of the incidents at the time of occurrence of each. The PA did not state to the facility staff at that time or any other time that [they] felt a discharge was in order for either resident. PA had made medication changes each time for resident #1 in addition to facility interventions but did not make any changes to resident #4 medications stating it was because the [other] resident in that situation was in resident #4 room and resident #4 had no increased sexually motivated behaviors noted before.o All residents that were interviewable have been interviewed and those that are non-interviewable were assessed with no evidence of abuse or inappropriate/ nonconsensual contact identified based on assessment/interview/observation.o Training of all staff in the areas of abuse/neglect risk including sexual behaviors and potential for such behaviors, identification of those at risk for neglect/abuse, protection measures to prevent abuse and neglect, and dementia care including documentation of 1:1 when provided and in-service lasted for 30 minutes for all current staff by the Nursing Leadership Team staff at 12:15pm September 9, 2025 and no other staff will be permitted to work until they have been in-serviced before their next scheduled shift by phone contact or in-person. The information for in-service covered is attached.o The facility will monitor residents (current and future) behaviors to observe for potential to administer/receive abuse or neglect, and verbalization of signs of behaviors that could escalate to abuse or neglect including sexual abuse. New admits will be screened through interviews and record reviews for at risk behavior including abuse and neglect potential including sexual abuse or behaviors that have the potential to affect others. If a resident is determined to be at risk, then this information will be care planned with individualized interventions for that resident will be determined and implemented which may include 1:1 supervision and/or safe discharge. This information will be captured on the initial baseline care plan for new admissions and on regular care plans for current residents. Any behaviors exhibited would be captured in behavior notes and screened daily by the DON or designee to identify behaviors that might lead to abuse/neglect including potential/actual sexual behaviors. The staff will also notify the DON or Administrator of residents that are having signs of increased sexuality at the time of the event so an immediate intervention can be placed and remain in-place until the behaviors are no longer putting anyone at risk. Psych plus services were recently added to our service offering at South Park East. Actions taken to prevent recurrence of alleged failed practice: DON or designee will:o Daily review of all incidents and behavior notes to identify residents at risk for behaviors affecting

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to ensure allegations of abuse were thoroughly investigated for 5 (#1, 2, 3, 4, and #5) of 5 sampled residents reviewed for abuse. The administrator identified 42 residents resided in the facility. Findings:A policy titled Abuse and Neglect - Clinical Protocol, read in part, The nurse will assess the individual and document related findings.An OSDH incident report, dated 08/20/25, showed Resident #1 touched the breast of Resident #3. There were no safe surveys/assessments of other residents to assure safety, and there was no abuse education documented for all staff.An OSDH incident report, dated 08/26/25, showed Resident #1 touched the breast of Resident #2. There were no safe surveys/assessments of other residents to assure safety, and there was no abuse education documented for all staff. An OSDH incident report, dated 08/31/25, showed Resident #1 touched the breast of Resident #5. There were no safe surveys/assessments of other residents to assure safety, and there was no abuse education documented for all staff.An OSDH incident report, dated 08/31/25, showed Resident #4 touched the breast of Resident #2. There were no safe surveys/assessments of other residents to assure safety, and there was no abuse education documented for all staff.On 09/04/25 at 3:07 p.m., the DON stated they were not aware they needed to complete part C (summary of the investigation details) of the incident report.On 09/05/25 at 10:28 a.m., the DON stated they did not do staff education on the incidents regarding sexual abuse/inappropriate touching. The DON stated QA was done monthly and had not had a meeting for this month yet. They stated they do education on abuse often on their training system. On 09/05/25 at 12:33 p.m., the DON stated they did not have documentation of the education but did do verbal education on abuse following each incident and they could write it down now. On 09/05/25 at 2:35 p.m., the DON stated the charge nurse or whoever finds the issue does the incident report. They stated the results of the assessments on the other residents potentially affected was done visually and not documented.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to revise/update care plan timely following incidents of abuse for 1 (#1) of 2 sampled residents reviewed for abuse allegations.The administrator identified 42 residents resided in the facility.Findings:A policy titled Care Plans, Comprehensive Person-Centered, dated 12/2016, read in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. The Interdisciplinary Team must review and update the care plan: . When the desired outcome is not met.A care plan, initiated on 06/12/25, read in part, I do at times make sexually inappropriate actions towards myself or others. I have a dx of sexual disfunction. The care plan showed an incident, dated 06/06/25, of Resident #1 grabbing staff private parts and making sexual comments about staff. The care plan showed a revision on 09/05/25.A quarterly assessment, dated 07/25/25, showed Resident #1 had a BIMS 3, which indicates severe cognitive impairment. The assessment showed they were independent with mobility. Review of the care plan changes since last review per the electronic record showed the incident on 08/31/25 was dated for 09/01/25. The incident on 08/20/25 was dated for 09/02/25. The incident on 08/26/25 was dated for 09/05/25. An order summary, dated 09/04/25, showed Resident #1 had diagnoses which included sexual dysfunction and dementia.On 09/05/25 at 2:06 p. m., the MDS coordinator stated the care plans were updated every three months and as necessary. They stated if a fall or something physical then they had to add something. The MDS coordinator was asked when Resident #1's care plan had been updated. The MDS coordinator stated they were in it on 09/05/25 and had added on 08/31/25. The MDS coordinator stated they added the behaviors on the 31st. They stated the care plan was updated after each incident of abuse on 6/6/25, 8/20/25, 8/26/25, and 8/31/25. After they reviewed the history of the care plan updates in the electronic record, the MDS coordinator acknowledged they were updated on 09/01/25 and not after the 08/20/25 or the 08/26/25 incidents of abuse. The MDS coordinator stated the care plan should have been updated prior 09/01/25 or 09/05/25 for the related incidents and they were the only ones to update the care plans.