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	05/08/2026

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

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interview, the facility failed to follow menus and provide bread for 1 of 1 meal observation. The dietary manager identified 38 residents in the facility received nutrition from the kitchen. Findings:On 05/04/26 at 12:00 p.m., cook #1 was observed serving the noon meal. [NAME] #1 was observed serving 38 out of 38 trays without any bread or bread sticks. On 05/04/26, the facility menu for the noon meal showed residents were to have the following items served: Ravioli, Italian blend vegetables, bread sticks, and desert. On 05/04/26 at 12:35 p.m., the dietary manager stated no bread had been served, but the cook was supposed to provide plain bread because the stove and oven was not working. On 05/06/26 at 11:15 a.m., cook #1 stated they did not serve bread because there was no way to toast it. They stated they had never had the stove break, so they did not know.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review and interview, the facility failed to have a water management program to prevent the growth and detection of Legionella. The DON identified 38 residents resided in the facility. Findings:A facility policy titled Legionella Surveillance and Detection, revised July 2017, read in part, Our facility is committed to the prevention, detection and control of water borne contaminants, including Legionella. A facility policy titled Legionella Water Management Program, revised July 2017, read in part, The purpose of the water management program are to identify areas in water system where Legionella bacteria can grow and spread and to reduce the risk of Legionnaire's disease.The water management program includes the following elements . A detailed description and diagram of the water system in the facility.The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria.Specific measures used to control the introduction and/or spread of legionella.The water management program will be reviewed at least once a year or sooner. A review of the infection control records, dated 12/01/25 through 05/07/26, did not show any residents were diagnosed with Legionella. On 05/07/26 at 3:30 p.m., the maintenance director was asked for their documentation relating to the water management program to prevent Legionella. They stated they would look and provide all information they had. On 05/08/26 at 9:25 a.m., the maintenance director stated they had no map or drawing of the facility, a system in place that assessed the water system, or had measures in place to monitor to ensure they were free of Legionella. The maintenance director then stated they were not aware they needed to have an assessment of the water system or monitoring in place

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to:a. report an allegation of abuse within 2 hours to the OSDH for 1 (#22); andb. complete a final report for an allegation of abuse within 5-days to the OSDH for 1 (#30) of 2 sampled residents reviewed for abuse.The DON identified 38 residents resided in the facility.Findings: 1.An undated face sheet showed Resident #22 was admitted to the facility on [DATE] with diagnoses which included dementia, depression, and psychosis. A Form 283 showed an initial/final incident report for an incident, dated 04/23/26, for Resident #22. The form narrative identified Resident #30. The optional page, read in part, Staff and other residents were interviewed with one further complaint of rape attempt from [Resident #22]. The report's fax transmittal showed the report was sent to OSDH on 04/27/26 at 2:31 p.m., three days after Resident #30 made the allegation. There was no documentation to show the allegation from Resident #22 was reported within two hours to the OSDH. An undated statement, signed by CMA #2, showed Resident #22 approached them and requested a medication to assist with sleep because someone of the opposite sex had just tried to rape them. The undated statement by CMA #2 showed they immediately reported the allegation to the nurse and administrator. On 05/06/26 at 11:21 a.m., CMA #2 stated they were working on April 24th when Resident #22 came out of their room and stated they needed a sleeping pill and someone of the opposite sex had just tried to rape them. CMA #2 stated they reported it to the nurse and the administrator and their statement was taken. CMA #2 stated after writing the statement they turned it in to the administrator and continued to work. They stated Resident #22 reported the allegation to them around 3:30 p.m., when their shift first started. On 05/06/26 at 1:51 p.m., the DON stated they assisted with the investigation after the administrator notified them. The DON stated all allegations needed to be reported within two hours. They stated each allegation, even those found during another investigation, must be reported within two hours and fully investigated. The DON stated the allegation made from Resident #22 was investigated with a previous allegation and it was discovered during the investigation of the allegation of abuse for Resident #30. The DON stated Resident #30 allegation was on 04/24/26. The DON stated the allegation of abuse for Resident #22 should have been reported within two hours, but the investigation was included with that of Resident #30. The DON stated the allegation of abuse for Resident #22 should have been handled differently. On 05/06/26 at 4:31 p.m., the administrator stated Resident #22 was reported to the adult protective services within two hours but was not reported to the OSDH within two hours. 2. A quarterly assessment, dated 02/27/26, showed Resident #30 had a BIMS score of six, which indicated the resident was severely impaired in cognition for daily decision making. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Form 283 showed an initial incident report for an incident, dated 04/23/26, for Resident #30. The form, read in part, It was reported to the Adon by the Activities Director that [Resident #30] stated that someone had touched [their] breast. [Resident #30] was immediately assessed with no new skin issues noted. [Resident #30] has a history of redness to the breast. [Resident #30] was also interviewed and stated a white [person] not too old and not too young touched [their] breast. [Resident #30] denied any pain or discomfort. The one white [person] on duty has been suspended pending investigation. Review of the facility's investigation did not show a final report had been submitted to the OSDH for the incident dated 04/23/26. On 05/05/26 at 4:00 p.m., the DON stated they had put the final results of the investigation for the incident dated 04/23/26 on the Form 283 for Resident #22. On 05/06/26 at 9:21 a.m., Resident #30 stated they had not ever been abused or touched inappropriately and felt safe in the facility. On 05/06/26 at 4:55 p.m., the administrator stated final reports were to be sent to the OSDH within five days. They stated they should not have sent the final report for Resident #30 on the report for Resident #22.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a quarterly assessment accurately reflected wandering behavior for 1 (#30) of 3 sampled residents reviewed for accidents and supervision. The DON identified one resident was coded on assessments as a wanderer in the facility. Findings:On 05/04/26 at 11:50 a.m., Resident #30 was observed to walk out of room [ROOM NUMBER]. The name plate on the door was not the name of Resident #30. On 05/04/26 at 12:20 p.m., Resident #30 was observed to come out room [ROOM NUMBER] with a purse and walk down to room [ROOM NUMBER], their assigned room. As Resident #30 exited room [ROOM NUMBER], they told another resident to get out of their room.On 05/04/26 at 1:56 p.m. Resident #30 was observed to enter room [ROOM NUMBER], got a pillow, and took it down the hall. Resident #30 was heard stating room [ROOM NUMBER] was their room. On 05/04/26 at 3:26 p.m., Resident #30 was observed in room [ROOM NUMBER] and told the resident who resided in the room to leave. The resident who was told to leave their room was observed leaving their room after being told to go.An undated face sheet showed Resident #30 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. An admission assessment, dated 11/28/25, showed Resident #30 wandered one to three days during the seven-day look back period of the assessment. The assessment showed the wandering behavior for Resident #30 would be addressed on the care plan. A quarterly assessment, dated 02/27/26, showed Resident #30 had a BIMS score of six, which indicated they had a severe impairment in their cognition. The assessment showed Resident #30 had no behaviors such as wandering or rummaging.Nurse progress notes, dated 11/21/25 through 05/06/26, did not show wandering behaviors for Resident #30.On 05/07/26 at 9:30 a.m., CNA #1 stated Resident #30 resided in room [ROOM NUMBER], was confused most of the time, and ended up in other residents' rooms. CNA #1 stated Resident #30 wandered into other resident rooms daily since being admitted to the facility.On 05/07/26 at 9:38 a.m., CNA #2 stated Resident #30 believed room [ROOM NUMBER] was theirs and claimed it as their room. CNA #2 stated when they redirected Resident #30 from other residents' rooms, they became upset with them. CNA #2 stated they did not document these behaviors anywhere.On 05/07/26 at 9:44 a.m., CNA #3 stated when Resident #30 was awake they went room to room and laid on other residents' beds. CNA #3 stated Resident #30 had these wandering behaviors daily since admission and they did not document it anywhere.On 05/07/26 at 9:51 a.m., CMA #1 stated Resident #30 resided in room [ROOM NUMBER], would bypass their room, and go to room [ROOM NUMBER]. CMA #1 stated this occurred every day when Resident #30 was awake. CMA #1 stated they did not document the wandering anywhere.On 05/07/26 at 10:01 a.m., LPN #1 stated Resident #30 was ambulatory and would wander into residents' rooms daily. LPN #1 stated they had worked at the facility since January 2026 and Resident #30 had this behavior daily.On 05/07/26 at 10:31 a.m., the MDS coordinator stated Resident #30 did not wander a lot. They stated there were no notes documented so wandering would not have been coded on the quarterly assessment. They stated they would interview staff but would not ask about wandering. They stated they relied on the documentation in the chart.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure comprehensive care plans were developed for 2 (#8 and #30) of 14 sampled residents whose care plans were reviewed.The DON identified 38 residents resided in the facility.Findings: 1.On 05/07/26 at 8:35 a.m., Resident #8 was observed in a Geri-chair with the fingers on their right and left hand curled inward. On 05/07/26 at 10:51 a.m., hospice aide #1 was observed to transport Resident #8 to the shower room. A facility policy titled Care Plans, Comprehensive Person-Centered, revised 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. An annual assessment, dated 02/26/26, showed a BIMS score of 00, which indicated the resident was severely impaired in cognition for daily decision making. The assessment showed the resident had impairment in range of motion to one side of their upper and lower extremities and received range of motion services during the lookback period. A Physician's Certification for Hospice Benefit form, dated 03/18/26, showed Resident #8 was admitted to hospice services. On 05/05/26 at 11:08 a.m., family member #1 stated Resident #8 had a contracture to the left hand. Family Member #1 stated they had elected the hospice benefit for Resident #8 a couple of months ago. On 05/07/26 at 8:38 a.m., LPN #1 stated Resident #8 had limited range of motion in both hands. On 05/07/26 at 10:52 a.m., LPN #1 stated Resident #8 had received hospice services for several months. On 05/07/26 at 10:54 a.m., the MDS coordinator reviewed the electronic clinical record and stated Resident #8 had elected the hospice benefit in March 2026. They stated they had failed to develop a care plan related to hospice services. On 05/07/26 at 11:02 a.m., the MDS coordinator reviewed the electronic clinical record and stated Resident #8 had a contracture to the left hand. They stated the care plan and interventions for limited range of motion/contracture had been on the previous care plan but it had not carried over when the care plan was revised on 02/26/26. On 05/07/26 at 2:13 p.m., the DON stated they were not sure why the limited range of motion/contracture was not on the current care plan. They stated they would need to monitor care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/26 at 2:16 p.m., the DON stated the care plan for hospice may have been overlooked but should have been completed. 2. On 05/04/26 at 11:50 a.m., Resident #30 was observed to walk out of room [ROOM NUMBER], the name plate on the door was not the name of Resident #30. On 05/04/26 at 12:20 p.m., Resident #30 was observed coming out room [ROOM NUMBER] with a purse and walk down to their assigned room, room [ROOM NUMBER]. As Resident #30 was exiting room [ROOM NUMBER] they told another resident to get out of their room. On 05/04/26 at 1:56 p.m. Resident #30 once again went into room [ROOM NUMBER], got a pillow, and took it down the hall. Resident #30 was heard stating room [ROOM NUMBER] was their room. On 05/04/26 at 3:26 p.m., Resident #30 was observed in room [ROOM NUMBER] and told the resident who resided in the room to leave. The resident who was told to leave their room was observed leaving. An undated face sheet showed Resident #30 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease. An admission assessment, dated 11/28/25, showed Resident #30 wandered one to three days during the seven-day look back period of the assessment. The assessment showed the wandering behavior for Resident #30 would be addressed on the care plan. A care plan, last revised on 12/08/25, did not address Resident #30's wandering, entering into other residents' rooms, or attempting to keep those residents out of their own room. A quarterly assessment, dated 02/27/26, showed Resident #30 had a BIMS score of six, which indicated they had a severe impairment in their cognition. The assessment showed Resident #30 had no behaviors such as wandering or rummaging. Nurse progress notes, dated 11/21/25 through 05/06/26, did not show wandering behaviors of Resident #30. On 05/07/26 at 9:30 a.m., CNA #1 stated Resident #30 resided in room [ROOM NUMBER] and they were confused most of the time and ended up in other residents' rooms. CNA #1 stated Resident #30 wandered into other resident rooms daily since being admitted to the facility. admitted to the facility. On 05/07/26 at 9:38 a.m., CNA #2 stated Resident #30 believed room [ROOM NUMBER] was theirs and claimed it was their room. CNA #2 stated when they redirected Resident #30 from other residents' rooms, they would become upset with them. CNA #2 stated they did not document these behaviors anywhere. On 05/07/26 at 9:44 a.m., CNA #3 stated when Resident #30 was awake they went room to room and laid on other residents' beds. CNA #3 stated Resident #30 had these wandering behaviors daily since admission and they did not document it anywhere. On 05/07/26 at 9:51 a.m., CMA #1 stated Resident #30 resided in room [ROOM NUMBER], but would go right by their room and go to room [ROOM NUMBER], CMA #1 stated this occurred every day when (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #30 was awake. CMA #1 stated they did not document the wandering behavior anywhere. On 05/07/26 at 10:01 a.m., LPN #1 stated Resident #30 was ambulatory and would wander into residents' rooms daily. LPN #1 stated they had been working at the facility since January 2026 and Resident #30 had wandering behavior daily. On 05/07/26 at 10:31 a.m., the MDS coordinator stated Resident #30 did not wander a lot. The MDS coordinator stated they reviewed documentation to determine if a resident had wandering behaviors to be care planned. They stated there were no notes documented so wandering would not have been coded on the quarterly assessment. They stated they would interview staff but would not ask about wandering and they relied on the documentation in the chart. The MDS coordinator stated they were not aware of the wandering, and the care plan did not address wandering into other residents' rooms, and it should have been care planned.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review, and interview, the facility failed to ensure inspection of u-bars was part of their regular maintenance program for 1 (#38) of 1 sampled resident reviewed for accident hazards related to bed rails.The DON identified one resident utilized bed rails.Findings: On 05/05/26 at 12:00 p.m., the bed for Resident #38 was observed to have a u-bar (a type of bed side rail) on the right side of their bed. On 05/05/26 at 2:21 p.m., Resident #38 was observed in their bed with their eyes closed with a u-bar on the right side of the bed. A Bed Safety policy, dated December 2007, read in part, Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks. A physician order, dated 06/14/25, showed a u-bar may be used to assist with transfers for Resident #38. A quarterly assessment, dated 04/17/26, showed a BIMS score of four, which indicated the resident was severely impaired in cognition for daily decision making and required partial to moderate assistance for transfers from their chair to their bed. A care plan, revised 04/20/26, showed Resident #38 could utilize a u-bar for assistance with bed transfers. A Medical Device Monthly Evaluation, dated 04/21/26, read in part, Device U bar .Promotes safety comfort and positioning. Review of the electronic clinical record did not show the u-bar for Resident #38 had been inspected as part of the maintenance program. On 05/06/26 at 11:17 a.m., the maintenance supervisor stated they did not regularly inspect u-bars as part of their maintenance program. They stated the only thing they did with u-bars was install and remove them when instructed. On 05/06/26 at 12:44 p.m., the administrator stated they did not know why the maintenance supervisor did not conduct regular inspections of u-bars as part of their maintenance program.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a thorough investigation of an allegation of sexual abuse for 1 (#22) of 2 sampled residents reviewed for abuse. The DON identified 38 residents resided in the facility. Findings: An undated face sheet showed Resident #22 was admitted to the facility on [DATE] with diagnoses which included dementia, depression, and psychosis.A Form 283 showed an initial/final incident report for an incident, dated 04/23/26, for Resident #22. The form narrative identified Resident #30. The optional page, read in part, Staff and other residents were interviewed with one further complaint of rape attempt from [Resident #22]. The report's fax transmittal showed the report was sent to OSDH on 04/27/26 at 2:31 p.m., three days after Resident #30 made the allegation.An undated statement, signed by CMA #2, showed Resident #22 approached them and requested a medication to assist with sleep because someone of the opposite sex had just tried to rape them. The undated statement by CMA #2 showed they immediately reported the allegation to the nurse and administrator. There was no documentation of an investigation into Resident #22's allegation of attempted rape made on 04/24/26 to CMA #2. On 05/06/26 at 11:21 a.m., CMA #2 stated they were working on April 24th when Resident #22 came out of their room and stated they needed a sleeping pill and someone of the opposite sex had just tried to rape them. CMA #2 stated they reported it to the nurse and the administrator and their statement was taken. CMA #2 stated after writing the statement they turned it in to the administrator and continued to work. They stated Resident #22 reported the allegation to them around 3:30 p.m., when their shift first started.On 05/06/26 at 1:51 p.m., the DON stated they assisted with the investigation after the administrator notified them. The DON stated all allegations needed to be reported within two hours. They stated each allegation, even those found during another investigation, must be fully investigated. The DON stated the allegation made from Resident #22 was investigated with a previous allegation and it was discovered during the investigation of the allegation of abuse for Resident #30. The DON stated the allegation of sexual abuse for Resident #30 was on 04/24/26. The DON stated the allegation of abuse for Resident #22 was investigated and included with that of Resident #30. The DON stated the allegation of abuse for Resident #22 should have been handled differently. On 05/06/26 at 2:33 p.m., the ADON stated CMA #2 and the administrator came to them and reported Resident #22 stated someone of the opposite sex attempted to rape them on 04/24/26. The ADON stated they talked with Resident #22 who stated someone of the opposite sex tried to come into their room. The ADON stated they had not documented the conversation with Resident #22. The ADON stated the investigation for Resident #22 was included with the investigation for Resident #30 and nothing was done separately. The ADON stated the allegation from Resident #22 should have been handled separately and investigated on its own. On 05/06/26 at 4:31 p.m., the administrator stated there was no documentation the allegation of rape from Resident #22 was investigated and it was part of the investigation for Resident #30.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on record review and interview, the facility failed to ensure a significant change assessment was completed for 1 (#8) of 1 sampled resident reviewed for hospice services.The DON identified eight residents received hospice services. Findings: A Physician's Certification for Hospice Benefit, dated 03/18/26, showed Resident #8 had been certified for hospice services for a terminal diagnosis of Alzheimer's disease. The form, read in part, It is my clinical judgement that this patient has a life expectancy of six months or less, if the terminal illness runs its normal course. The form had been signed by the physician. Review of the electronic clinical record did not show a significant change assessment had been completed when the resident elected the hospice benefit. On 05/07/26 at 10:52 a.m., LPN #1 stated Resident #8 had received the hospice benefit for a couple of months. On 05/07/26 at 10:54 a.m., the MDS coordinator stated Resident #8 had received the hospice benefit since March 2026. They stated when a resident elected the hospice benefit a significant change assessment was to be completed. They reviewed the electronic clinical record and stated they had forgotten to complete a significant change assessment when Resident #8 elected the hospice benefit in March 2026. On 05/07/26 at 2:16 p.m., the DON stated they did not know why a significant change assessment had not been completed when Resident #8 elected the hospice benefit in March 2026. They stated, It must have been overlooked.