

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Anadarko Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 300 West Washington Anadarko, OK 73005	
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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to protect the resident's right to be free from sexual abuse for 1 (#2) of 3 sampled residents reviewed for sexual abuse. The director of nursing identified 73 residents resided in the facility. Findings: An undated policy titled Abuse Policy and Procedure, read in part, protect our occupants .sexual abuse .resident rights to be free from physical or mental abuse Resident To Resident Incidents .Assessment of risk .Upon admission to the facility, each person will be assessed through the MDS process to determine if they are a risk for abusing others .Care Plan .designed to prevent occurrences. An undated admission summary for Resident #1, showed the resident had diagnoses to include dementia and other sexual dysfunction. A physician order for Resident #1, dated 09/14/23, showed the resident was administered Provera (progestin hormone) 40 mg by mouth every day for sexual dysfunction. Provera use includes hypersexuality to lower testosterone levels and safely reduce libido or sexually inappropriate behaviors. A nurses note for Resident #1, dated 05/25/26, showed the resident was redirected and was on every 15-minute checks due to behaviors. A nurses note for Resident #1, dated 06/07/26, showed the resident was on observation and every 15-minute checks due to behaviors. A nurses note for Resident #1, dated 06/16/26, showed the resident continued on 15-minute behavior checks. A behavior monitoring sheet for Resident #1, dated 06/2026, showed the resident was monitored for wandering, yelling, and sexual behavior. Wandering was documented 16 out of 22 days with a total number of 67 observations of wandering. Yelling was documented two days out of 22 days with a total of three observations of yelling. Sexual behavior was documented nine days out of 22 days with a total number of 30 observations of sexual behavior. A final state reported incident form, dated 07/02/26, showed Resident #2 reported to charge nurse Resident #1 came into their room while they were sleeping and was rubbing their crotch over their clothes. Both Resident #2 and Resident #3 yelled at Resident #1 to get out of their room. Resident #1 was immediately placed on one-to-one observation by staff due to behaviors and remained on one-to-one monitoring. A nurses note for Resident #2, dated 07/02/26 at 12:32 a.m., showed Resident #2 came up to the nurse and stated, the new admission came in my room and was rubbing my crotch. A nurses note for Resident #1, dated 07/02/26, showed the nurse went to Resident #1's room and observed the resident touching themselves under the blanket. The note showed the nurse told Resident #1 you cannot be going in other resident's rooms, and you cannot touch them. Resident #1 stated are you going to do it? Resident #1 pulled their right hand from under the covers and began rubbing their genital area. The note showed all residents' doors were closed and halls were monitored. The note showed the DON was notified of occurrence. A one-to-one monitoring form for Resident #1, dated 07/02/26 through 07/06/26, showed Resident #1 had been monitored until they were transferred to geriatric psychiatry. A quarterly assessment, dated 07/08/26, showed Resident #2 had a brief interview for mental status score of 15 which indicated intact cognition. On 07/14/26 at (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 - Some	12:06 p.m., Resident #2 stated they awoke to find Resident #1 standing over them. Resident #2 stated Resident #1 was fondling them over their clothes in their crotch area. Resident #2 stated they had been sexually assaulted before and was traumatized. Resident #2 stated they kicked Resident #1 in the chest and began yelling until Resident #1 left. Resident #2 stated they told the nurse and the nurse aide and they came immediately. Resident #2 stated the staff closed their door and moved Resident #1 to the other end of the building. They stated the staff placed Resident #1 on one-to-one monitoring. On 07/16/26 at 12:25 p.m., the transporter stated Resident #1 was talking dirty to the other transporter. The transporter stated Resident #1 wanted them to turn around to do something sexually to them. The transporter stated Resident #1 continued to speak inappropriately during the drive to the facility. The transporter stated Resident #1 stated they had money for a hotel for a threesome. The transporter stated they had reported Resident #1's behavior and conversations to the nurses' station, but they did not remember who was at the nurses' station. On 07/16/26 at 1:17 p.m., the ADON stated there was documentation Resident #1 had been monitored in May and June in the nurses notes. The ADON stated Resident #1 was being monitored for wandering, yelling, and sexual dysfunction. On 07/16/26 at 1:18 p.m., the DON stated they did not question the use of Provera. They stated other residents used the same medication. On 07/16/26 at 1:25 p.m., the ADON stated they had reviewed Resident #1's paperwork the other facility had faxed or emailed over to them before determining the resident would be admitted to their facility.		