| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edmond Health Care Center | 39 East 33rd Street<br>Edmond, OK 73013 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 07/31/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to:a. ensure Residents #1 and #2 were free from abuse;b. act on Resident #2's known behavioral patterns; andc. protect Resident #1 from serious harm.Resident #2 with known behavioral patterns was observed by staff to be impaired and suspected of being under the influence of drugs on the night or early morning hours of 07/24/25 with glossy eyes, dilated pupils, talking to themselves and with noted confusion. Resident #2 was documented as entering other resident rooms while suspected of being under the influence of drugs and with impaired decision making. The facility did not implement interventions. The following night the resident was observed to be speaking to themself using profane language in the hallway after returning from the community and subsequently sexually assaulted (raped) Resident #1 on the early hours of 07/25/25. These failures put all residents at risk of serious harm. An admission resident assessment, dated 06/04/25, showed Resident #2's cognition was intact (BIMS 15). The assessment showed the resident exhibited verbal behavioral symptoms directed toward others that significantly disrupted care or the living environment. The assessment showed the resident required supervision or touching assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, sitting to standing, and chair/bed-to-chair transfer. An annual resident assessment, dated 06/16/25, showed Resident #1's cognitive skills for daily decision making were severely impaired per staff assessment for mental status. The assessment showed the resident required substantial/maximum assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, and was dependent on staff for chair to bed transfers.A quarterly resident assessment, dated 06/29/25, showed Resident #4's cognition was severely impaired (BIMS 04). The assessment showed the resident was independent for rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, and walking 10 feet.A nurse progress note, dated 07/25/25 at 3:30 a.m., showed at approximately 3:25 a.m., RN #1 was alerted by another resident (Resident #4) to a situation occurring in their room. Upon entering the room, RN #1 observed concerning behavior between (Resident #1 and Resident #2). RN #1 instructed Resident #2 to stop and leave the area. A CNA (CNA #1) was directed to supervise and escort Resident #2 out of the room while RN #1 contacted the DON for further guidance. The note showed Resident #1 was briefly assessed with no visible injuries noted at the time. The note showed Resident #2 was placed on 1:1 supervision for close monitoring. The note showed the provider on call and facility administration were notified and appropriate reporting procedures were initiated per protocol. The initial report, dated 07/25/25, showed the DON and administrator were notified Resident #2 was in Resident #1's room. The initial report showed the residents were immediately separated and Resident #2 left the property. The initial report showed Resident #1 was sent to the emergency room for precautionary evaluation. The initial report showed the police, family, physician, resident's legal representative, and APS were notified. The initial report was received by the state agency on 07/25/25 at 7:14 a.m. The final report, dated 07/25/25, was received by the state agency on 07/30/25 at 12:12 p.m. The final report contained additional information in the description of the incident. The final report showed at 3:42 a.m., (RN #1) contacted the DON regarding (Resident #2) in (Resident #1's) room and in (Resident #1's) bed. The final report showed staff reported (Resident #2) was in (Resident #1's) room with (Resident #2's) pants halfway pulled down. The final report showed (Resident #2) was on the bed with (Resident #1). The DON notified (RN #1) to immediately separate the residents. (Resident #2) was to be placed on 1:1. (Resident #2) then exited the facility while staff was attempting to talk with them. Police were notified and (Resident #1) was sent to the emergency room for precautionary evaluation. The final report showed staff stayed with (Resident #1) until they left to the emergency room. The final report showed (Resident #1) was transported via ambulance and report was given. When police arrived, (Resident #2) was taken into custody by the police department. The DON notified the administrator at 3:48 a.m. The final report showed (Resident #1's) most recent BIMS was 0/15, required total assistance with ADLs, and had diagnoses which included dementia. The final report showed investigation of the incident revealed staff was present on the hall at 2:42 a.m. giving medication to (Resident #2). At 2:49 a.m., (Resident #2) entered (Resident #1's) room. At 2:52 a.m., (Resident #2) shut (Resident #1's) door. At 3:06 a.m. (Resident #4) heard (Resident #2) enter, got up, and reported to staff (name not provided) that (Resident #2) was in their room. At 3:09 a.m., (RN #1) went down to the room and when they entered, (RN #1) saw (Resident #2) in the bed with (Resident #1) appearing to be engaged in sex. (RN #1) reported they told (Resident #2) to stop and exit the room and (Resident #2) was |

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| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Edmond Health Care Center | 39 East 33rd Street<br>Edmond, OK 73013 |

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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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An abuse, neglect, exploitation or misappropriation policy, revised 04/2021, read in part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management.If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies .The resident's representative.Immediately is defined as .within two hours of an allegation involving abuse.The administrator ensures that he resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator.Witness statements are obtained in writing, signed, and dated.<br><br>An abuse and neglect policy, dated 05/02/25, read in part, It is the Policy of any [name withheld] Long Term Care managed facility that no resident shall be subject to abuse and/or neglect.All incidents to include suspected resident abuse will be reported to the Administrator and Director of Nursing.Any occurrence of abuse/neglect will be evaluated at the time for removal of a resident to a more appropriate facility.Following the initial verbal investigation, the Administrator will take written statements from all employees, residents, any witness if any, and will determine action to be taken.Administration will evaluate and analyze any occurrence and make any necessary changes that would prevent the situation from recurring in the future.<br><br>1. On 07/30/25 at 9:28 a.m., the room with Resident #2's name on it was observed. Resident #2's side of the room was free from any personal items from a resident and did not have a resident on that side of the room.<br><br>A significant change resident assessment, dated 04/28/25, showed Resident #7's (who was Resident #2's roommate at the time of the incident) cognition was intact (BIMS 13).<br><br>Resident #2 admission health record, dated 05/28/25, showed they were admitted with diagnoses which included osteomyelitis, acquired absence of the left leg above the knee, and schizoaffective disorder.<br><br>An admission resident assessment, dated 06/04/25, showed Resident #2's cognition was intact (BIMS 15). The assessment showed the resident exhibited verbal behavioral symptoms directed toward others that significantly disrupted care or the living environment. The assessment showed the resident required supervision or touching assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, sitting to standing, and chair/bed-to-chair transfer.<br><br>Resident #2's care plan for behaviors, dated 06/16/25, showed the resident had a focus for behaviors which showed they had a history of being verbally aggressive and has the potential for being manipulative. The focus showed the resident had a history of homelessness, begging for money, food, and personal items in the community.<br><br>Resident #2's behavior note, dated 06/15/25, showed another Resident #2 was threatened by another resident. The police were notified and came and spoke with the residents.<br><br>Resident #2's behavior note, dated 06/16/25, showed Resident #2 was calling staff names and refusing to do ADL's.<br><br>(continued on next page) |

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|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #2's behavior note, dated 06/18/25, showed Resident #2 became loud in a care plan meeting and would not let staff talk or assist them with alternative activities that would separate them from other residents. The resident stated they will do what they want, and no one was going to tell them anything. The note showed the resident continued to yell at staff and was hard to redirect.<br><br>The facility's document titled Behavioral Contract, dated 06/19/25, read in part, This agreement is between [Resident #2] and [name of facility withheld]. In efforts to better care for you, the following expectations are required to maintain and effective provider relationship. You were witnessed to have inappropriate conversations of a sexual nature, scream at other residents, and treat residents and staff negatively. You have been made aware that these actions are unacceptable verbally on numerous occasions. Resident is aware that all residents, including [themselves], have the right to live in a home like environment free from abuse/neglect/exploitation. Resident is expected to respect the rights of other residents, just as [their] rights are respected, going forward. I [Resident #2] have read and understand the above-listed behavioral expectations. I also understand that failure to meet these expectations may result in termination of the provider relationship. This is a 30-day contract to ensure you are able to comply with the facility policy.<br><br>Resident #2's Behavioral Contract, dated 06/19/25 was signed by Resident #2. the ex-administrator, and SSD.<br><br>A review of incident reports, state reportables, progress notes, and Resident #2's care plan did not document inappropriate conversations of a sexual nature.<br><br>Resident #2's behavior note, dated 06/20/25, showed Resident #2 was visited by the social services director and administrator regarding a reported concerns related to illicit drugs. The resident's room had a non-invasive search. No illicit drugs were found. The resident was reminded of the drug and alcohol policy.<br><br>Resident #2's alert note, dated 06/21/25 at 12:06 p.m., showed Resident #2 went to the lobby, signed themselves out, and the consequences were explained for leaving AMA. Resident #2's nurse notes, dated 06/23/25 at 7:43 a.m., showed Resident #2 signed out at 3:00 a.m., came back and left at 6:00 am but refused to sign out and left against medical advice (AMA).<br><br>Resident #2's nurse note, dated 06/23/25 at 9:57 a.m., showed Resident #2 returned to the facility and was educated on the safety risk related to leaving AMA.<br><br>Resident #2's behavior note, dated 07/24/25 at 6:43 a.m., showed the resident had been up all-night wandering around in the hallways going into other residents' room and waking them up. The note showed the resident was told not to go into other residents' room and the resident was talking when nobody was in the area.<br><br>Resident #2's nurse notes, dated 07/24/25 at 4:06 p.m., read in part, resident came back to the facility with glossy eyes pupils dilatated, increased respirations, and noted confusion and resident talking to [themselves] with impaired decision making. FNP (facility nurse practitioner) notified and ordered a drug urinalysis and blood work. Notified resident that [they]would have to take a ua (urinalysis) and give blood and resident had an aggressive attitude toward this nurse and stated [they] was not going to give urine or let lab take blood work.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #2's behavior notes, dated 07/24/25 at 10:53 p.m., read in part, resident returned from outside, with two bags of fast foods. Resident was talking to himself loud on the hallway, this nurse redirected the Resident but refused to comply, Resident was offered ice in his pitcher but refused, I don't want ice water in that pitcher. Resident continued to be loud and cursing using profane language.<br><br>On 07/30/25 at 9:24 a.m., Resident #7 (who was Resident #2's roommate the day of the incident) stated they had not been a roommate with (Resident #2) for long. Resident #7 stated Resident #2 Went to jail. Resident #7 stated the reason Resident #2 went to jail was because they were a sexual predator. Resident #7 stated Resident #2 had shared stories with them parenting children at the age of eight.<br><br>On 07/30/25 at 5:16 p.m., the ex-administrator stated they were unaware of the Behavior Contract, dated 06/19/25. They stated Resident #2 would argue with other residents and had to be redirected frequently.<br><br>On 07/31/25 at 4:42 a.m., the social services director (SSD) was asked about Resident #2's, Behavior Contract, dated 06/19/25. The SSD stated the administrator and themself went to Resident #2's room because there were allegations Resident #2 had crack cocaine, and Resident #2 allegedly said something inappropriate to staff or residents. The SSD stated they were not sure exactly to who or what Resident#2 said. The SSD stated, the DON gave them the Behavior Contract to go over with the Resident #2. The SSD stated they did a soft search of Resident #2's room and did not locate any drugs. The SSD stated Resident #2 denied making any inappropriate sexual remarks. They stated the Administrator said Resident #2 had to sign the Behavior Contract.<br><br>On 07/31/25 at 6:40 a.m., the DON stated they were not aware of the Behavior Contract, dated 06/19/25, because they had a care plan meeting scheduled and Resident #2 refused to participate. They stated they were unaware of any incidents of sexual inappropriate behaviors with other residents.<br><br>On 08/04/25 at 8:19 a.m., the MDS coordinator stated they were unaware of the Behavior Contract, dated 06/19/25.<br><br>2.On 07/30/25 at 10:10 a.m., Resident #1's name was observed outside the fourth room down from the nurse's station on the right side of hall 300. Resident #1 was not observed inside the room.<br><br>On 07/30/25 at 10:14 a.m., Resident #1 was observed seated in a standard wheelchair at the beginning of hall 300. Resident #1 was observed wearing a light green shirt with a flower on it, blue/grey pants, and tan skid proof socks on. Resident #1 was able to identify their first name, but was unable to provide any additional information to the surveyor.<br><br>On 07/30/25 at 11:32 a.m., Resident #1 was observed in the television room on hall 300 seated in a standard wheelchair at the front of all other residents in the room, watching a movie.<br><br>An annual resident assessment, dated 06/16/25, showed Resident #1's cognitive skills for daily decision making were severely impaired per staff assessment for mental status. The assessment showed the resident required substantial/maximum assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, and was dependent on staff for chair to bed transfers.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An initial facility reported incident, dated 07/25/25, showed the DON and administrator were notified Resident #2 was in Resident #1's room. The initial report showed the residents were immediately separated and Resident #2 left the property. The initial report showed Resident #1 was sent to the emergency room for precautionary evaluation. The initial report showed the police, family, physician, resident's legal representative, and APS were notified. The initial report was received by the state agency on 07/25/25 at 7:14 a.m.<br><br>A final facility reported incident, dated 07/25/25, was received by the state agency on 07/30/25 at 12:12 p.m. The final report contained additional information in the description of the incident. The final report showed at 3:42 a.m., (RN #1) contacted the DON regarding (Resident #2) in (Resident #1’s) room and in (Resident #1’s) bed. The final report showed staff reported (Resident #2) was in (Resident #1’s) room with (Resident #2’s) pants halfway pulled down. The final report showed (Resident #2) was on the bed with (Resident #1). The DON notified (RN #1) to immediately separate the residents. (Resident #2) was to be placed on 1:1. (Resident #2) then exited the facility while staff was attempting to talk with them. Police were notified and (Resident #1) was sent to the emergency room for precautionary evaluation. The final report showed staff stayed with (Resident #1) until they left to the emergency room. The final report showed (Resident #1) was transported via ambulance and report was given. When police arrived, (Resident #2) was taken into custody by the police department. The DON notified the administrator at 3:48 a.m. The final report showed (Resident #1’s) most recent BIMS was 0/15, required total assistance with ADLs, and had diagnoses which included dementia. The final report showed investigation of the incident revealed staff was present on the hall at 2:42 a.m. giving medication to (Resident #2). At 2:49 a.m., (Resident #2) entered (Resident #1’s) room. At 2:52 a.m., (Resident #2) shut (Resident #1’s) door. At 3:06 a.m. (Resident #4) heard (Resident #2) enter, got up, and reported to staff (name not provided) that (Resident #2) was in their room. At 3:09 a.m., (RN #1) went down to the room and when they entered, (RN #1) saw (Resident #2) in the bed with (Resident #1) appearing to be engaged in sex. (RN #1) reported they told (Resident #2) to stop and exit the room and (Resident #2) was getting up and attempting to explain what (Resident #2) was doing when (RN #1) exited the room to call the DON. At 3:12 a.m., (CNA #1) walked into (Resident #1’s) room and (Resident #2) was still in the bed with (Resident #1). (CNA #1) separated (Resident #2 and #1) and (Resident #2) was placed on 1:1. The police department was contacted by the DON along with the facility administrator. (Resident #2) exited the building while staff was attempting 1:1 supervision with (Resident #2) until the police arrived. The police department escorted (Resident #2) back into the building and took them into custody. (Resident #1’s) family was notified of the incident and of the resident being transported to the emergency room. (Resident #1) was sent to the emergency room for evaluation and treatment. A SANE exam was completed. (Resident #1) returned to the facility and was moved to a room closer to the nurse’s station for family comfort. Psych NP to see (Resident #1) upon return from the hospital to evaluate and treat as needed. Safe surveys for all resident’s completed with each resident. No concerns for safety or incidents of abuse reported. In-service with staff completed, small roundtables completed with staff over abuse types, appropriate interventions related and who to report abuse to. In house counselor made available for staff and residents as needed. Immediate QAPI completed and ongoing QAPI review. (RN #1) suspended indefinitely.<br><br>The immediate QAPI provided for this abuse investigation, dated 07/25/25, showed the COO was called, the administrator was notified, and the DON, ADON, and the SSD were present for the QAPI. The immediate QAPI showed Resident #1 and #2 were placed on 1:1 on 07/25/25 and an in-service was held for all types of abuse. The immediate QAPI showed the physician, nursing board, police, OSDH, and APS were notified of the event and Resident #1 was went to the emergency room for an evaluation.<br><br>(continued on next page) |

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| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | There was no documentation of the 1:1 for Resident #1 and Resident #2 provided to the surveyors. There was no documentation of any monitoring component for this immediate QAPI.<br><br>Resident #1's hospital records, dated 07/25/25, showed final diagnosis of sexual assault of adult, initial encounter. The hospital records showed a staff member had gone into Resident #1's room on 07/25/25 and found another resident (Resident #2) vaginally penetrating Resident #1. The hospital records showed Resident #1 was nonverbal. The hospital records showed Resident #1 had diagnoses which included anxiety, brain tumor, dementia with behavioral disturbance, and traumatic brain injury.<br><br>On 07/30/25 at 10:10 a.m., CNA #8 stated Resident #1 had just moved to hall 300 because there was an incident on hall 100. CNA #8 stated they did not know the details of the incident, but if something traumatic did occur, [they] wouldn't want [Resident #1] returned to the same room.<br><br>On 07/30/25 at 2:33 p.m., family member #4 stated the first call they received from the facility was on 07/25/25 at 5:57 a.m. Family Member #4 stated the regional director of operations informed family member #4 Resident #1 had been sexually assaulted. Family Member #4 stated no details were provided from the facility at the time. Family member #4 stated the next call they received was from the hospital to obtain consent for a rape kit. Family Member #4 stated they were with Resident #1 at the hospital all day and returned with the resident to the facility around 3:00 p.m. Family Member #4 stated the facility informed them (Resident #2) was found in (Resident #1's) room and they did not have pants on. Family Member #4 stated they did not know the details until they saw the story come across their social media page.<br><br>On 07/30/25 at 2:36 p.m., family member #4 stated, at this time, Resident #1 doesn't even know who family member #4 is when they visit. Family Member #4 stated Resident #1 could not consent for anything. Family Member #4 stated Resident #1 was able to speak, but just can't speak up for [themselves].<br><br>On 07/30/25 at 2:38 p.m., family member #4 stated they came up to the facility on Tuesday (07/29/25) and asked Resident #1 if they remembered anything about what happened, but the resident went on to talk about something that occurred in the 1990s. Family Member #4 stated they did not know at the time who raped Resident #1, but since the news broadcast, they looked Resident #2 up and discovered they were a convicted felon.<br><br>On 07/30/25 at 2:40 p.m., family member #4 stated right after the assault, the nurse completed a rape exam and there was redness in the area. Family Member #4 stated Resident #1 showed signs of discomfort in that area (private area). Family Member #4 stated, That was confirmation to me that [Resident #2] did rape [Resident #1].<br><br>On 07/30/25 at 2:42 p.m., family member #4 stated staff had reported they were going to move Resident #1 by the nurses' station, but they did not. Family Memb[TRUNCATED] |

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|---|---|---|---|
| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

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|---|---|
| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>(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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on observation, record review, and interview, the facility failed to implement their abuse policy for 3 (#1, 2, and #4) of 6 sampled residents reviewed for abuse. The BOM identified 78 residents resided in the facility.Findings: On 07/30/25 at 9:13 a.m., Resident #4 was observed seated on the bed in their room with family member #1 present in the room. On 07/30/25 at 9:28 a.m., the room with Resident #2's name on it was observed. Resident #2's side of the room was free from any personal items from a resident and did not have a resident on that side of the room. On 07/30/25 at 10:10 a.m., Resident #1's name was observed outside the fourth room down from the nurse's station on the right side of hall 300. Resident #1 was not observed inside the room. On 07/30/25 at 10:14 a.m., Resident #1 was observed seated in a standard wheelchair at the beginning of hall 300. Resident #1 was observed wearing a light green shirt with a flower on it, blue/grey pants, and tan skid proof socks on. Resident #1 was able to identify their first name, but was unable to provide any additional information to the surveyor. An abuse, neglect, exploitation or misappropriation policy, revised 04/2021, read in part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator.Witness statements are obtained in writing, signed, and dated.A significant change resident assessment, dated 04/28/25, showed Resident #7's cognition was intact (BIMS 13).An abuse and neglect policy, dated 05/02/25, read in part, It is the Policy of any [name withheld] Long Term Care managed facility that no resident shall be subject to abuse and/or neglect.All incidents to include suspected resident abuse will be reported to the Administrator and Director of Nursing.Any occurrence of abuse/neglect will be evaluated at the time for removal of a resident to a more appropriate facility.Following the initial verbal investigation, the Administrator will take written statements from all employees, residents, any witness if any, and will determine action to be taken.Administration will evaluate and analyze any occurrence and make any necessary changes that would prevent the situation from recurring in the future. An admission resident assessment, dated 06/04/25, showed Resident #2's cognition was intact (BIMS 15). The assessment showed the resident exhibited verbal behavioral symptoms directed toward others that significantly disrupted care or the living environment. The assessment showed the resident required supervision or touching assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, sitting to standing, and chair/bed-to-chair transfer. An annual resident assessment, dated 06/16/25, showed Resident #1's cognitive skills for daily decision making were severely impaired per staff assessment for mental status. The assessment showed the resident required substantial/maximum assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, and was dependent on staff for chair to bed transfers. A quarterly resident assessment, dated 06/29/25, showed Resident #4's cognition was severely impaired (BIMS 04). The assessment showed the resident was independent for rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, and walking 10 feet. A nurse progress note, dated 07/25/25 at 3:30 a.m., showed at approximately 3:25 a.m., RN #1 was alerted by another resident (Resident #4) to a situation occurring in their room. Upon entering the room, RN #1 observed concerning behavior between (Resident #1 and Resident #2). RN #1 instructed Resident #2 to stop and leave the area. A CNA (CNA #1) was directed to supervise and escort Resident #2 out of the room while RN #1 contacted the DON for further guidance. The note showed Resident #1 was briefly assessed with no visible injuries noted at the time. The note showed Resident #2 was placed on 1:1 supervision for close monitoring. The note showed the provider on call and facility administration were notified and appropriate reporting procedures were initiated per protocol. An initial facility reported incident, dated 07/25/25, showed the DON and administrator were notified Resident #2 was in Resident #1's room. The initial report showed the residents were immediately separated and Resident #2 left the property. The initial report showed Resident #1 was sent to the emergency room for precautionary evaluation. The initial report showed the police, family, physician, resident's legal representative, and APS were notified. The initial report was received by the state agency on 07/25/25 at 7:14 a.m. The final facility reported incident, dated 07/25/25, was received by the state agency on 07/30/25 at 12:12 p.m. The final report contained additional information in the description of the incident. The final report showed at 3:42 a.m., (RN #1) contacted the DON regarding (Resident #2) in (Resident #1's) room and in (Resident #1's) bed. The final report showed |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edmond Health Care Center | 39 East 33rd Street<br>Edmond, OK 73013 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

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| Edmond Health Care Center | 39 East 33rd Street<br>Edmond, OK 73013 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on record review and interview, the facility failed to ensure an initial facility reported incident regarding an allegation of abuse was sent within two hours to the state agency for 3 (#1, 2, and #4) of 6 sampled residents reviewed for abuse. The BOM identified 78 residents resided in the facility. Findings: An abuse, neglect, exploitation or misappropriation policy, revised 04/2021, read in part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management.If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.Immediately is defined as .within two hours of an allegation involving abuse. An admission resident assessment, dated 06/04/25, showed Resident #2's cognition was intact (BIMS 15). The assessment showed the resident exhibited verbal behavioral symptoms directed toward others that significantly disrupted care or the living environment. The assessment showed the resident required supervision or touching assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, sitting to standing, and chair/bed-to-chair transfer. An annual resident assessment, dated 06/16/25, showed Resident #1's cognitive skills for daily decision making were severely impaired per staff assessment for mental status. The assessment showed the resident required substantial/maximum assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, and was dependent on staff for chair to bed transfers. A quarterly resident assessment, dated 06/29/25, showed Resident #4's cognition was severely impaired (BIMS 04). The assessment showed the resident was independent for rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, and walking 10 feet. A nurse progress note, dated 07/25/25 at 3:30 a.m., showed at approximately 3:25 a.m. RN #1 was alerted by another resident (Resident #4) to a situation occurring in their room. Upon entering the room, RN #1 observed concerning behavior between (Resident #1 and Resident #2). RN #1 instructed Resident #2 to stop and leave the area. A CNA (CNA #1) was directed to supervise and escort Resident #2 out of the room while RN #1 contacted the DON for further guidance. The note showed Resident #1 was briefly assessed with no visible injuries noted at the time. The note showed Resident #2 was placed on 1:1 supervision for close monitoring. The note showed the provider on call and facility administration were notified and appropriate reporting procedures were initiated per protocol. An initial facility reported incident, dated 07/25/25, showed the DON and administrator were notified Resident #2 was in Resident #1's room. The reported incident showed the residents were immediately separated and Resident #2 left the property. The reported incident showed Resident #1 was sent to the emergency room for precautionary evaluation. The reported incident showed the police, family, physician, resident's legal representative, and APS were notified. The initial report was received by the state agency on 07/25/25 at 7:14 a.m. Resident #1's hospital records, dated 07/25/25, showed final diagnoses of sexual assault of adult, initial encounter. The hospital records showed a staff member had gone into Resident #1's room on 07/25/25 and found another resident (Resident #2) vaginally penetrating Resident #1. The hospital records showed Resident #1 was nonverbal. The hospital records showed Resident #1 had diagnoses which included anxiety, brain tumor, dementia with behavioral disturbance, and traumatic brain injury. On 07/30/25 at 10:34 a.m., Resident #4 stated they reported, [Resident #2's] laying on top of [Resident #1]. Resident #4 stated when they saw the two residents, Resident #2 told Resident #4 to shut the door, so they did. Resident #4 stated Resident #1 had to be sexually assaulted because [Resident #2] was on top of [Resident #1]. On 07/30/25 at 2:33 p.m., family member #4 stated the first call they received from the facility was on 07/25/25 at 5:57 a.m. Family member #4 stated the regional director of operations informed family member #4 Resident #1 had been sexually assaulted. Family member #4 stated no details were provided from the facility at the time. Family member #4 stated the next call they received was from the hospital to obtain consent for a rape kit. On 07/30/25 at 4:41 p.m., an attempt was made to call and speak with RN #1. RN #1's phone was not accepting calls at the time and did not return the state agency's call. On 07/31/25 at 12:00 a.m., CNA #1 stated if they saw any abuse or neglect, they would report it. They stated they would reach out to the administrator. On 07/31/25 at 12:01 a.m., CNA #1 stated they believed the administrator and DON were responsible for investigating abuse. On 07/31/25 at 12:16 a.m., CNA #1 stated they had gone down to Resident #4's room to get clothes for the resident to put on 07/25/25. They stated when they walked in the room they saw Resident #2 in Resident #1's bed. They stated Resident #1 was in the bed too. They stated no one else was in the room at the time |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edmond Health Care Center | 39 East 33rd Street<br>Edmond, OK 73013 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>(continued on next page) |

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|---|---|---|---|
| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edmond Health Care Center | 39 East 33rd Street<br>Edmond, OK 73013 |

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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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on observation, record review, and interview, the facility failed to complete a thorough investigation after an allegation of abuse for 3 (#1, 2, and #4) of 6 sampled residents reviewed for abuse. The BOM identified 78 residents resided in the facility.Findings: On 07/30/25 at 9:13 a.m., Resident #4 was observed seated on the bed in their room with family member #1 present in the room. On 07/30/25 at 9:28 a.m., the room with Resident #2's name on it was observed. Resident #2's side of the room was free from any personal items from a resident and did not have a resident on that side of the room. On 07/30/25 at 10:10 a. m., Resident #1's name was observed outside the fourth room down from the nurse's station on the right side of hall 300. Resident #1 was not observed inside the room. On 07/30/25 at 10:14 a.m., Resident #1 was observed seated in a standard wheelchair at the beginning of hall 300. Resident #1 was observed wearing a light green shirt with a flower on it, blue/grey pants, and tan skid proof socks on. Resident #1 was able to identify their first name, but was unable to provide any additional information to the surveyor. An abuse, neglect, exploitation or misappropriation policy, revised 04/2021, read in part, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator.Witness statements are obtained in writing, signed, and dated.A significant change resident assessment, dated 04/28/25, showed Resident #7's cognition was intact (BIMS 13).An abuse and neglect policy, dated 05/02/25, read in part, It is the Policy of any [name withheld] Long Term Care managed facility that no resident shall be subject to abuse and/or neglect.All incidents to include suspected resident abuse will be reported to the Administrator and Director of Nursing.Any occurrence of abuse/neglect will be evaluated at the time for removal of a resident to a more appropriate facility.Following the initial verbal investigation, the Administrator will take written statements from all employees, residents, any witness if any, and will determine action to be taken. Administration will evaluate and analyze any occurrence and make any necessary changes that would prevent the situation from recurring in the future. An admission resident assessment, dated 06/04/25, showed Resident #2's cognition was intact (BIMS 15). The assessment showed the resident exhibited verbal behavioral symptoms directed toward others that significantly disrupted care or the living environment. The assessment showed the resident required supervision or touching assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, sitting to standing, and chair/bed-to-chair transfer. An annual resident assessment, dated 06/16/25, showed Resident #1's cognitive skills for daily decision making were severely impaired per staff assessment for mental status. The assessment showed the resident required substantial/maximum assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, and was dependent on staff for chair to bed transfers. A quarterly resident assessment, dated 06/29/25, showed Resident #4's cognition was severely impaired (BIMS 04). The assessment showed the resident was independent for rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, and walking 10 feet. A nurse progress note, dated 07/25/25 at 3:30 a.m., showed at approximately 3:25 a.m., RN #1 was alerted by another resident (Resident #4) to a situation occurring in their room. Upon entering the room, RN #1 observed concerning behavior between (Resident #1 and Resident #2). RN #1 instructed Resident #2 to stop and leave the area. A CNA (CNA #1) was directed to supervise and escort Resident #2 out of the room while RN #1 contacted the DON for further guidance. The note showed Resident #1 was briefly assessed with no visible injuries noted at the time. The note showed Resident #2 was placed on 1:1 supervision for close monitoring. The note showed the provider on call and facility administration were notified and appropriate reporting procedures were initiated per protocol. An initial facility reported incident, dated 07/25/25, showed the DON and administrator were notified Resident #2 was in Resident #1's room. The initial report showed the residents were immediately separated and Resident #2 left the property. The initial report showed Resident #1 was sent to the emergency room for precautionary evaluation. The initial report showed the police, family, physician, resident's legal representative, and APS were notified. The initial report was received by the state agency on 07/25/25 at 7:14 a.m. The final facility reported incident, dated 07/25/25, was received by the state agency on 07/30/25 at 12:12 p.m. The final report contained additional information in the description of the incident. The final report showed at 3:42 a.m., (RN #1) contacted the DON regarding (Resident #2) in (Resident #1's) room and in (Resident #1's) bed. The |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edmond Health Care Center | 39 East 33rd Street<br>Edmond, OK 73013 |

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 0742<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.<br><br>(continued on next page) |

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|---|---|---|---|
| | 375483 | A. Building<br>B. Wing | 08/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edmond Health Care Center | 39 East 33rd Street<br>Edmond, OK 73013 |

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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 0742<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident who had a mental health disorder and observed a traumatic event at the facility [NAME]. a care plan developed that thoroughly described the distress from a person-centered perspective; andb. appropriate interventions in place to address the trauma the resident experienced for 1 (#4) of 6 sampled residents reviewed for abuse. The BOM identified 78 residents resided in the facility.Findings: On 07/30/25 at 9:13 a.m., Resident #4 was observed seated on the bed in their room with family member #1 present in the room. A quarterly resident assessment, dated 06/29/25, showed Resident #4's cognition was severely impaired (BIMS 04). The assessment showed the resident had diagnoses which included bipolar disorder. An initial facility reported incident, dated 07/25/25, showed the DON and administrator were notified Resident #2 was in Resident #1's room. The initial report showed the residents were immediately separated and Resident #2 left the property. The initial report showed Resident #1 was sent to the emergency room for precautionary evaluation. The initial report showed the police, family, physician, resident's legal representative, and APS were notified. The initial report was received by the state agency on 07/25/25 at 7:14 a.m. A final facility reported incident, dated 07/25/25, was received by the state agency on 07/30/25 at 12:12 p.m. The final report contained additional information in the description of the incident. The final report showed at 3:42 a.m., (RN #1) contacted the DON regarding (Resident #2) in (Resident #1's) room and in (Resident #1's) bed. The final report showed staff reported (Resident #2) was in (Resident #1's) room with (Resident #2's) pants halfway pulled down. The final report showed (Resident #2) was on the bed with (Resident #1). The DON notified (RN #1) to immediately separate the residents. (Resident #2) was to be placed on 1:1. (Resident #2) then exited the facility while staff was attempting to talk with them. Police were notified and (Resident #1) was sent to the emergency room for precautionary evaluation. The final report showed staff stayed with (Resident #1) until they left to the emergency room. The final report showed (Resident #1) was transported via ambulance and report was given. When police arrived, (Resident #2) was taken into custody by the police department. The DON notified the administrator at 3:48 a.m. The final report showed (Resident #1's) most recent BIMS was 0/15, required total assistance with ADLs, and had diagnoses which included dementia. The final report showed investigation of the incident revealed staff was present on the hall at 2:42 a.m. giving medication to (Resident #2). At 2:49 a.m., (Resident #2) entered (Resident #1's) room. At 2:52 a.m., (Resident #2) shut (Resident #1's) door. At 3:06 a.m. (Resident #4) heard (Resident #2) enter, got up, and reported to staff (name not provided) that (Resident #2) was in their room. At 3:09 a.m., (RN #1) went down to the room and when they entered, (RN #1) saw (Resident #2) in the bed with (Resident #1) appearing to be engaged in sex. (RN #1) reported they told (Resident #2) to stop and exit the room and (Resident #2) was getting up and attempting to explain what (Resident #2) was doing when (RN #1) exited the room to call the DON. At 3:12 a.m., (CNA #1) walked into (Resident #1's) room and (Resident #2) was still in the bed with (Resident #1). (CNA #1) separated (Resident #2 and #1) and (Resident #2) was placed on 1:1. The police department was contacted by the DON along with the facility administrator. (Resident #2) exited the building while staff was attempting 1:1 supervision with (Resident #2) until the police arrived. The police department escorted (Resident #2) back into the building and took them into custody. (Resident #1's) family was notified of the incident and of the resident being transported to the emergency room. (Resident #1) was sent to the emergency room for evaluation and treatment. A SANE exam was completed. (Resident #1) returned to the facility and was moved to a room closer to the nurse's station for family comfort. Psych NP to see (Resident #1) upon return from the hospital to evaluate and treat as needed. Safe surveys for all resident's completed with each resident. No concerns for safety or incidents of abuse reported. In-service with staff completed, small roundtables completed with staff over abuse types, appropriate interventions related and who to report abuse to. In house counselor made available for staff and residents as needed. Immediate QAPI completed and ongoing QAPI review. (RN #1) suspended indefinitely. Resident #4's care plan, last revised 07/30/25, did not contain information regarding Resident #4 experiencing the traumatic event of seeing their roommate (Resident #1) being raped by Resident #2. The care plan did not include interventions for staff to implement following Resident #4 observing their roommate (Resident #1) being raped by Resident #2. On 07/30/25 at 10:34 a.m., Resident #4 stated they reported, [Resident #2's] laying on top of [Resident #1]. Family Member #1 stated (Resident #1) had been moved out of Resident #4's room. Family Member #1 stated the incident |