STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375487	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAlester Nursing & Rehab	615 E Morris Ave McAlester, OK 74501

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review, and interview, the facility failed to ensure a resident was free from sexual abuse for 1 (#2) of 4 sampled residents reviewed for abuse. The DON identified 43 residents resided in the facility.Findings:1. On 05/18/26 at 12:25 p.m., Resident #2 was observed sitting in a wheelchair in a common area. The resident was clean and dressed for the day. Resident #2 did not verbally respond when spoken to, just smiled. Resident #2 did not have any visible bruises or wounds noted. Staff approached Resident #2 and spoke in a calm pleasant manner. Resident #2 smiled at the staff and did not appear fearful.An undated admission report showed Resident #2 had diagnoses which included frontotemporal neurocognitive disorder, focal traumatic brain injury, cognitive social or emotional deficit, and speech and language deficit.A quarterly assessment for Resident #2, dated 02/24/26, showed the resident had a BIMS of 3 (which indicated they were severely impaired in cognition) and did not have behaviors. 2. An undated admission record showed Resident #1 had diagnoses which included chronic obstructive pulmonary disease, diabetes mellitus, acute respiratory failure, and major depressive disorder.A quarterly assessment for Resident #1, dated 04/09/26, showed the resident had a BIMS of 15 (which indicated they were cognitively intact for daily decision making) and did not have behaviors toward others.A facility video for 05/12/26 at 5:20 p.m. was reviewed on 05/19/26 at 1:35 p.m. The video showed Resident #1 position their motorized wheelchair beside Resident #2's wheelchair in the lobby area. The video showed Resident #1 placed their hand through the open space of the arm rest of Resident #2's wheelchair and touched Resident #2's right breast area. An OSDH initial incident report, dated 05/12/26, showed an allegation of abuse regarding Resident #2 and Resident #1. The report showed CNA #1 witnessed Resident #1 touch Resident #2 on the breast. The report showed the administrator, physician, resident's legal representative, adult protective services, and local law enforcement were notified.An OSDH final incident report, dated 05/12/26, showed residents who were alert and oriented were questioned regarding Resident #1 touching inappropriately or witnessed them touching others inappropriately. The report showed body audits were completed for residents who were not cognitively intact. The report showed no resident verbalized, witnessed, or signs of abuse were noted. The report showed Resident #1 was transported to a psychiatric facility on 05/13/26. The report showed the physician, family, adult protective services, and the local police department was notified of the incident. The report showed a staff in-service regarding abuse and an emergency quality assurance and performance improvement meeting was completed.A Police offense/incident report, dated 05/12/26 at 5:19 p.m., showed a report of sexual assault. The report showed the suspect as Resident #1 and the victim as Resident #2. Facility forms titled 1:1 Monitoring for Resident Safety, dated 05/12/26 at 5:20 p.m. through 05/13/26 at 12:15 p.m., showed Resident #1 was monitored every 15 minutes for behaviors. The forms did not identify behaviors for Resident #1.A form titled Emergency QAPI [quality assurance and performance improvement], dated 05/12/26, showed the problem as Resident #1 touched Resident #2 on the breast. The form showed Resident #1 was immediately monitored 1:1 and a body audit was completed for Resident #2. The form showed a physician order was obtained to send Resident #1 to a psychiatric unit. A nursing progress note for Resident #1, dated 05/13/26 at 12:35 (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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(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 - Few	p.m., showed Resident #1 was discharged to the hospital. Facility forms for skin monitoring, dated 05/13/26, were completed for cognitively impaired residents. Facility survey forms, dated 05/13/26 through 05/14/26, showed residents were surveyed regarding being inappropriately touched or witnessed inappropriate touching.A facility in-service sign in sheet, dated 05/14/26, showed the staff were in-serviced regarding abuse.On 05/18/26 at 2:47 p.m., the administrator stated Resident #1 was not anticipated to return to the facility. The administrator stated if Resident #1 did return to the facility they would be monitored 1:1 with a staff member.On 05/19/26 at 12:24 p.m., CNA #1 was interviewed regarding the incident on 05/12/26. CNA #1 stated they saw Resident #1 touch Resident #2's right breast area over their clothes. CNA #1 stated they removed Resident #1 from the area of Resident #2 and reported the incident immediately to the assistant director of nursing.On 05/19/26 at 1:41 p.m. the DON stated abuse education was on going and was mentioned twice a month with in-services. The DON stated the staff were reminded they only had two hours to report abuse and it was important to notify them immediately. The DON stated Resident #1 had never shown inappropriate sexual actions prior to the incident date.On 05/19/26, direct care staff was interviewed regarding abuse. The staff were able to state types of abuse and the facility policy regarding abuse and reporting abuse.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure the shower curtain was kept clean and ceiling tiles were in good repair for 1 (east hall shower room) of 2 shower rooms observed.The administrator identified 25 residents used the east hall shower room. Findings:On 05/19/26 at 12:39 p.m., the east hall shower room was observed to have a grey and white shower curtain hanging with spots of black discoloration (too numerous to count) and two ceiling tiles with brown rings and water damage.A Laundry and Bedding, Soiled policy, revised 11/2010, read in part, shower linen ie curtains .shall be laundered as needed.A Bathrooms_Showers policy, revised 02/2021, read in part, showers . are cleaned and disinfected daily, shower linen is to be laundered monthly or when residue is noticed in accordance with our established procedures. On 05/19/26 at 12:45 p.m., maintenance #1 stated the black discoloration on the shower curtain looked like mold or mildew.On 05/19/26 at 12:47 p.m., maintenance #1 pointed at the damaged ceiling tiles and stated, Those are water leaks, it's wet right here and right there. They stated, The roof has leaks I only know when we get rain like this.On 05/19/26 at 1:29 p.m., the housekeeping and laundry supervisor stated housekeeping was responsible to ensure the shower curtains were clean. They stated the policy was to wash them and if the stains did not come out, they were discarded and the facility purchased new ones. They stated housekeeping was to check shower rooms and linens daily and ensure they were clean.