STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375554	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Simeons Episcopal Home	3701 Martin Luther King Jr Blvd Tulsa, OK 74106

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 41809 Based on record review and interview, the facility failed to ensure residents were treated with dignity and respect for 1 (#4) of 4 residents who were reviewed for dignity. The administrator identified 78 residents who resided at the facility. Findings: Resident #4 had diagnoses which included mood disorder, PTSD, and anxiety. The five day assessment, dated 01/20/25, showed Resident #4 had a BIMS score of 13 and was cognitively intact for decision making. Review of the care plan, dated 01/31/25, for Resident #4, showed a focus of being dependent on staff for ADLs in toileting hygiene and transfers. Review of the ODH Form 283, dated 02/26/25, showed Resident #4 had alleged allegations of abuse/mistreatment by CNA #1. The form showed on 02/26/25 CNA #2 had reported Resident #4 told them they feared CNA #1 and did not want them to return to their room at night. The form documented Resident #4 stated CNA #1 came to their room to change their wet brief, removed their brief and left them naked to soil the bed and never returned. The form showed CNA#1 had been suspended pending the investigation. On 02/27/25 at 2:34 p.m., Resident #4 stated an incident occurred when a CNA #1 had left them naked in bed. They stated they were pleased CNA #1 had been suspended and that it was unlikely CNA #1 would return. Resident #4 stated CNA #1 was not mean or hurt them, they felt CNA #1 did not like their job. They stated no other CNA had left them like that, just CNA #1. On 03/03/25 at 1:26 p.m., CNA #3 stated they made sure dignity was maintained by ensuring residents were dressed, knocked on their door before entering. On 03/03/25 at 1:53 p.m., LPN #1 stated they ensured residents were treated with dignity and respect by closing doors, taking residents to a private area, knocked on the door, called them by their name or whatever they wanted to be called. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/03/25 at 6:20 p.m., Resident #4 was asked how they felt when the aide left them in bed. Resident #4 stated when CNA #1 left them in the bed, they did not know how it made them feel at that time. Resident #4 stated they did wonder where CNA #1 had gone. Resident #4 stated they guessed they felt abandoned by CNA #1. On 03/04/25 at 3:15 p.m., the CEO/president stated they ensured residents were treated with dignity and respect during on-boarding and training, daily rounding by the director of nursing, assistant director of nursing, nurses, and administration. They stated the residents were provided opportunities to tell administration about their care. The CEO stated nurses were supposed to check on resident care throughout their shift. They stated it was not acceptable for a resident to be left soiled and it definitely did not leave the residents feeling dignified or respected.

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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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41809 Based on record review and interview, the facility failed to ensure residents were free from neglect for 1 (#4) of 4 residents who were sampled and reviewed for neglect. The administrator identified 78 residents who resided at the facility. Findings: Resident #4 had diagnoses which included mood disorder, PTSD, and anxiety. The five day assessment, dated 01/20/25, showed Resident #4 had a BIMS score of 13 and was cognitively intact for decision making The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, read in part, Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; b. neglect of residents. An Identifying Neglect policy, revised September 2022, read in part, Preventing resident neglect is a priority throughout all levels of this organization.Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical pain, mental anguish, or emotional distress.Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them and this has resulted in (or may result in) physical harm, pain mental anguish or emotional distress.Failure to provide supervision ad/or monitoring of the delivery and implementation of care. Review of the care plan, dated 01/31/25, for Resident #4, showed a focus of being dependent on staff for ADLs in toileting hygiene and transfers. Review of the ODH Form 283, dated 02/26/25, showed Resident #4 had alleged allegations of abuse/mistreatment by CNA #1. The form showed on 02/26/25 CNA #2 had reported Resident #4 told them they feared CNA #1 and did not want them to return to their room at night. The form documented Resident #4 stated CNA #1 came to their room to change their wet brief, removed their brief and left them naked to soil the bed and never returned. The form showed CNA#1 had been suspended pending the investigation. On 02/27/25 at 2:34 p.m., Resident #4 stated an incident occurred when a CNA #1 had left them naked in bed. They stated they were pleased CNA #1 had been suspended and that it was unlikely CNA #1 would return. Resident #4 stated CNA #1 was not mean or hurt them, they felt CNA #1 did not like their job. They stated no other CNA had left them like that, just CNA #1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/25 at 3:25 p.m., the administrator stated they started the investigation 02/26/25 and CNA #1 had just come back from a suspension for a previous allegation that they had been unable to corroborate. They stated they provided CNA #1 with a teaching moment and the employee was allowed to return to work, but now there was another abuse allegation and the employee was again suspended. On 03/03/25 at 10:30 a.m., the administrator stated they completed the abuse investigation on 2/28/25. They stated CNA #1 was terminated. They stated the incident was brought before the IDT at the meeting this morning, and staff re-education had began. The administrator stated they would analyze the situation and determine if another process would be needed to monitoring. They stated they had notified the representative and updated them on the outcome of the investigation. The administrator stated there would be a weekly check in with residents for three months to ensure no further incidents of abuse and the social services person would be asking about abuse and quality of care during future care plan meetings. They stated any issues would be reported to them immediately. They stated all findings would be discussed during the daily IDT meetings Monday through Friday and addressed at the quality assurance meetings which were held quarterly. The administrator stated they were unable to get an interview with the staff, because once the staff member was suspended they no longer answered their phone. On 03/03/25 at 6:14 p.m., CNA #4 stated they had found Resident #4 at the start of their day shift on 02/26/25, sitting on the side of their bed that was raised too high. They stated Resident #4 stated they were waiting for CNA #1 to return. CNA #4 stated it was unusual because their bed should be in a low position. They stated they did not know what time CNA #1 had entered or left the room of Resident #4. CNA #4 stated Resident #4 was dressed and wearing a brief, was wet but not overly wet. On 03/03/25 at 6:20 p.m., Resident #4 was asked how they felt when the aide left them in bed. Resident #4 stated when CNA #1 left them in the bed, they did not know how it made them feel at that time. Resident #4 stated they did wonder where CNA #1 had gone. Resident #4 stated they guessed they felt abandoned by CNA #1 because they needed to be changed. On 03/04/25 at 12:19 p.m., CNA #2 stated the incident when Resident #4 was left without a brief by CNA #1 was a prior incident and could not remember the date. They stated they worked the evening shift before CNA #1 and their shifts overlapped by 30 minutes. CNA #2 stated during the 30 minute overlap, CNA #1 would take over the hall and answer the call lights so they could complete their charting for the evening shift. CNA #2 stated they observed CNA #1 was slow in answering the call lights. On 03/04/25 at 3:15 p.m., the CEO/president stated they expected requested care to be provided. They stated interrupted care that was left incomplete for 30 - 45 minutes did not meet their expectations. They stated a resident left soiled fell into neglect.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41809 Based on record review and interview, the facility failed to ensure assistance with activities of daily living was provided for 1 (#4) of 4 residents who were reviewed for ADL assistance. The administrator identified 78 residents who resided in the facility. Findings: Resident #4 had diagnoses which included fracture of neck of left femur, fracture of left pubis and glaucoma. The five day assessment, dated 01/20/25, showed Resident #4 had a BIMS score of 13 and was cognitively intact for decision making. A care plan, revised 01/29/25, showed Resident #4 was dependent for toileting hygiene. On 02/27/25 at 2:34 p.m., Resident #4 stated an incident occurred when a CNA #1 had left them naked in bed. They stated they were pleased CNA #1 had been suspended and that it was unlikely CNA #1 would return. Resident #4 stated CNA #1 was not mean or hurt them, they felt CNA #1 did not like their job. They stated no other CNA had left them like that, just CNA #1. On 03/03/25 at 6:14 p.m., CNA #4 stated they had found Resident #4 at the start of their day shift on 02/26/25, sitting on the side of their bed that was raised too high. They stated Resident #4 stated they were waiting for CNA #1 to return. CNA #4 stated it was unusual because their bed should be in a low position. They stated they did not know what time CNA #1 had entered or left the room of Resident #4. CNA #4 stated Resident #4 was dressed and wearing a brief, was wet but not overly wet. On 03/03/25 at 6:20 p.m., Resident #4 was asked how they felt when the aide left them in bed. Resident #4 stated when CNA #1 left them in the bed, they did not know how it made them feel at that time. Resident #4 stated they did wonder where CNA #1 had gone. Resident #4 stated they guessed they felt abandoned by CNA #1 because they needed to be changed. On 03/04/25 at 12:19 p.m., CNA #2 stated the incident when Resident #4 was left without a brief by CNA #1 was a prior incident and could not remember the date. They stated they worked the evening shift before CNA #1 and their shifts overlapped by 30 minutes. CNA #2 stated during the 30 minute overlap, CNA #1 would take over the hall and answer the call lights so they could complete their charting for the evening shift. CNA #2 stated they observed CNA #1 was slow in answering the call lights. On 03/04/25 at 3:15 p.m., the CEO/president stated they expected requested care to be provided. They stated interrupted care that was left incomplete for 30 - 45 minutes did not meet their expectations.