STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375582	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Healthcare and Rehab	1530 NE Grand Blvd Oklahoma City, OK 73117

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. On 05/28/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents were free from verbal abuse and failure to implement interventions to protect residents from physical abuse. An admission resident assessment, dated 12/18/24, showed Resident #3's cognition was intact (BIMS 15). A quarterly resident assessment, dated 01/15/25, showed Resident #5's cognition was intact (BIMS 15). A quarterly resident assessment, dated 01/25/25, showed Resident #4's cognition was intact (BIMS 13). A facility reported incident, dated 02/28/25, showed an allegation of abuse/mistreatment involving Resident #3, Resident #4, and Resident #5. The reported incident showed at approximately 6:00 p.m., the residents were outside smoking when an alleged altercation involving threats of physical harm occurred between residents. The reported incident showed Resident #3 made verbal threats of physical harm to Resident #5. Resident #4 became upset and allegedly made threats of physical harm to Resident #3. Residents #3 and #4 were immediately separated and placed on 1:1 for the protection of all residents. The reported incident showed residents were placed on 1:1 for the duration of the investigation. The reported incident showed care plans were updated as appropriate. The reported incident showed Resident #3 was sent out for a geri-psych evaluation and their care plan would be revised as needed upon return. The reported incident showed staff were re-educated on the signs and symptoms of abuse, and the policies and procedures for reporting abuse, neglect, and misappropriation. The final facility reported incident was faxed to OSDH on 03/05/25 at 3:50 p.m. There were no updates to Resident #3 or Resident #4's care plan regarding the above incident. The facility did not provide documentation of 1:1 provided for each shift for the duration of the investigation. The facility did not provide documentation of staff having been in-serviced related to abuse, neglect, and misappropriation as documented in the facility reported incident. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	An incident note, effective 02/28/25 at 7:30 p.m. showed it was reported to LPN #1 Resident #4 verbally threatened another resident with bodily harm. The resident stated, I will kick your [explicit]. Resident #4 separated from other residents until they went to bed. A behavior note, dated 02/28/25 at 8:44 p.m., showed Resident #3 was being observed 1:1 by the previous DON due to an alleged incident of verbal threats of physical harm to another resident. While sitting in this nurse's office, Resident #3 went into their purse and retrieved a small 1 ½ inch knife. The previous DON asked Resident #3 for the knife and the resident refused. The previous DON then informed the resident that it was illegal to posses a knife on the property. Resident #3 then attempted to jab knife at this nurse while simultaneously handing the knife to the previous DON. An incident note, effective 02/28/25 at 9:50 p.m., showed it was reported to LPN #2 Resident #3 was threatening another resident with bodily harm. They stated, ILL [SIC] WILL SET YOU ON FIRE AND HAVE SOMEONE SHOOT YOU IN THE HEAD. The note showed the resident was separated and placed on 1:1 until EMSA arrived. A behavior note, dated 03/01/25 at 8:47 p.m., showed Resident #3 continued to display verbal outbursts including yelling directed towards staff and other residents. A behavior note, dated 03/03/25 at 9:53 a.m., showed staff spoke with Resident #3 regarding their aggressive behaviors and them pulling a knife on the nurse. The resident admitted they did it and agreed to go to the hospital for treatment. On 05/28/25 at 2:02 p.m., LPN #2 stated at the time of the incident on 02/28/25, Resident #3 was very verbally aggressive with other residents and making threats. LPN #2 stated at the time of the incident, Resident #3 stated to Resident #5, I'll beat your [explicit] and burn you up. LPN #2 stated Resident #3 stated they would call a family member to kill Resident #5. They stated Resident #3 was placed on one on one and had additional incidents. LPN #2 stated on one incident Resident #3 pulled a knife on the former DON and the wound care nurse. They stated staff were able to get the knife away and sent the resident out for a psychiatric evaluation. LPN #2 stated Resident #3 had the knife hidden in their purse. On 05/28/25 at 2:07 p.m., LPN #1 stated on 02/28/25 Resident #3 was yelling at Resident #5 and Resident #4 was taking up for Resident #5. They stated the residents were separated and Resident #3 was in the former DONs office when the resident pulled out a knife and acted like they were going to stab the former DON. They stated the facility tried to get Resident #3 sent out for evaluation. On 05/28/25 at 3:51 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 05/28/25 at 4:00 p.m., the administrator and DON were notified of the IJ situation and provided the IJ template. On 05/30/25 at 5:01 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Deficiency Summary: Resident #3 made verbal threats of physical harm to Resident #5. Resident #4 became upset at Resident #3 and allegedly made verbal threats of physical harm to Resident #3 which had the potential to put Resident #3 and Resident #5 at risk of serious harm or death. This continues to be a hazard for all residents in the facility. 1. Immediate Action Taken: a. Resident #3 and Resident #4 were immediately separated from other residents at the time of incident. b. Resident #3 was immediately placed on 'One on One' with Protection of Resident until [they] was transferred to Geri-Psych for evaluation and treatment. c. Resident #4 was immediately placed on 'One on One' with Protection of Resident until he was evaluated and treated by Geri-Psych. d. Resident #3 and Resident #4 care plans were reviewed and updated. 2. Systemic Changes Implemented: a. Change in Director of Nursing on 4/28/2025. b. QA - The following Performance Improvement Plan (PIPs) were developed through QA: i. Documentation/Charting on 5/9/2025 ii. Care Plans on 5/9/2025 iii. Employee Orientation on 5/9/2025 iv. Grievances on 5/14/2025 v. Clinical concerns on 5/28/2025 c. Staff were educated on 'One on One' with Protection of Resident on 05/28/2025. d. Staff were educated on 'One on One' with Protection of Resident documentation on 05/28/2025. e. Firearm and Weapon Prohibition Policy updated to specifically include knives 3. Education and Training a. In-service of all staff on the following: Completed on 5/28/2025 i. Abuse, Neglect, and Exploitation Policy. - inclusive of threatening behaviors and no weapons including knives. ii. Firearm and Weapon Prohibition Policy Update for residents - includes knives (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	iii. Firearm and Weapon Prohibition Policy Update for staff - includes knives iv. 'One on One' with Protection of Resident. v. 'One on One' with Protection of Resident documentation [sic]. b. In-service of all members of nurse management on the following: Completed on 5/28/2025 i. Care Plan Development. Facility will be in compliance on 5-30-2025 at 8:00 am. On 06/02/25 at 9:46 a.m., CNA #5 stated they had not received any recent training or in-services. They stated they were new and their second day of work was Thursday 05/29/25. They stated they had not received any information regarding 1:1 or weapons. On 06/02/25 at 11:36 a.m., the DON stated CNA #5 was brand new. The DON stated CNA #5 was not on the list of who completed the training for the plan of removal because they were new. On 06/02/25 at 11:38 a.m., the DON stated CNA #5 trained with CNA #3 on 05/28/25 and on 05/29/25. The DON stated CNA #5 would receive the training related to the POR today 06/02/25. On 06/02/25 at 11:58 a.m., the administrator provided documentation of CNA #5 completing abuse training on 05/16/25. The administrator stated CNA #5's hire date was 05/16/25 and they had not been on the floor since Thursday, 05/29/25. In-service sheets for abuse and neglect, no knives, guns, ammunition, explosives, on the premises, and supervising a resident who was on 1:1, were all dated 06/02/25 at 12:30 p.m., and were signed as completed by CNA #5. The IJ was lifted, effective 06/02/25 at 12:30 p.m., when all components of the plan of removal had been verified as completed. This was verified by staff interviews, review of in-service information, and a review of resident records to ensure interventions were in place for residents who exhibited threatening behaviors and what the facility was to do when there was a knife concern. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on observation, record review, and interview, the facility failed to: a. ensure residents were free from verbal abuse for 3 (#3, 4 and #5) of 5 sampled residents reviewed for abuse; b. implement interventions to protect residents from potential physical abuse for 1 (#3) of 5 sampled residents reviewed for abuse; and c. ensure residents were free from neglect for 1 (#1) of 5 sampled residents reviewed for abuse. The DON and the regional clinical director identified 51 residents resided in the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings: A firearm and weapon prohibition policy, dated 2024, read in part, A safe and secure environment is fundamental for fulfilling our company's mission of providing medical care and related health care services. Our company is committed to maintaining a safe workplace that is free of violence.To prevent the unauthorized possession of weapon(s) while on company premises .Any employee who becomes aware of a violation of this policy is required to immediately notify his/her supervisor of such violation .Violation of this policy is considered a serious offense that endangers the safety of our patients, staff, and visitors. Therefore, this offense may result in termination of employment (Staff), discharge from facility (Resident), and criminal prosecution. An abuse, neglect, and exploitation policy, dated 2025, read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Establish policies and procedures to investigate any such allegation .Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures .Establish coordination with the QAPI [Quality Assessment and Performance Improvement] program .Employee Training .Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as .Aggressive and/or catastrophic reactions of residents . Outbursts or yelling out .The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.Possible indicators of abuse include, but are not limited to .Verbal abuse of a resident overheard .Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning [and] repositioning.Protection of Resident .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.Responding immediately to protect the alleged victim .Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed .Increased supervision of the alleged victim and residents .Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator .Providing emotional support and counseling to the resident during and after the investigation, as needed .Revision of the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse .This coordinated effort results in the QAA [Quality Assessment and Assurance] Committee determining .If a thorough investigation is completed .Whether the resident is protected .Whether an analysis was conducted as to why the situation occurred .Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors). (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility reported incident, dated 02/28/25, showed an allegation of abuse/mistreatment involving Resident #3, Resident #4, and Resident #5. The reported incident showed at approximately 6:00 p.m., the residents were outside smoking when an alleged altercation involving threats of physical harm occurred between residents. The reported incident showed Resident #3 made verbal threats of physical harm to Resident #5. Resident #4 became upset and allegedly made threats of physical harm to Resident #3. Residents #3 and #4 were immediately separated and placed on 1:1 for the protection of all residents. The reported incident showed residents were placed on 1:1 for the duration of the investigation. The reported incident showed care plans were updated as appropriate. The reported incident showed Resident #3 was sent out for a geri-psych evaluation and their care plan would be revised as needed upon return. The reported incident showed staff were re-educated on the signs and symptoms of abuse, and the policies and procedures for reporting abuse, neglect, and misappropriation. The final facility reported incident was faxed to OSDH on 03/05/25 at 3:50 p.m. The facility did not provide documentation of staff having been in-serviced related to abuse, neglect, and misappropriation as documented in the facility reported incident. The facility did not provide documentation of 1:1 provided for each shift for the duration of the investigation. The daily staffing sheets showed: a. on 03/01/25 1:1 was assigned for Resident #3 and Resident #4 for the 3:00 p.m. to 11:00 p.m. shift. There was no documentation 1:1 was assigned for the 7:00 a.m. to 3:00 p.m. or the 11:00 p.m. to 7:00 a.m. shift; b. on 03/02/25 1:1 was assigned Resident #3 and Resident #4 for the 3:00 p.m. to 11:00 p.m. shift. One staff member was assigned 1:1 for the 7:00 a.m. to 3:00 p.m. shift but it did not document what resident they were assigned to. There was no documentation 1:1 was assigned for the 11:00 p.m. to 7:00 a.m. shift; and c. on 03/03/25 there was no documentation 1:1 was assigned for Resident #4 for the 3:00 p.m. to 11:00 p.m. shift or the 11:00 p.m. to 7:00 a.m. shift. Resident #4 was still in the facility and had not yet been evaluated by mental health services. There were no updates to Resident #3 or Resident #4's care plan regarding the above incident. 1. On 05/28/25 at 2:20 p.m., Resident #3 was observed lying in their bed in their room watching television. The resident began voicing concerns with wanting to get out of the facility. An admission resident assessment, dated 12/18/24, showed Resident #3's cognition was intact (BIMS 15). The assessment showed Resident #3 had diagnoses which included depression, anxiety disorder, and schizophrenia. A behavior note, dated 02/28/25 at 8:44 p.m., showed Resident #3 was being observed 1:1 by the previous DON due to an alleged incident of verbal threats of physical harm to another resident. While sitting in this nurse's office, Resident #3 went into their purse and retrieved a small 1 ½ inch knife. The previous DON asked Resident #3 for the knife and the resident refused. The previous DON then informed the resident that it was illegal to posses a knife on the property. Resident #3 then attempted to jab knife at this nurse while simultaneously handing the knife to the previous DON. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An incident note, effective 02/28/25 at 9:50 p.m., showed it was reported to LPN #2 Resident #3 was threatening another resident with bodily harm. They stated, ILL [SIC] WILL SET YOU ON FIRE AND HAVE SOMEONE SHOOT YOU IN THE HEAD. The note showed the resident was separated and placed on 1:1 until EMSA arrived. A behavior note, dated 03/01/25 at 8:47 p.m., showed Resident #3 continued to display verbal outbursts including yelling directed towards staff and other residents. A behavior note, dated 03/03/25 at 9:53 a.m., showed staff spoke with Resident #3 regarding their aggressive behaviors and them pulling a knife on the nurse. The resident admitted they did it and agreed to go to the hospital for treatment. Behavioral health hospital records, dated 03/03/25 through 03/14/25, showed Resident #3's presenting problem was they threatened a staff member with a knife. The records showed the reason for Resident #3's admission was they were a danger to others and had severe mood symptoms. The record showed key factors contributing to admission were increased aggression and violent behavior. 2. A quarterly resident assessment, dated 01/15/25, showed Resident #5's cognition was intact (BIMS 15). The assessment showed Resident #5 had diagnoses which included heart failure and hypertension. An order note, dated 02/28/25 at 9:58 p.m., showed LPN #2 was informed Resident #5 was threatened bodily harm by another resident. The note showed another resident told Resident #5 they would set the resident on fire and have someone shoot them in the head. The note showed the resident was checked for bodily harm. 3. A quarterly resident assessment, dated 01/25/25, showed Resident #4's cognition was intact (BIMS 13). The assessment showed Resident #4 had diagnoses which included hypertension, aphasia following cerebral infarction, parkinsonism, and history of traumatic brain injury. An incident note, effective 02/28/25 at 7:30 p.m., showed it was reported to LPN #1 Resident #4 verbally threatened another resident with bodily harm. The resident stated, I will kick your [explicit]. Resident #4 was separated from other residents until they went to bed. A mental health provider note for Resident #4, dated 03/04/25, read in part, resident reportedly threatened another resident (per another resident) with bodily harm saying 'I will kick your [explicit]'. This was after [they] heard the resident threatening another resident with bodily harm including having someone shoot them. [Resident #4] reports today that [they] would never hurt a woman and [they] has no feeling of wanting to hurt anyone. What [they] was doing, [they] relates, was trying to get this [resident] to hit [them] to show that [they] is violent. [They] reports that this resident often verbally abuses one particular resident and [they] were tired of it.today reports [they] is 'over' the situation that prompted [their] 1:1, and that [they] never intended to hurt anyone and does not want to hurt anyone or end their life.[They] does voice understanding of [their] behaviors and that words have certain outcomes in a tightly ran facility that has to follow many guidelines per state.I do not see the need for 1:1 to continue at this time. The note was signed on 03/04/25 by PA #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/23/25 at 1:01 p.m., CNA #4 stated they had received abuse education about a month ago. They stated they watched for verbal abuse, physical abuse, and neglect of patient care. They stated they would notify the administrator if abuse/neglect was observed or reported to them. On 05/23/25 at 1:07 p.m., CNA #2 stated they had received education on abuse and neglect. They stated they watched for every form of abuse including yelling, facial expressions, hand motions, anything that made a resident feel uncomfortable. They stated they would notify their charge nurse and DON if abuse/neglect was observed or reported to them. On 05/23/25 at 1:15 p.m., CNA #3 stated they were unsure of the last education they received regarding abuse/neglect. They stated they believed it was around January 2025. They stated they had not observed any signs or symptoms of abuse or neglect in the facility. They stated if abuse was observed or reported to them, they would contact the charge nurse immediately. On 05/23/25 at 1:19 p.m., ACMA #1 stated they had received education on abuse/neglect a couple Fridays ago. They stated they observed for financial, verbal, physical abuse, and misappropriation. They stated they would report any concerns with abuse/neglect to their nurse, DON, and administrator. On 05/23/25 at 1:22 p.m., LPN # 3 stated they had received education related to abuse/neglect multiple times. They stated they observed for emotional, spiritual, and physical abuse. They stated if abuse/neglect was observed or reported to them, they would notify their supervisor, complete an incident report, and ensure everything was documented. On 05/23/25 at 1:24 p.m., LPN #4 stated they had received an in-service last Friday on abuse/neglect. They stated they monitored for resident to resident abuse, staff to resident abuse, and resident to staff abuse. They stated if they observed abuse or it was reported to them, they would first remove the stressor, then report it to the DON and administrator who was the abuse coordinator. On 05/28/25 at 11:22 a.m., Resident #4 stated they had previously had an incident with Resident #3. They stated Resident #3 was cussing at Resident #5 and Resident #4 stated they told Resident #3 to quit. On 05/28/25 at 11:49 a.m., ACMA #1 stated they remembered Resident #3 talking smack on the day of the incident. They stated it was Resident #3 and Resident #5. They stated Resident #4 stepped in and they were talking about viscous stuff, setting people on fire, and killing them. They stated Resident #3 said it to Resident #5. ACMA #1 stated they heard them yelling initially. ACMA #1 stated Resident #3 said [explicit], shut the [explicit] up, I will set your [explicit] on fire. They stated Resident #5 said Don't nobody like your ugly [explicit]. ACMA #1 stated Resident #4 said they would beat Resident #3 up. They stated nobody touched anyone, it was all verbal and heated. ACMA #1 stated they tried to separate them and hollered for the nurse. They stated Resident #3 and #4 were placed on 1:1. ACMA #1 stated the only other staff present at the time no longer worked at the facility. On 05/28/25 at 12:23 p.m., the administrator stated when they were made aware of an allegation of abuse or neglect, they would immediately make sure the residents were safe. They stated staff would notify the abuse coordinator who was the administrator, and they would ensure statements were obtained and the resident was assessed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/28/25 at 12:24 p.m., the administrator stated the responsible party, DON, physician, and depending on what happened, psych services would be notified of an allegation of abuse or neglect. On 05/28/25 at 12:26 p.m., the administrator stated in the abuse allegation involving Residents #3, #4, and #5, the residents were outside smoking and got into a verbal altercation. They stated Resident #4 thought Resident #3 was calling them names. They stated Resident #3 started yelling at Resident #5. The administrator stated Resident #4 approached Resident #3 and told them they were tired of the name calling. The administrator stated staff were present and immediately separated the residents. They stated the physician was notified and Resident #3 and #4 were put on 1:1 observations. On 05/28/25 at 12:29 p.m., the administrator stated they completed an initial reportable incident form and interviewed residents and staff. They stated assessments were completed and the records were reviewed. They stated senior psych services were contacted for an evaluation and medication review. They stated Residents #3, #4, and #5 showed no signs or symptoms of abuse or distress. The administrator stated Resident #3 was admitted for psych services. They stated Resident #3 remained on 1:1 until they were admitted and there were no other incidents. On 05/28/25 at 12:37 p.m., the administrator and the DON were asked to review the behavior note dated 02/28/25 which discussed Resident #3 taking a knife out of their purse and attempting to jab at the former DON. They were asked what the facility did in response to Resident #3's knife incident. The DON stated staff got the knife from the resident. On 05/28/25 at 1:48 p.m., the DON and administrator were asked how the facility was ensuring Resident #3 did not obtain a knife and attempt to use it again. The administrator stated Resident #3 had no family or friends and did not go anywhere. The DON stated staff should not be carrying anything like that on their person or in their purse. The administrator stated they did not know how Resident #3 got a knife. The DON stated they were not at the facility at the time of the incident and did not know how the resident got a knife. On 05/28/25 at 1:51 p.m. the administrator stated they were not in the building at the time of the knife incident. They stated they did not know about the knife incident at the time. They stated they did not recall when they were made aware of the knife incident. On 05/28/25 at 1:52 p.m., the administrator stated they could not answer for who was providing 1:1 for the 7:00 a.m. to 3:00 p.m. or the 11:00 p.m. to 7:00 a.m. shift on 03/01/25. They stated they would look for additional documentation of who was assigned 1:1 for the other dates and to see if the resident had a roommate for the 11:00 p.m. to 7:00 a.m. shift. On 05/28/25 at 2:02 p.m., LPN #2 stated at the time of the incident on 02/28/25, Resident #3 was very verbally aggressive with other residents and making threats. LPN #2 stated at the time of the incident, Resident #3 stated to Resident #5, I'll beat your [explicit] and burn you up. LPN #2 stated Resident #3 stated they would call a family member to kill Resident #5. They stated Resident #3 was placed on one on one and had additional incidents. LPN #2 stated on one incident Resident #3 pulled a knife on the former DON and the wound care nurse. They stated staff were able to get the knife away and sent the resident out for a psychiatric evaluation. LPN #2 stated Resident #3 had the knife hidden in their purse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375582	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Healthcare and Rehab	1530 NE Grand Blvd Oklahoma City, OK 73117

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/28/25 at 2:07 p.m., LPN #1 stated on 02/28/25 Resident #3 was yelling at Resident #5 and Resident #4 was taking up for Resident #5. They stated the residents were separated and Resident #3 was in the former DON's office when the resident pulled out a knife and acted like they were going to stab the former DON. They stated the facility tried to get Resident #3 sent out for evaluation. 4. An admission resident assessment, dated 04/07/25, showed Resident #1 was dependent on staff for toileting hygiene and lower body dressing and required substantial/maximum assistance for oral hygiene, upper body dressing, and personal hygiene. The cognition part of the assessment was incomplete. A facility reported incident, dated 05/16/25, showed an allegation of abuse/mistreatment and an allegation of neglect involving Resident #1 and CNA #6. The reported incident showed Resident #1 stated CNA #6 was mean to them. They stated, When I push my call light the CNA comes in and says what do you want with a mean tone. The reported incident showed Resident #1 told CNA #6 they needed to be changed and CNA #6 stated, I only have to change you every [two] hours and you have to urinate more before I change you. The reported incident showed Resident #1 could only separate their legs partially and stated CNA #6 forcefully pulled their legs apart which caused a great deal of pain. The reported incident showed Resident #1 reported it was not the first time CNA #6 was mean to them and they did not feel safe with CNA #6 in the building. The reported incident showed CNA #6 was terminated effective immediately. The report was completed by the DON. A BIMS evaluation, dated 05/26/25, showed Resident #1's cognition was intact (BIMS score 15). On 05/23/25 at 10:18 a.m., Resident #1 stated they had asked CNA #6 to change them. They stated the CNA informed them We only change you every two hours. Resident #1 stated CNA #6 reported, So I'm not going to change you until five o'clock. Resident #1 stated five o'clock passed so they pushed their call light. They stated CNA #6 came in huffing and puffing and said just because they said they would change them at five did not mean they would be in right at five. CNA #6 stated, I'll change you when I get the chance. Resident #1 stated CNA #6 started hollering and pointing their finger in their face. They stated CNA #6 told them they were not the only resident they had to take care of. Resident #1 stated they left the room and slammed the door. On 05/23/25 at 10:23 a.m., Resident #1 stated CNA #6 came back shortly after and was extremely rough when they changed them. They stated the CNA held their leg down with what felt like Extreme pressure. Resident #1 stated they received a lot of fluid through a feeding tube and urinated frequently. On 05/23/25 at 10:26 a.m., Resident #1 stated the DON had spoken to them again today and asked if they were comfortable with CNA #6 returning to work. Resident #1 stated if CNA #6 did that to them, who else would they do it to. They stated they would hate to find out they mistreated a resident who was unable to speak up for themselves. On 05/23/25 at 1:15 p.m., CNA #3 stated they had been at the facility about four months and were not sure of any abuse/neglect allegations involving Resident #1. On 05/23/25 at 1:19 p.m., ACMA #1 stated they were not aware of any abuse/neglect allegations involving Resident #1. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/23/25 at 1:24 p.m., LPN #4 stated Resident #1 was talking with them in their room while they were completing a treatment. They stated the resident reported one of the CNAs only changed them every two hours and would fuss when they had to go in the resident's room. They stated it was a night shift aide. LPN #4 stated they reported it to the DON and were unsure of the findings of the investigation. On 05/23/25 at 1:33 p.m., the DON stated if abuse or neglect was reported to them, they would immediately suspend the staff member involved. They stated they would start the initial state reportable and if applicable notify the nurse aide registry. The DON stated they would have social services go in with a form to at least 50 percent of the residents on the hall and survey them without coaxing them. The DON stated they would then speak with staff and gather all their information before completing the final report. They stated based on the investigation findings, they determined what action to take. The DON stated in regards to the abuse allegation involving Resident #1, they went back and spoke to the resident. The DON stated based on their discussion, they did not feel it would not happen again to another resident if CNA #6 returned to work. The DON stated they terminated CNA #6. The DON stated it was their first time to complete an abuse allegation. On 05/23/25 at 1:36 p.m., the DON stated they monitored for signs of abuse such as missing money, how a resident was spoken to, the way they were cared for, and the way staff were treating residents overall. They stated if a resident stated they needed to be changed, staff were to change them. The DON stated they did not care if the resident was changed two minutes ago, even if the brief was bone dry, they stated it didn't matter because this is the resident's home not theirs. On 05/23/25 at 1:38 p.m., the DON[TRUNCATED]

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	375582	A. Building B. Wing	06/02/2025

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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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report an allegation of abuse to local law enforcement for 3 (#3, 4 and #5) of 5 sampled residents reviewed for abuse. The DON and the regional clinical director identified 51 residents resided in the facility. Findings: An abuse, neglect, and exploitation policy, dated 2025, read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Law enforcement is the full range of potential responders to elder abuse, neglect, and exploitation including: police .Establish policies and procedures to investigate any such allegation .Reporting of all alleged violation to the Administrator, state agency, adult protective services, and to all other required agencies (e.g. law enforcement when applicable). A facility reported incident, dated 02/28/25, showed an allegation of abuse/mistreatment involving Resident #3, Resident #4, and Resident #5. The reported incident showed at approximately 6:00 p.m., the residents were outside smoking when an alleged altercation involving threats of physical harm occurred between residents. The reported incident showed Resident #3 made verbal threats of physical harm to Resident #5. Resident #4 became upset and allegedly made threats of physical harm to Resident #3. Residents #3 and #4 were immediately separated and placed on 1:1 for the protection of all residents. The reported incident showed residents were placed on 1:1 for the duration of the investigation. The reported incident showed care plans were updated as appropriate. The reported incident showed Resident #3 was sent out for a geri-psych evaluation and their care plan would be revised as needed upon return. The reported incident showed staff were re-educated on the signs and symptoms of abuse, and the policies and procedures for reporting abuse, neglect, and misappropriation. The final facility reported incident was faxed to OSDH on 03/05/25 at 3:50 p.m. There was no documentation law enforcement was made aware of this allegation of abuse. 1. An admission resident assessment, dated 12/18/24, showed Resident #3's cognition was intact (BIMS 15). The assessment showed Resident #3 had diagnoses which included depression, anxiety disorder, and schizophrenia. A behavior note, dated 02/28/25 at 8:44 p.m., showed Resident #3 was being observed 1:1 by the previous DON due to alleged incident of verbal threats of physical harm to another resident. While sitting in this nurse's office, Resident #3 went into their purse and retrieved a small 1 ½ inch knife. The previous DON asked Resident #3 for the knife and the resident refused. The previous DON then informed the resident that it was illegal to posses a knife on the property. Resident #3 then attempted to jab knife at this nurse while simultaneously handing the knife to the previous DON. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An incident note, effective 02/28/25 at 9:50 p.m., showed it was reported to LPN #2 Resident #3 was threatening another resident with bodily harm. They stated, ILL [SIC] WILL SET YOU ON FIRE AND HAVE SOMEONE SHOOT YOU IN THE HEAD. It showed the resident was separated and placed on one 1:1 until EMSA arrived. A behavior note, dated 03/01/25 at 8:47 p.m., showed Resident #3 continued to display verbal outbursts including yelling directed towards staff and other residents. A behavior note, dated 03/03/25 at 9:53 a.m., showed staff spoke with Resident #3 regarding their aggressive behaviors and them pulling a knife on the nurse. The resident admitted they did it and agreed to go to the hospital for treatment. Behavioral health hospital records, dated 03/03/25 through 03/14/25, showed Resident #3's presenting problem was they threatened a staff member with a knife. The records showed the reason for Resident #3's admission was they were a danger to others and had severe mood symptoms. The records showed key factors contributing to admission were increased aggression and violent behavior. 2. A quarterly resident assessment, dated 01/15/25, showed Resident #5's cognition was intact (BIMS 15). The assessment showed Resident #5 had diagnoses which included heart failure and hypertension. An order note, dated 02/28/25 at 9:58 p.m., showed LPN #2 was informed Resident #5 was threatened bodily harm by another resident. The note showed another resident told Resident #5 they would set the resident on fire and have someone shoot them in the head. The note showed the resident was checked for bodily harm. 3. A quarterly resident assessment, dated 01/25/25, showed Resident #4's cognition was intact (BIMS 13). The assessment showed Resident #4 had diagnoses which included hypertension, aphasia following cerebral infarction, parkinsonism, and history of traumatic brain injury. An incident note, effective 02/28/25 at 7:30 p.m., showed it was reported to LPN #1 Resident #4 verbally threatened another resident with bodily harm. The resident stated, I will kick your [explicit]. Resident #4 separated from other residents until they went to bed. A mental health provider note for Resident #4, dated 03/04/25, read in part, resident reportedly threatened another resident (per another resident) with bodily harm saying 'I will kick your [explicit]'. This was after [they] heard the resident threatening another resident with bodily harm including having someone shoot them. [Resident #4] reports today that [they] would never hurt a woman and [they] has no feeling of wanting to hurt anyone. What [they] was doing, [they] relates, was trying to get this [resident] to hit [them] to show that [they] is violent. [They] reports that this resident often verbally abuses one particular resident and [they] were tired of it.today reports [they] is 'over' the situation that prompted [their] 1:1, and that [they] never intended to hurt anyone and does not want to hurt anyone or end their life.[They] does voice understanding of [their] behaviors and that words have certain outcomes in a tightly ran facility that has to follow many guidelines per state.I do not see the need for 1:1 to continue at this time. The note was signed on 03/04/25 by PA #1. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/25 at 11:22 a.m., Resident #4 stated they had previously had an incident with Resident #3. They stated Resident #3 was cussing at Resident #5 and Resident #4 stated they told Resident #3 to quit. On 05/28/25 at 11:49 a.m., ACMA #1 stated they remembered Resident #3 talking smack on the day of the incident. They stated it was Resident #3 and Resident #5. They stated Resident #4 stepped in and they were talking about viscous stuff, setting people on fire, and killing them. They stated Resident #3 said it to Resident #5. ACMA #1 stated they heard them yelling initially. They stated Resident #3 said [explicit], shut the [explicit] up, I will set your [explicit] on fire. They stated Resident #5 said Don't nobody like your ugly [explicit]. ACMA #1 stated Resident #4 said they would beat Resident #3 up. They stated nobody touched anyone, it was all verbal and heated. ACMA #1 stated they tried to separate them and hollered for the nurse. They stated Resident #3 and #4 were placed on 1:1. ACMA #1 stated the only other staff present at the time no longer worked at the facility. On 05/28/25 at 12:23 p.m., the administrator stated when they were made aware of an allegation of abuse or neglect, they would immediately make sure the residents were safe. They stated staff would notify the abuse coordinator who was the administrator, and they would ensure statements were obtained and the resident was assessed. On 05/28/25 at 12:24 p.m., the administrator stated the responsible party, DON, physician, and depending on what happened, psych services would be notified of an allegation of abuse or neglect. The administrator stated law enforcement would be notified if a resident agreed to have them notified. On 05/28/25 at 12:26 p.m., the administrator stated in the abuse allegation involving Residents #3, #4, and #5, the residents were outside smoking and got into a verbal altercation. They stated Resident #4 thought Resident #3 was calling them names. They stated Resident #3 started yelling at Resident #5. They stated Resident #4 approached Resident #3 and told them they were tired of the name calling. The administrator stated staff were present and immediately separated the residents. They stated the physician was notified and Resident #3 and #4 were put on 1:1 observations. On 05/28/25 at 12:29 p.m., the administrator stated they completed an initial reportable incident form and interviewed residents and staff. They stated assessments were completed and the records were reviewed. They stated senior psych services were contacted for an evaluation and medication review. They stated Residents #3, #4, and #5 showed no signs or symptoms of abuse or distress. The administrator stated Resident #3 was admitted for psych services. They stated Resident #3 remained on 1:1 until they were admitted and there were no other incidents. On 05/28/25 at 12:31 p.m., the administrator stated the residents did not want them to notify the local law enforcement. They were asked where that information was documented. The administrator stated, I need to review the records and get back with you. The administrator was asked to review the incident note, effective 02/28/25 at 9:50 p.m., and was asked if a resident stated they would set another resident on fire and shoot them in the head, if that was a time they would notify local law enforcement. The administrator stated they Would have to look at [their] notes. (continued on next page)

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	375582	A. Building B. Wing	06/02/2025

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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 - Few	On 05/28/25 at 2:02 p.m., LPN #2 stated at the time of the incident on 02/28/25, Resident #3 was very verbally aggressive with other residents and making threats. LPN #2 stated at the time of the incident, Resident #3 stated to Resident #5, I'll beat your [explicit] and burn you up. LPN #2 stated Resident #3 stated they would call a family member to kill Resident #5. They stated Resident #3 was placed on one on one and had additional incidents. LPN #2 stated on one incident Resident #3 pulled a knife on the former DON and the wound care nurse. They stated staff were able to get the knife away and sent the resident out for a psychiatric evaluation. LPN #2 stated Resident #3 had the knife hidden in their purse. On 05/28/25 at 2:07 p.m., LPN #1 stated on 02/28/25 Resident #3 was yelling at Resident #5 and Resident #4 was taking up for Resident #5. They stated the residents were separated and Resident #3 was in the former DONs office when the resident pulled out a knife and acted like they were going to stab the former DON. They stated the facility tried to get Resident #3 sent out for evaluation.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to update a residents care plan after abusive behaviors were observed for two (#3 and #4) of 5 sampled residents reviewed for abuse. The DON and the regional clinical director identified 51 residents resided in the facility. Findings: An abuse, neglect, and exploitation policy, dated 2025, read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Establish policies and procedures to investigate any such allegation .Revision of the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse .Whether an analysis was conducted as to why the situation occurred .Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors). A facility reported incident, dated 02/28/25, showed an allegation of abuse/mistreatment involving Resident #3, Resident #4, and Resident #5. The reported incident showed at approximately 6:00 p.m., the residents were outside smoking when an alleged altercation involving threats of physical harm occurred between residents. The reported incident showed Resident #3 made verbal threats of physical harm to Resident #5. Resident #4 became upset and allegedly made threats of physical harm to Resident #3. Residents #3 and #4 were immediately separated and placed on 1:1 for the protection of all residents. The reported incident showed residents were placed on 1:1 for the duration of the investigation. The reported incident showed care plans were updated as appropriate. The reported incident showed Resident #3 was sent out for a geri-psych evaluation and their care plan would be revised as needed upon return. The reported incident showed staff were re-educated on the signs and symptoms of abuse, and the policies and procedures for reporting abuse, neglect, and misappropriation. The final facility reported incident was faxed to OSDH on 03/05/25 at 3:50 p.m. There were no updates to Resident #3 or Resident #4's care plan regarding the above incident. 1. An admission resident assessment, dated 12/18/24, showed Resident #3's cognition was intact (BIMS 15). The assessment showed Resident #3 had diagnoses which included depression, anxiety disorder, and schizophrenia. A behavior note, dated 02/28/25 at 8:44 p.m., showed Resident #3 was being observed 1:1 by the previous DON due to an alleged incident of verbal threats of physical harm to another resident. While sitting in this nurse's office, Resident #3 went into their purse and retrieved a small 1 ½ inch knife. The previous DON asked Resident #3 for the knife and the resident refused. The previous DON then informed the resident that it was illegal to posses a knife on the property. Resident #3 then attempted to jab knife at this nurse while simultaneously handing the knife to the previous DON. (continued on next page)

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	375582	A. Building B. Wing	06/02/2025

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An incident note, effective 02/28/25 at 9:50 p.m., showed it was reported to LPN #2 Resident #3 was threatening another resident with bodily harm. They stated, ILL [SIC] WILL SET YOU ON FIRE AND HAVE SOMEONE SHOOT YOU IN THE HEAD. The note showed the resident was separated and placed on 1:1 until EMSA arrived. A behavior note, dated 03/01/25 at 8:47 p.m., showed Resident #3 continued to display verbal outbursts including yelling directed towards staff and other residents. A behavior note, dated 03/03/25 at 9:53 a.m., showed staff spoke with Resident #3 regarding their aggressive behaviors and them pulling a knife on the nurse. The resident admitted they did it and agreed to go to the hospital for treatment. Behavioral health hospital records, dated 03/03/25 through 03/14/25, showed Resident #3's presenting problem was they threatened a staff member with a knife. The records showed the reason for Resident #3's admission was they were a danger to others and had severe mood symptoms. The records showed key factors contributing to admission were increased aggression and violent behavior. Resident #3's care plan did not address the incident involving the knife or the threats made to other residents on 02/28/25. 2. A quarterly resident assessment, dated 01/25/25, showed Resident #4's cognition was intact (BIMS 13). The assessment showed Resident #4 had diagnoses which included hypertension, aphasia following cerebral infarction, parkinsonism, and history of traumatic brain injury. An incident note, effective 02/28/25 at 7:30 p.m., showed it was reported to LPN #1 Resident #4 verbally threatened another resident with bodily harm. The resident stated, I will kick your [explicit]. Resident #4 separated from other residents until they went to bed. A mental health provider note for Resident #4, dated 03/04/25, read in part, resident reportedly threatened another resident (per another resident) with bodily harm saying 'I will kick your [explicit]'. This was after [they] heard the resident threatening another resident with bodily harm including having someone shoot them. [Resident #4] reports today that [they] would never hurt a woman and [they] has no feeling of wanting to hurt anyone. What [they] was doing, [they] relates, was trying to get this [resident] to hit [them] to show that [they] is violent. [They] reports that this resident often verbally abuses one particular resident and [they] were tired of it.today reports [they] is 'over' the situation that prompted [their] 1:1, and that [they] never intended to hurt anyone and does not want to hurt anyone or end their life.[They] does voice understanding of [their] behaviors and that words have certain outcomes in a tightly ran facility that has to follow many guidelines per state.I do not see the need for 1:1 to continue at this time. The note was signed on 03/04/25 by PA #1. Resident #4's care plan did not address the threats made to other residents on 02/28/25. On 05/28/25 at 1:29 p.m., the administrator identified the DON as responsible for completing resident care plans. On 05/28/25 at 1:30 p.m., the DON stated the regional clinical coordinator had completed the residents' care plans. (continued on next page)

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	375582	A. Building B. Wing	06/02/2025

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/25 at 1:33 p.m., the DON stated the facility completed initial care plans upon admission. On 05/28/25 at 1:34 p.m., the DON stated they used activities of daily living, falls, nutrition, psychosocial, and medications to develop a resident's care plan. They stated if any area changed, they would go in and update the care plan. On 05/28/25 at 1:36 p.m., the DON stated the facility completed 24 hour reports every morning. They stated if a resident experienced a fall, they would update the care plan. They stated behaviors were huge when updating a care plan. They stated if psych medications changed or they had a change in their condition, they would update the care plan. The DON was asked where Resident #3 and #4's care plan were updated related to the above abuse allegation as documented in the facility reported incident. On 05/28/25 at 1:39 p.m., the administrator stated the above complaint report documented care plans would be updated If appropriate. On 05/28/25 at 1:41 p.m., the regional clinical coordinator stated they had never care planned allegations of abuse. They stated allegations of abuse were handled internally. They stated if a resident required a care in pairs, the care plan would reflect that. They stated they were not involved in the 02/28/25 allegation and were only peeling through the information. They stated it was not something they were aware of. On 05/28/25 at 1:44 p.m., the regional clinical coordinator stated they truly did not know how the knife incident involving Resident #3 was addressed in their care plan. They stated verbally aggressive behaviors was identified on 05/12/25. They stated they only saw psychotropic use for behavioral management.