STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375583	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parc Place Medical Resort	1400 East Memorial Road Oklahoma City, OK 73131

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. 46216 Based on record review and interview, the facility failed to ensure residents were free from physical abuse for two (#2 and #5) of three sampled residents reviewed for abuse. LPN #1 identified 59 residents resided in the facility. Findings: An undated Abuse, Neglect and Exploitation policy, 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. The policy also read, The facility has written policies and procedures that define how staff will communicate and coordinate situations of abuse. 1. Resident #2 had diagnoses which included anxiety disorder and depression. A MDS assessment, dated 01/05/24, documented the resident's cognition was intact with a BIMS score of 15. It documented the resident was always incontinent of bladder and required substantial/maximal assist of staff for toileting hygiene. An initial OSDH Incident Report, received at OSDH on 08/19/24 at 12:07 p.m., read in part, [Resident #2] reported that employee was rough with [them] during care. [CNA #3] suspended pending investigation. The incident report also read the physician, family, APS, law enforcement, and the Nurse Aide Registry were notified. On 08/20/24, the facility interviewed residents in regard to how staff treated residents. Resident #2 stated they could tell one of the aides was nervous because they did not want to be there. Resident #2 stated they had asked the aide to slowly pull them up or be careful. Resident #2 stated the aide stated they should be in a bubble. On 08/21/24, the facility interviewed staff regarding the incident. CNA #3 stated they did make the statement, Bless your heart, you need to live in a bubble. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A final OSDH Incident Report, received on 08/23/24 at 1:34 p.m., read in part, Interviews completed with resident and staff. Employee was anxious while learning on new unit, which then caused the resident to be anxious. 2. Resident #5 had diagnoses which included epileptic seizures, polyneuropathy, and muscle wasting and atrophy. A MDS assessment, dated 08/20/24, documented the resident's cognition was moderately impaired with a BIMS score of nine. It documented the resident was always incontinent of bladder and was dependent upon staff for toileting hygiene. An initial OSDH Incident Report Form, received at OSDH on 08/28/24 at 11:27 a.m., read in part, [CMA #1], reported that last night [they] was assisting [CNA #3] with care for [Resident #5] when [they] heard [CNA #3] make some comments to the resident in a harsh manner that [they] felt like were inappropriate. [CNA #3] was placed on suspension pending investigation. Investigation is ongoing. The incident report also read, the physician, family, APS, law enforcement, and Nurse Aide Registry were notified. On 08/28/24, Resident #5 was interviewed by the administrator. Resident #5 stated CNA #3 had come in their room with an attitude because it did not go the way CNA #3 wanted. Resident #5 stated CNA #3 wanted to roll them side to side to change them and they could not do that because of the stroke that left them with pain and deformities to their left side. Resident #5 stated CNA #3 stated, I am just going to see if I can get you kicked out of here. On 08/29/24, the facility interviewed other residents in regard to how they were treated by staff. (Resident name withheld) stated they rang their bell [CNA #3] told them I just changed you, we only check every 2 hours. (Resident name withheld) stated they were fearful to press their call light because of the aides attitude. A final OSDH Incident Report, received at OSDH on 08/30/24 at 3:33 p.m., read in part, Statements and interviews completed. Staff and resident interviews had similar stories with differences in wording. During the interviews an additional concern presented regarding [CNA #3] The report also read, [CNA #3] had presented with an attitude when [another resident] had used [their] call light to ask for assistance with have [their] brief changed, telling the resident that [they] had just done that. Brief was changed promptly, however resident no longer wanted interaction with [CNA #3]. [CNA #3] is no longer employed at [facility name withheld]. Abuse in-services were documented as completed on 09/24/24. On 11/27/24 at 9:45 a.m., CMA #1 stated the way CNA #3 treated Resident #5 was unprofessional and they spoke to them like a stranger on the street. On 11/27/24 at 9:47 a.m., CMA #1 stated they had in-services on abuse and how to treat residents. On 11/27/24 at 9:52 a.m., CMA #1 stated the policy on abuse was Don't do it, mental, physical, verbal, is not acceptable. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 11:21 a.m., CNA #4 stated the policy on abuse was Not tolerated, physical or emotional it was to be reported. On 11/27/24 at 12:28 p.m., the administrator stated CMA #1 had been assisting CNA #3 with care for Resident #5. The administrator stated CNA #3's demeanor and their language was unprofessional. The administrator stated during interviews another resident had stated CNA #3 spoke to them rudely as well. The administrator stated CNA #3 would have be termed, but they self dissolved their position between the initial and final reports. On 11/27/24 at 12:33 p.m., the administrator stated staff had been in-serviced after the incidents. On 11/27/24 at 12:34 p.m., the administrator stated state reportables were discussed at the monthly QAPI meeting to decrease/minimize the risk to residents. Also, monitoring was conducted through rounds and social service follow-ups. They stated if a concern were to arise the facility would pull a sample pool to question.