

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375583	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2025
NAME OF PROVIDER OR SUPPLIER Parc Place Medical Resort		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the State agency within two hours for 1 (#1) of 3 sampled residents reviewed for abuse. The DON identified 55 residents resided in the facility. Findings: The facility 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 .Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies .within specified timeframes . Immediately, but no more than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. A quarterly resident assessment, dated 06/04/25, showed Resident #1's cognition was intact (brief interview for mental status score of 15) and the resident did not experience delirium or behaviors. The assessment showed the resident had diagnoses which included mood disorder and acute myocardial infarction. A combined initial and final facility reported incident form, dated 07/15/25, showed Resident #1 made an allegation of abuse against CNA #1. Resident #1 reported when CNA #1 put them to bed and changed them, they looked in the direction of the resident's vagina where they had blisters between their legs and stated they would like to bust their cherry. The form was received by the State agency on 07/16/25 at 7:23 p.m. On 07/24/25 at 2:53 p.m., Resident #1 stated they had a concern regarding sex stuff. They stated the staff member was no longer on their floor. Resident #1 was asked if they could elaborate on what had occurred and they stated, Not really, it was taken care of. They stated the lady in charge, whose name they did not know, handled it and the male staff member was moved to a different floor. They stated they did not know the staff member's name. They stated it occurred about a month ago and they would not share what they remembered. On 07/25/25 at 10:11 a.m., CNA #2 stated they received training on abuse when they joined the facility. They stated they would report allegations of abuse to the nurse. They stated a week or so ago, they came to work in the morning and was informed Resident #1 had reported an allegation of abuse. CNA #2 stated they were assigned to care for Resident #1 and had asked CNA #1 to assist with transferring the resident on two occasions during the shift. They stated the allegation was against CNA #1, but CNA #1 was never alone with the resident and only assisted with the transfers. CNA #2 stated they did not observe any abusive behaviors between Resident #1 and CNA #1. On 07/25/25 at 10:17 a.m., CNA #1 stated on 07/15/25, there were three CNAs assigned to hall 300. They stated they were not assigned to care for Resident #1. They stated CNA #2 was assigned to care for Resident #1. They stated CNA #2 asked CNA #1 to assist with transferring Resident #1 two times during their shift. [NAME] stated they did not provide any personal care to the resident. They stated they were suspended on 07/15/25 when the allegation was made. CNA #1 stated they were permitted to come back to work after the investigation was complete, and no longer assists with the care of Resident #1. On 07/25/25 at 10:30 a.m., the activity director stated they had completed angel rounds (where department heads check on assigned residents) on 07/15/25. They stated while they were asking Resident #1 how everything was going, Resident #1 informed them of an allegation of abuse. They stated the resident was confused and unable to provide the name of the CNA, but was able to identify it was the CNA who took the resident to a previous doctor's appointment. The activity director stated Resident #1 reported the CNA told the resident they wanted to pop their cherry. The resident reported having blisters between their legs by their vagina and was not sure of the exact wording used. Resident #1 stated they told the CNA not to talk nasty to them. The activity director reported the allegation immediately to the DON who instructed them to write out a statement of what Resident #1 reported. The activity director stated they could not be sure of the exact time it was reported to them, but it was during the morning on 07/15/25. On 07/25/25 at 10:51 a.m., the DON stated the administrator was responsible for starting an immediate investigation when an allegation of abuse was made. They stated if it was against an employee, the employee would be suspended pending the investigation. On 07/25/25 at 10:54 a.m., the DON stated the initial report of abuse had to be sent to the State agency within two hours. The DON stated anytime an allegation of abuse was reported to them, they would immediately report it to the administrator. On 07/25/25 at 10:56 a.m., the DON stated they received a call on the way to work on 07/15/25 between 6:30 a.m. and 7:30 a.m. regarding an allegation of abuse involving Resident #1. On 07/25/25 at 10:58 a.m. the DON reviewed the combined initial and final facility reported incident involving</p>		